

Akademia WSB

Dąbrowa Górnicza, Cieszyń, Olkusz, Żywiec, Kraków

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**CONTINUING LIFE AFTER SUICIDE LOSS:
THE NECESSITY AND CHALLENGES OF POSTVENTION
FROM THE PERSPECTIVE OF BEREAVED FAMILIES AND
PROFESSIONALS**

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2026

SUPERVISOR’S STATEMENT ON THE DOCTORAL DISSERTATION

I declare that the dissertation entitled “Continuing life after suicide loss: The necessity and challenges of postvention from the perspective of bereaved families and professionals” by Elke Gerlach was prepared under my supervision and fulfills the requirements for submission in the doctoral procedure.

Date April 7, 2026

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DECLARATION

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1 Introduction

During the systematic examination of the topic, it became increasingly apparent that suicide cannot be perceived solely as an individual event, but also as an occurrence that impacts social, cultural, and institutional structures. The interviews conducted as part of this study showed how closely personal experiences in Lower Bavaria are linked to regional conditions. In addition to the immediate emotional consequences, those affected also described structural barriers that influenced their coping, such as limited access to professional services, a culture of reticence, a lack of transparency about responsibilities, and concerns about becoming the unwanted center of attention in small communities. These experiences are consistent with international findings that rural areas have specific risk constellations that increase social isolation and make access to psychosocial support more difficult. People without a supportive environment, therefore, face challenges, as they often lack both places of refuge and structured assistance.

Another dimension concerns the institutional processes that follow a suicide. In the first hours and days, bereaved relatives often encounter formal procedures such as police investigations, medical examinations, administrative requirements, and funeral arrangements. These processes take place during a period of intense emotional distress, yet they require rapid decision-making. This situation highlights the importance of coordinated early support and clear communication between institutions and bereaved families.

Professionals such as emergency services, counseling centers, schools, and pastoral care providers often become the first institutional contacts for bereaved families. Their role extends beyond organizational tasks to include communication, emotional stabilization, and coordination with other services. However, rural professionals frequently operate under structural constraints, including long travel distances, limited resources, and the absence of standardized postvention procedures.

Postvention is most effective when individual support services are embedded within coordinated regional care structures. Clear responsibilities, accessible information, and cooperation between institutions are essential for ensuring that bereaved individuals are not left to navigate support systems on their own.

This paper focuses on structural responsibility in dealing with suicide-related grief. It is not enough to be aware of the burdens on the bereaved. What matters is what consequences care systems draw from this. The conditions must be created so that those

affected are not left to fend for themselves. Postvention is a joint task for communities, specialist agencies, educational institutions, health services, and civil society actors. The documented voices make it clear how central sensitive, accessible, and reliable postvention is. If it is lacking, additional harm can occur.

This dissertation aims to systematically analyze the experiences of bereaved relatives after a suicide and the perspectives of professional actors in rural Lower Bavaria, and to derive structural requirements for needs-based and sustainable postvention. Both individual coping processes and institutional and regional framework conditions are considered.

1.1 Research objective and questions

Support following suicide in Lower Bavaria is often provided on an ad hoc basis and depends heavily on individual initiatives rather than coordinated institutional structures. This situation reflects a broader tension between the social invisibility of suicide-related grief and its significant consequences for families, communities, and professional support systems.

This study examines suicide bereavement and postvention in the rural region of Lower Bavaria, focusing on the interaction between the experiences of bereaved individuals and the institutional perspectives of professionals involved in postvention.

The study focuses on three central analytical dimensions:

- (1) the experiences of bereaved individuals in coping with suicide loss and navigating everyday life after the death,
- (2) the structural and institutional conditions under which professionals provide postvention support, and
- (3) the interaction between bereaved individuals and professional support systems, particularly at institutional and communicative interfaces.

These dimensions frame the empirical investigation and guide the research questions that structure the study.

The study is guided by the following research questions:

1. How do bereaved individuals in Lower Bavaria interpret and cope with the suicide loss of a close relative?
2. What social reactions, forms of recognition or non-recognition, and experiences of stigma shape their bereavement process?
3. What forms of formal and informal support are used, avoided, or experienced as helpful or unhelpful?
4. How do professionals describe their routines, responsibilities, and structural challenges in postvention practice?
5. Where do the experiences and needs of bereaved individuals converge with, or diverge from, the institutional logics and support structures described by professionals?

Together, these questions make it possible to examine suicide bereavement and postvention as interconnected processes that involve individual coping, social recognition, and institutional support structures. By integrating the perspectives of bereaved individuals and professionals within a shared analytical framework, the study seeks to illuminate how personal experiences of loss intersect with the organizational and structural conditions of postvention in a rural context.

From the perspective of the bereaved, communication, accessibility, and the suitability of available support are of central importance. Professionals, in contrast, often emphasize questions of role clarity, institutional embedding, and interprofessional coordination. The analytical value of the study lies particularly in the interface between these perspectives. It is at this intersection that it becomes visible whether institutional support structures correspond to the needs of bereaved individuals or whether structural asymmetries and gaps in care emerge.

In this sense, the study follows a conceptualization of postvention as a multidimensional process operating across individual, organizational, and societal levels (Finkeldei et al., 2023). Postvention is therefore not understood merely as a set of isolated support measures, but as a broader field of practice shaped by the interaction of personal experiences, professional practices, and regional institutional contexts.

Overall, the study contributes to making postvention visible as a complex and multidimensional field of action whose quality depends not only on individual

interventions but also on the interaction of regional structures, cultural norms, and professional competencies. The insights generated by this research are intended not only to contribute to scientific understanding but also to provide practical guidance for professionals and regional decision-makers involved in the development and coordination of postvention support.

1.2 Definition of key terms

This section defines the key concepts used in the study. Clear conceptual definitions are necessary to ensure consistency between the theoretical framework, the empirical analysis, and the interpretation of the findings.

In this study, suicide is defined as a deliberate self-initiated act resulting in death. This functional definition is used to maintain conceptual clarity and to avoid normative or moral interpretations of the phenomenon. Contemporary international guidelines emphasize the importance of precise and value-neutral terminology when discussing suicide, as historically the term has been associated with criminalization and moral judgement (World Health Organization, 2014; Oexle et al., 2022).

Recent research also shows that attitudes toward suicide and the language used to describe it can influence stigmatization, help-seeking behaviour, and the psychological burden experienced by affected individuals (Ross et al., 2024; Wyllie et al., 2025). At the same time, suicide is increasingly understood as a phenomenon embedded in complex relational and social contexts rather than as an isolated individual act. Studies therefore emphasize the interaction of psychological, social, and structural stressors that may accumulate over time (Levi-Belz et al., 2021; Kavanagh et al., 2023).

In this dissertation, postvention refers to the range of structured measures and support practices aimed at assisting individuals and communities after a suicide. These measures are intended to reduce acute distress, provide orientation in the immediate aftermath of the death, and support longer-term coping and adjustment among those affected.

Historically, the concept of postvention has been closely associated with support for people bereaved by suicide (Shneidman, 1976). Contemporary research, however, increasingly emphasizes the dual function of postvention: supporting survivors while also contributing to the prevention of further psychological crises and suicidal behaviour (Krysińska & Andriessen, 2022).

Recent studies further highlight that postvention is most effective when it is initiated early, coordinated across institutions, and adapted to the social and regional context in which suicide occurs (Hill et al., 2022; Andriessen et al., 2019; Clements et al., 2022). In this study, postvention is therefore understood as a multidimensional system of formal and informal support that operates at the intersection of individual coping processes, professional practices, and community responses.

In this study, the term bereaved refers to individuals who are emotionally, socially, or practically affected by the suicide of a person to whom they were closely connected. Contemporary bereavement research emphasizes that such connections are not limited to formal family relationships but may also include friends, colleagues, or other significant social ties (Doka, 2002; Radde, 2023).

Studies on suicide bereavement indicate that survivors often experience specific psychological and social challenges, including feelings of guilt, stigma, social withdrawal, and difficulties in negotiating social roles following the death (Marek & Oexle, 2024). In addition, research highlights that the social recognition of grief plays an important role in the adjustment process and that some bereaved individuals may experience forms of disenfranchised grief when their loss is not fully acknowledged by the surrounding social environment (Doka, 2002; Jakoby et al., 2013).

In this dissertation, the term professionals refer to individuals who are professionally involved in crisis response or postvention following a suicide. This includes psychosocial counselors, medical personnel, emergency services, police officers, pastoral care providers, educational professionals, and representatives of self-help or support organizations.

Research indicates that professionals involved in suicide-related interventions often face complex communicative, emotional, and organizational demands. In rural contexts, these challenges may be intensified by limited institutional resources, overlapping social roles, and increased social visibility within small communities (Kavanagh et al., 2023). Professional confidence and the ability to provide effective support therefore depend not only on individual competencies but also on institutional structures, cooperation between actors, and access to specialized training (Andriessen et al., 2022).

1.3 Significance and originality of the study

The significance of this dissertation lies in its examination of suicide bereavement and postvention within the specific social and institutional context of rural Lower Bavaria. While international research has extensively explored suicidal behaviour and bereavement processes, less attention has been given to how postvention is experienced and organized in rural regions, particularly within German-speaking contexts. By focusing on a regional setting and integrating the perspectives of bereaved individuals and professionals, this study seeks to contribute to a more context-sensitive understanding of postvention practices.

The study therefore treats the regional context not merely as a background variable but as a central analytical setting. Rural regions such as Lower Bavaria are characterized by lower densities of psychosocial services, strong informal networks, and limited anonymity. These characteristics influence both the experience of suicide bereavement and the organization of postvention support (Mayland et al., 2021; Gunnel et al., 2020).

The significance of the study, therefore, stems from its ability to reveal social and institutional dynamics that would otherwise remain hidden. While many international studies primarily examine urban or centralized care systems, the region of Lower Bavaria represents a unique research landscape in which problems arise differently, solutions look different, and social processes have different consequences.

A central contribution of this dissertation lies in the integration of two perspectives that are often studied separately: the experiences of bereaved individuals and the institutional perspectives of professionals involved in postvention. By analysing both perspectives within the same empirical framework, the study highlights how support processes emerge at the intersection of personal experiences, institutional practices, and regional conditions.

Another aspect of this dissertation's originality lies in the combination of empirical findings with an interdisciplinary theoretical framework. Recent work emphasizes that grief processes, especially after suicide, take place in social, cultural, and institutional fields and cannot be understood exclusively in psychological terms (Leaune et al., 2025; Tosini et al., 2022). The present study shows that the “social landscape of grief” takes different forms in rural regions than in urban contexts and that support processes are more relational and community-based.

The study's originality is also evident in its focus on institutional gray areas between acute crisis intervention and long-term support. Many institutions operate

without clearly defined post-traumatic strategies, which leads to significant gaps in care, especially in rural regions. International studies from Australia, Great Britain, and Canada also document a lack of coordination and unclear responsibilities in rural regions, which make continuous support difficult (Kavanagh et al., 2023; Radde, 2023).

Another contribution of the study lies in its examination of the relationship between formal and informal support structures in rural contexts. While informal networks such as families, neighbourhoods, and community organizations often provide important forms of support, they may also limit help-seeking due to social visibility and local norms surrounding suicide.

Finally, the study helps shed light on a social taboo. In many regions, suicides are kept secret for fear of stigmatization or social control. This silence leads to the isolation of the bereaved and prevents structural improvements. The dissertation shows that dealing with suicide-related grief has not only individual but also collective significance and provides insight into how communities deal with existential crises and what resources they mobilize.

Taken together, the study contributes to the field of suicide bereavement and postvention research in three ways. First, it provides an empirically grounded analysis of postvention practices within a rural regional context that has received limited attention in existing research. Second, it integrates the perspectives of bereaved individuals and professionals within a single analytical framework, thereby illuminating the interaction between personal experiences and institutional practices. Third, it highlights structural and organizational challenges in the provision of postvention support in rural areas and identifies potential implications for the development of more coordinated support systems.

1.4 Methodological and ethical considerations

The methodological design of this study reflects the complexity and sensitivity of suicide bereavement as a research topic. Given the vulnerability of the individuals involved and the sociocultural characteristics of the rural research context, a qualitative interpretative approach was chosen to explore subjective experiences and institutional perspectives in depth (Lajoie et al., 2020).

Semi-structured interviews proved to be a suitable method for gaining differentiated insights into the perceptions and experiences of bereaved relatives and professionals. This form of data collection enables targeted coverage of key topics while

leaving room for narrative, spontaneous, and personal accounts. The research objective was to identify patterns, structures of meaning, and discontinuities that standardized methods could not adequately capture. Current qualitative suicide research confirms that bereaved individuals and professional helpers provide more nuanced insights in open discussion formats than in highly structured interviews (Maple et al., 2010; Spillane et al., 2017). It is often emphasized, especially for people affected by suicide, that telling their story at their own pace, having the opportunity to pause, and avoiding interruptions are key prerequisites for a safe and trusting exchange. Open-ended interviews also make it possible to reveal individual and collective meanings, which in rural areas may be shaped by specific cultural rules and norms of discretion, and at the same time require a reflective, participation-oriented attitude on the part of the professional (Cvinar, 2005; Spillane et al., 2017).

Participants included bereaved individuals and professionals involved in postvention in the rural region of Lower Bavaria. The selection aimed to capture different perspectives on suicide bereavement and institutional support structures.

The goal was not statistical variance, but contextual diversity. The sample included first- and second-degree bereaved persons, as well as professionals from psychosocial counseling, emergency rescue, pastoral care, medical institutions, and local government settings.

The interviews were mainly conducted in person, supplemented by individual telephone interviews or, when time or distance barriers made travel difficult, by written correspondence. Recent work indicates that digital interviews with people affected by suicide pose specific challenges, such as the potential risk of unintended listeners, unstable internet connections, or the reduced ability to adequately perceive nonverbal cues (Vahedi et al., 2022). Systematic reviews of distance-based data collection emphasize that digital surveys with vulnerable groups pose special methodological and ethical requirements regarding security, consent processes, and crisis plans (Vahedi et al., 2022). For this reason, digital formats were used only if participants expressly preferred them.

Interviews were recorded with participants' consent, transcribed, and pseudonymized to ensure confidentiality. The empirical material was analysed using thematic analysis, combining deductive categories derived from the research questions with inductively developed themes emerging from the interview material.

The study in Lower Bavaria was characterized by special conditions, which are described in detail in Chapter 5 of this thesis and were incorporated into the methodological planning. These include a low density of specialized psychosocial services, sometimes unclear responsibilities between institutions, temporary positions and project logic, strong informal networks, social desirability, and discreet communication cultures.

These structures influence both the quality of the data and the possibilities for interpretation. For example, in rural areas, a high degree of social proximity can lead participants to break off conversations or avoid certain topics out of fear of being “recognized” or judged. To increase the reliability of the statements, recurring patterns were always given special attention when they occurred across interviews from different social contexts. Similarly, institutional statements were triangulated with structural data from the regional context analyses.

Given the participants' high vulnerability, ethical considerations were central to the research design. Informed consent was not understood as a one-time act but as a continuous process in which participants could at any time ask questions, express uncertainties, or withdraw from participation. Particular attention was paid to explaining possible risks such as emotional distress caused by memories, potential reactivation of grief reactions, and the occurrence of physical stress symptoms.

The study's protection concept was based on current recommendations for research with highly stressed groups (Allie et al., 2023; Leaune et al., 2025). It included preliminary screening to assess emotional stability, a clear crisis-intervention chain, the option to immediately interrupt the interview without giving a reason, the option to skip topics, the provision of regional support addresses after the interview, and a return to stabilizing conversation elements at the end of the interview.

Additionally, professionals were also regarded as a vulnerable group. As the literature reviewed in this dissertation clearly shows, professional helpers themselves often experience stress reactions following suicide-related interventions. They are frequently individuals who are repeatedly exposed to traumatic situations and, at the same time, have limited resources for self-care. Therefore, they were permitted to pause conversations, complete questionnaires in writing, omit certain topics, or speak anonymously about institutional challenges. Reflexivity played a central role in the research process. As a researcher with many years of social work experience in the field under investigation, I needed to continuously examine my own assumptions, implicit

attitudes, and institutionally influenced past experiences critically. This approach aimed to prevent professionally influenced patterns of interpretation from prematurely narrowing the scope of analysis. Reflection was a constant throughout the research process, involving both analytical decisions and addressing situational uncertainties and emotional reactions related to the empirical material. Furthermore, alternative methodological approaches and interpretations were continuously evaluated. Research on investigator subjectivity and the emotional demand of qualitative research indicates that such a reflexive stance is a key ethical safeguard when working with vulnerable groups.

A particular challenge was that social roles can quickly become intertwined in rural areas. The roles of researcher, potential supporter, and trusted person from previous professional contexts could become intertwined. To counteract this, rules for role differentiation were formulated. For example, interviews were avoided in settings where potential role conflicts could arise. In addition, it was clearly communicated in advance that the research was not part of a counseling or support process, but rather an independent scientific project.

The sensitivity of the data requires particularly strict data protection measures. In addition to pseudonymization, a multi-layered security system was implemented, including the separate storage of transcripts and identification lists, password-protected data carriers, no cloud storage, and access limited to the researcher. The procedure complies with current European data protection guidelines and considers current recommendations for research with people affected by suicide (Westerlund et al., 2020). Digital interviews were conducted exclusively via platforms that guarantee end-to-end encryption.

As is usual in qualitative designs, some limitations should be understood not as shortcomings but as indications of the structural conditions of the research field. The sample is not representative, and participation requires a certain willingness to disclose personal information. At the same time, it is well known in suicide research that willingness to participate voluntarily allows important conclusions to be drawn about the subjective relevance of the topic (Ligier et al., 2020). The regional limitation to Lower Bavaria restricts the transferability to urban areas, but precisely because of this, it allows a view of the specific care logic of rural areas.

Another limitation concerns the perspective of institutionalized professionals, who, due to their organizational affiliation, may be reluctant to discuss certain topics out of loyalty or concern about negative consequences. The interviews were therefore

designed so that professionals could also discuss structural challenges without their statements being traced back to individuals or institutions.

However, it is precisely these limitations that enable a significant gain in knowledge. They highlight the structural conditions under which aftercare can succeed or fail, the resources available in rural areas, and the need for political or organizational action. The scientific relevance thus lies not only in the presentation of individual experiences but also in the analysis of the framework conditions indispensable for the development of sustainable support structures.

Overall, the methodological approach of this study is characterized by its sensitivity to vulnerability, regionality, and relational processes. It combines analytical depth with strict ethical standards and responds to the specificities of the Lower Bavarian research context. It is precisely this methodological clarity that reveals the connections that are structurally significant for successful postvention and have received little attention in German-language research to date.

Against this methodological and contextual background, the following chapter reviews the existing literature on suicide bereavement and postvention to situate the present study within the current state of international research.

1.5 Structure of the dissertation

This dissertation is structured into eight chapters, each contributing to a comprehensive analysis of suicide bereavement and postvention in the rural context of Lower Bavaria. The structure follows a systematic progression from conceptual foundations through empirical investigation to discussion, implications, and conclusions.

Chapter 1 introduces the research topic and establishes the conceptual and empirical relevance of the study. It outlines the research problem, defines key terms, formulates the research objectives and questions, and highlights the significance and originality of the dissertation. The chapter also provides an initial overview of the methodological and ethical considerations that guide the study.

Chapter 2 presents a comprehensive review of the literature on suicide bereavement and postvention. It traces the development of research in this field, examines psychological and relational consequences of suicide loss, and discusses survivors as a vulnerable population. Furthermore, it analyses existing postvention approaches, barriers to accessing support, and the specific characteristics of rural contexts. The chapter concludes by identifying key research gaps addressed by the present study.

Chapter 3 outlines the theoretical framework of the dissertation. It integrates contemporary grief theories, trauma-informed perspectives, and sociocultural theories of stigma and recognition into a multidimensional analytical framework. These perspectives provide the conceptual basis for interpreting the empirical material and understanding suicide bereavement as a socially and relationally embedded process.

Chapter 4 describes the methodological design and implementation of the study. It explains the qualitative, interpretative research paradigm, the multiple case study design, and the abductive research logic. The chapter details participant selection, data collection methods, and the procedures of thematic analysis. Ethical considerations are addressed as a central component of the research process, reflecting the sensitivity of the topic and the vulnerability of the participants.

Chapter 5 situates the empirical investigation within the regional context of Lower Bavaria. It examines existing counseling and support structures, institutional responsibilities, and the specific challenges of postvention in rural areas. This contextual analysis provides an essential framework for interpreting the empirical findings.

Chapter 6 presents the empirical findings of the study. It analyses the experiences of bereaved individuals, including coping processes, social reactions, and encounters with support systems. In parallel, it examines professional perspectives on postvention, institutional practices, and structural challenges. The chapter identifies central themes, patterns, and tensions emerging from the data.

Chapter 7 discusses the findings in relation to the theoretical framework and the international state of research. It provides an integrated interpretation of the empirical results, highlighting convergences and divergences between bereaved individuals and professionals. The chapter also reflects on the implications of the findings for understanding postvention in rural contexts and identifies structural and practical challenges.

Chapter 8 concludes the dissertation by summarizing the main findings and contributions of the study. It outlines theoretical, empirical, and practical implications, discusses limitations, and formulates recommendations for future research and the development of postvention structures. The chapter closes with a final reflection on the relevance of the study for science, practice, and policy.

2 Literature Review

2.1 Development of Suicide Bereavement Research

Research on bereavement has experienced significant conceptual growth over the past few decades. Early approaches often viewed grief as a universal, linear process, frequently depicted through stage-based models such as Kübler-Ross's phase theory. However, current research increasingly highlights the diversity, individuality, and contextual factors involved in grieving processes. Studies in thanatology, psychotraumatology, and social psychology have shown that grief reactions vary widely depending on personal traits, relational dynamics, cultural background, and the circumstances surrounding death (Menzies et al., 2020; Stroebe & Schut, 2010; Wagner et al., 2022; Daniel, 2023). Consequently, grief is now understood more as a dynamic, non-linear process rather than a fixed sequence of stages.

Within this broader transformation of bereavement research, increasing attention has been given to losses that occur under particularly complex circumstances, including suicide. Studies have shown that the death of a family member or close relative by suicide often involves additional emotional, relational, and social challenges that distinguish it from many other forms of bereavement. In addition to the emotional pain associated with the loss itself, survivors frequently confront unanswered questions, disrupted narratives of meaning, and the need to renegotiate roles and relationships within the family system (Andriessen et al., 2019; Lenferink et al., 2020; Maddrell, 2020; McCarthy et al., 2023). These dynamics highlight that suicide bereavement cannot be fully understood as an individual psychological reaction but must be considered within the relational contexts in which grief unfolds.

Empirical studies further indicate that suicide bereavement may involve exposure to distressing circumstances surrounding the death, which can contribute to trauma-related reactions among survivors (De Leo, 2022; Titlestad, Stroebe & Dyregrov, 2020). In addition to trauma-related reactions, bereaved relatives often face complex emotional responses such as guilt, anger, shame, or persistent rumination about possible warning signs or missed opportunities for intervention (Levi-Belz & Ben-Yaish, 2022; Wagner, 2022; Wagner et al., 2021; Pitman et al., 2016).

Another distinctive feature of suicide bereavement concerns the social and relational environment in which grieving takes place. Research consistently shows that survivors may encounter subtle or overt forms of stigma, silence, or moral attribution

within their social surroundings. These reactions can complicate communication within families and communities and may contribute to social withdrawal or feelings of isolation (Jordan, 2017; Higgins et al., 2020; Toffol et al., 2022). Because grieving processes often unfold within family networks, such reactions can influence how loss is collectively processed, how family members support one another, and how communication about the death is negotiated over time.

Taken together, contemporary research increasingly conceptualizes suicide bereavement as a multidimensional phenomenon shaped by psychological, relational, and social processes. Rather than viewing grief solely as an internal emotional reaction, scholars emphasize the interaction between individual coping processes, family dynamics, and broader social responses to suicide. This shift has contributed to the growing recognition of suicide survivors as a distinct group within bereavement research and has stimulated empirical investigation into their specific needs, risks, and support structures (Lenferink et al., 2020; Andriessen et al., 2019; Levi-Belz & Ben-Yaish, 2022; Pitman et al., 2016).

2.2 Psychological and Relational Consequences of Suicide Loss

Empirical research indicates that bereavement following suicide is associated with a complex constellation of emotional, cognitive, and relational responses. In addition to common grief reactions such as sadness and emotional pain, survivors frequently report intensified feelings of guilt, anger, shame, and persistent rumination about the circumstances of the death. These reactions are often connected to attempts to reconstruct causal explanations, particularly recurring questions about why the suicide occurred and whether it could have been prevented (Menzies et al., 2020; Barboza et al., 2021; Eisma, 2020). Meaning-making therefore becomes a central element of the grieving process and shapes how survivors integrate the loss into their life narratives.

In many cases, suicide loss also involves elements of traumatic exposure. Survivors may encounter the death scene, receive distressing information about the circumstances of the death, or become involved in police and forensic procedures shortly after the event. Such experiences can intensify psychological stress and contribute to trauma-related reactions, including intrusive memories, heightened physiological arousal, or dissociative responses (De Leo, 2022; Titlestad, Stroebe & Dyregrov, 2020; Bell et al., 2022; Wallace et al., 2020). Suicide bereavement therefore often combines grief-related and trauma-related processes.

These psychological reactions frequently unfold within family and close social networks. Suicide may destabilize established roles, communication patterns, and expectations of mutual support. Some family members seek open discussion of the death, while others avoid the topic to protect themselves or others from additional distress.

Differences in coping strategies may therefore generate tensions within the family system and complicate collective grieving processes (Pitman et al., 2024; Maple et al., 2025; Bonsaksen et al., 2023).

Relational dynamics are also shaped by broader social environments. Survivors may encounter avoidance, discomfort, or implicit moral judgments from acquaintances, neighbors, or community members, which can restrict open communication about the loss and contribute to social withdrawal or isolation (Jordan, 2017; Higgins et al., 2020; Toffol et al., 2022; Pitman et al., 2024). In response, bereaved individuals may regulate what they disclose about the death, limiting access to informal support networks that are typically important during grieving.

Overall, research suggests that the consequences of suicide loss extend beyond individual emotional distress. Psychological reactions, trauma-related experiences, family dynamics, and social responses interact in shaping how grief unfolds over time. This interaction between personal coping processes and relational contexts has become a central focus of contemporary suicide bereavement research (Levi-Belz et al., 2023; McDonnell et al., 2022; Wainwright et al., 2020).

2.3 Suicide Survivors as a Vulnerable Population

A substantial body of research identifies individuals bereaved by suicide as a particularly vulnerable population within bereavement studies. Their vulnerability arises not only from individual grief reactions but also from the specific circumstances of the death, the relational consequences of the loss, and the social environment in which grieving occurs (Levi-Belz et al., 2023; Pitman et al., 2024; Goodall et al., 2022). These interacting factors create a risk constellation that distinguishes suicide bereavement from many other forms of loss.

One frequently discussed concept in this context is the “ripple effect.” Early conceptual work suggested that the impact of suicide extends beyond the deceased to affect a wider network of relatives, friends, and acquaintances. Subsequent empirical research confirms that close relatives of individuals who died by suicide show an increased risk of suicidal ideation, suicide attempts, and completed suicide compared to

the general population (Shneidman, 1976; McDonnell et al., 2022; Maple et al., 2025; Toffol et al., 2022; Liang et al., 2025; Andriessen et al., 2020). This elevated risk is associated with interacting processes such as traumatic exposure, disrupted meaning-making, stigma, and reduced access to stable support systems.

Research also documents higher prevalence rates of several mental health difficulties among suicide survivors, including depressive disorders, anxiety disorders, post-traumatic stress disorder, and prolonged grief disorder (Linde et al., 2017; Boelen & Lenferink, 2019; Eisma, 2020; Levi-Belz et al., 2023). These outcomes are often linked to the sudden and often traumatic nature of suicide as well as to ongoing cognitive efforts to understand the circumstances of the death.

Vulnerability is further shaped by relational and intergenerational dynamics. Suicide may disrupt family roles, communication patterns, and shared interpretations of the loss, which can affect how grief is negotiated within the family system (Pitman et al., 2024; Maple et al., 2025; Bonsaksen et al., 2023). Studies also indicate that children and adolescents exposed to suicide within their family environment may face increased risks of emotional distress, behavioral difficulties, and later suicidal behavior (Andriessen et al., 2022; Andriessen et al., 2020). These effects are generally understood as relationally and contextually mediated rather than as deterministic transmission.

2.4 Postvention and Support Structures

The recognition of suicide survivors as a vulnerable group has led to growing interest in postvention, a term referring to organized support provided to individuals bereaved by suicide. Early conceptualizations emphasized the ethical responsibility to assist bereaved relatives and the potential preventive function of such support in reducing further psychological harm or suicidality (Shneidman, 1976). More recent research has examined postvention empirically, focusing on how different forms of support influence coping processes, help-seeking behavior, and long-term psychosocial outcomes among survivors (Andriessen et al., 2022; Ramamurthy et al., 2025; Jackson, 2025).

One important area of research concerns early intervention following suicide. Proactive contact and structured support during the initial days or weeks after the death may facilitate engagement with longer-term support services. Programs that include immediate outreach, clear referral pathways, and follow-up contact are associated with higher service utilization and lower dropout rates compared to systems in which bereaved

individuals must seek help independently (Andriessen et al., 2017; Shea et al., 2021; Kapur et al., 2013; Hill et al., 2022; Maple et al., 2025).

Another research focus concerns the role of first responders and other professionals who encounter bereaved relatives shortly after suicide. Police officers, emergency medical personnel, and crisis intervention teams often represent the first institutional contact for family members and may shape later perceptions of professional support. Studies show that respectful communication, transparent explanations of procedures, and structured guidance toward available resources increase trust in support systems and the likelihood of later help-seeking (Brown et al., 2022; Bennett et al., 2022; Hawgood et al., 2023). Conversely, insensitive communication or unclear institutional procedures may discourage further contact with professional services.

In addition to professional interventions, peer-based support has become an important component of postvention. Survivor support groups provide opportunities to share experiences with others who have faced similar losses and are associated with reduced feelings of isolation, lower perceived stigma, and increased opportunities for emotional expression and meaning-making (Jordan, 2017; Levi-Belz & Feigelman, 2022; Andriessen et al., 2020). Such settings may also facilitate normalization processes and identity reconstruction by creating social spaces in which suicide-related grief can be openly discussed (Larsen, Guldborg & Kring, 2021; Kalsås et al., 2023).

Recent studies have also examined coordinated, multi-level postvention systems that combine crisis response, short-term counseling, and longer-term psychosocial support within structured networks involving healthcare providers, counseling centers, and community organizations. Evaluations indicate that such systems improve continuity of care and increase the likelihood that survivors remain connected to support services over time (Kölves et al., 2020; Sax Institute, 2024; Ramamurthy et al., 2025; Niederkrotenthaler et al., 2025; Toffol et al., 2022). Postvention is therefore increasingly conceptualized not as isolated interventions but as coordinated systems of professional, community-based, and peer-led responses to suicide loss.

2.5 Barriers to Accessing Support

Despite increasing recognition of the needs of suicide survivors and the development of postvention programs, empirical studies show that many bereaved individuals do not access professional support services. Research identifies several structural, social, and contextual barriers that limit the utilization and continuity of

postvention care (McDonnell et al., 2022; Nicholls et al., 2024). These barriers operate at multiple levels, including institutional structures, social environments, and individual help-seeking processes.

A frequently documented structural barrier is the limited availability of specialized services and long waiting times for professional support. In many healthcare systems, access to psychotherapy or specialized grief counseling can involve delays of several months. For individuals experiencing acute distress, trauma-related symptoms, or suicidal ideation after a suicide, such delays may reduce the likelihood of engagement with professional support (Hill et al., 2022). Motivation to seek help is often highest shortly after the loss, meaning that limited service availability during this period may result in missed opportunities for early intervention (Shea et al., 2021).

Stigma represents another important barrier. Survivors frequently report concerns about being judged, blamed, or socially marked because of their association with suicide. Anticipated stigma and internalized shame may discourage individuals from seeking counseling or discussing the death openly with professionals or community members (Levi-Belz & Gilo, 2020; Jahan et al., 2023). Such perceptions are associated with reduced help-seeking and greater reliance on private coping strategies within families or immediate social networks (Toffol et al., 2022; Evans & Abrahamson, 2020; Mayer et al., 2020).

Institutional fragmentation can further complicate access to support. Responsibilities for postvention are often distributed across multiple organizations, including healthcare providers, counseling centers, emergency services, and community institutions. When coordination mechanisms are weak or referral pathways are unclear, survivors may struggle to navigate available services or receive inconsistent information about support options (Niederkrötenhaler et al., 2025; Toffol et al., 2022; Maple et al., 2025).

Socioeconomic and administrative pressures may also limit help-seeking. Bereaved families often face financial strain, employment demands, or bureaucratic procedures related to insurance, legal investigations, or administrative obligations following the death. These secondary stressors can consume time and emotional resources, making it more difficult to engage with psychosocial support during an already demanding period (Adshead & Runacres, 2024).

Taken together, these findings indicate that barriers to postvention are often cumulative and arise from the interaction of structural limitations, stigma-related dynamics, and practical challenges faced by bereaved families.

2.6 Suicide Bereavement in Rural Contexts

Recent research increasingly emphasizes that suicide bereavement must be understood within the regional and sociocultural contexts in which it occurs. Rural environments are not merely geographic locations but social spaces shaped by interaction patterns, institutional structures, and cultural norms. These conditions influence both grieving processes and the availability of support services for those bereaved by suicide (Kaspersen et al., 2022). Consequently, rurality has become an important analytical category in studies examining how social environments shape bereavement experiences.

One frequently described feature of rural communities is the high level of social visibility within local networks. In smaller communities, personal relationships often overlap across family, work, and community life, creating both opportunities for support and challenges to privacy. While close social ties may facilitate informal assistance after a loss, survivors may also feel exposed to observation or speculation following a suicide (Maddrell, 2020). This heightened visibility can influence how openly families speak about the death and may lead some bereaved individuals to withdraw from community life.

Limited anonymity represents a related challenge affecting help-seeking behavior in rural areas. Attending counseling services, psychotherapy practices, or support groups may be perceived as more visible in small communities than in urban settings. Concerns about confidentiality or potential social judgment can therefore discourage individuals from accessing professional services even when they are available (Gehrmann et al., 2020). As a result, survivors in rural contexts often rely more heavily on informal support networks within families or close social circles (Kalsås et al., 2023; Graves et al., 2020).

Structural characteristics of rural regions may further restrict access to postvention services. Studies from several European contexts document lower densities of specialized mental health providers, greater travel distances to counseling centers, and limited public transportation infrastructure in rural areas (Toffol et al., 2022). These conditions can delay or prevent engagement with professional support, particularly for individuals already experiencing emotional and practical burdens after the loss.

Overall, existing studies indicate that suicide bereavement in rural contexts is shaped by the interaction between social visibility, limited anonymity, and structural characteristics of local service systems. These factors influence both the availability of professional support and the ways in which families and communities respond to suicide (Kaspersen et al., 2022; Maddrell, 2020).

2.7 Research Gaps and Relevance of the Present Study

Despite the considerable growth of research on suicide bereavement in recent decades, several gaps remain in the empirical literature. Many studies have focused primarily on psychological outcomes such as depression, post-traumatic stress symptoms, or prolonged grief disorder. While this work has generated valuable knowledge about the mental health risks associated with suicide loss, it has often concentrated on individual symptom patterns rather than on the relational and social contexts in which bereavement unfolds (Levi-Belz et al., 2023; Eisma, 2020). As a result, the ways in which bereavement processes are shaped by family relationships, social environments, and institutional support structures remain comparatively underexplored.

A further limitation concerns the methodological orientation of much existing research. Quantitative approaches dominate the field and have provided important information about prevalence rates and risk factors associated with suicide bereavement. However, such approaches capture symptom patterns more effectively than the lived experiences through which bereaved individuals interpret, negotiate, and adapt to the loss over time (Levi-Belz et al., 2023; McDonnell et al., 2022). Qualitative studies exploring these processes in depth remain comparatively limited, particularly with regard to how survivors experience postvention support within specific social and institutional contexts.

Another gap concerns the separation between studies focusing on survivors and those examining professional or institutional perspectives. Research on bereaved individuals has largely explored emotional reactions, coping strategies, and peer support experiences, whereas implementation studies have focused on service organization, institutional practices, or professional training (Nicholls et al., 2024; Maple et al., 2025). Studies that systematically integrate the perspectives of both bereaved individuals and professionals within a single analytical framework remain comparatively rare, even though postvention practices emerge precisely at the intersection of these perspectives.

Contextual variation also remains insufficiently explored. Although some studies address differences in mental health service availability between rural and urban areas,

regional contexts are often treated as background variables rather than as central analytical settings. Yet research suggests that characteristics such as social visibility, limited anonymity, and structural undersupply of specialized services may significantly shape bereavement experiences and help-seeking trajectories (Kaspersen et al., 2022).

Against this background, the present study addresses these gaps by examining suicide bereavement from a multi-perspective and context-sensitive perspective. By integrating the experiences of bereaved individuals with the perspectives of professionals involved in postvention within a rural region, the study explores how psychological reactions, family dynamics, and institutional support structures intersect in shaping post-suicide support processes. In doing so, it contributes to a more integrated understanding of postvention practices and the challenges of supporting suicide survivors in rural contexts.

2.8 Summary of the Literature Review

The literature reviewed in this chapter demonstrates that suicide bereavement represents a particularly complex form of loss that differs in several important respects from many other bereavement contexts. Studies consistently indicate that survivors often experience a combination of grief-related distress, trauma-related reactions, and persistent efforts to understand the circumstances of the death (Menzies et al., 2020; Barboza et al., 2021; Eisma, 2020; De Leo, 2022; Titlestad, Stroebe & Dyregrov, 2020).

Research further highlights that the consequences of suicide loss extend beyond individual psychological reactions. Grieving frequently unfolds within relational environments shaped by family dynamics, social interactions, and broader community responses. Communication patterns within families, differing coping strategies, and social reactions such as stigma or avoidance may significantly influence how survivors process the loss and whether they seek support (Pitman et al., 2024; Maple et al., 2025; Bonsaksen et al., 2023; Jordan, 2017; Higgins et al., 2020; Toffol et al., 2022).

Empirical studies also identify suicide survivors as a population exposed to elevated risks of psychological distress, including depression, post-traumatic stress symptoms, prolonged grief disorder, and increased suicidality (Linde et al., 2017; Boelen & Lenferink, 2019; Eisma, 2020; Levi-Belz et al., 2023; McDonnell et al., 2022). In response, growing attention has been directed toward postvention as a field of research and practice aimed at supporting survivors and mitigating the longer-term consequences of suicide loss (Andriessen et al., 2022; Ramamurthy et al., 2025; Jackson, 2025).

At the same time, the literature indicates that access to postvention services is often shaped by structural and social barriers. Limited service availability, long waiting times, fragmented institutional coordination, and stigma-related dynamics may restrict help-seeking and lead some survivors to rely primarily on informal support networks (Hill et al., 2022; Levi-Belz & Gilo, 2020; Jahan et al., 2023; Toffol et al., 2022; Evans & Abrahamson, 2020; Mayer et al., 2020).

Regional and sociocultural contexts further influence bereavement experiences and access to support. In rural environments, factors such as high social visibility, limited anonymity, and reduced availability of specialized services may shape how families and communities respond to suicide and how survivors navigate grief and help-seeking pathways (Kaspersen et al., 2022; Maddrell, 2020; Gehrmann et al., 2020; Kalsås et al., 2023; Graves et al., 2020).

Taken together, existing research indicates that suicide bereavement involves interacting psychological, relational, and sociocultural processes that unfold across multiple levels, including individual coping, family relationships, institutional encounters, and community dynamics. While empirical studies have documented many of these dimensions, their interaction remains difficult to interpret within purely descriptive frameworks.

To address this challenge, the present study draws on a set of complementary theoretical perspectives that enable the systematic interpretation of these interrelated processes. Contemporary grief theories provide a framework for understanding coping and adaptation after loss, trauma-informed perspectives illuminate vulnerability and stabilization in the aftermath of sudden and distressing events, and sociocultural theories of stigma and recognition help explain how social norms and patterns of visibility shape the experience of suicide bereavement. The following chapter therefore outlines the theoretical framework that guides the interpretation of the empirical material.

3 Theoretical Framework

3.1 Positioning the Theoretical Lens

The empirical material of this study consists of subjective accounts and professional reflections that are contextually embedded and interpretive in nature. To move beyond descriptive reconstruction toward systematic interpretation, the study therefore employs a theoretical lens as an analytical instrument that structures perception, sensitizes coding, and supports cross-case comparison (Flick, 2018; Braun & Clarke, 2022).

This approach is particularly relevant in the context of suicide bereavement. Suicide is not only an individual loss event but also a relational and socially embedded occurrence that may disrupt biographies, family dynamics, and community relations. Bereaved individuals often describe emotional pain alongside experiences of stigma, role destabilization, and tensions within family or institutional environments. Interpreting these multi-layered dynamics therefore requires conceptual tools capable of capturing psychological processes, relational shifts, and sociocultural contexts simultaneously.

The present study adopts a multidimensional theoretical perspective that integrates contemporary grief theory, trauma-informed principles, and sociocultural concepts of stigma and recognition. These perspectives function as sensitizing concepts that guide the thematic analysis and support cross-case comparison (Braun & Clarke, 2022). Contemporary grief theories provide a process-oriented understanding of coping and adjustment (Stroebe & Schut, 2010; Worden, 2009), trauma-informed perspectives introduce sensitivity to stabilization and vulnerability in highly stressful situations, and sociocultural theories illuminate how grief is shaped by social norms, moral attributions, and patterns of visibility (Doka, 2002; Goffman, 1967).

Explicitly positioning this theoretical lens enhances analytical transparency by clarifying the conceptual assumptions guiding the interpretation of the empirical material. Rather than claiming theoretical neutrality, the study acknowledges that qualitative interpretation is always conceptually situated and informed by analytical perspectives (Flick, 2018). Within this framework, theory functions as an interpretive matrix that enables the integration of individual narratives, professional perspectives, and contextual conditions into a coherent analytical perspective.

3.2 Contemporary Grief Theories

This section outlines the two central grief models that guide the analytical reading of the empirical material. The aim is not to review prevalence findings or intervention effects, but to specify the conceptual logic through which bereavement experiences and professional practices can be interpreted.

Contemporary grief research has moved away from linear, phase-based assumptions and instead emphasizes variability, oscillation, and contextual embeddedness in coping processes (Stroebe & Schut, 2010; Worden, 2009). For the present study, the Dual Process Model (DPM) provides a process-oriented perspective on coping dynamics, while Worden's task model offers a structured heuristic for identifying key domains of adjustment.

The Dual Process Model conceptualizes grieving as a dynamic regulatory process characterized by oscillation between two orientations: loss-oriented coping and restoration-oriented coping (Stroebe & Schut, 2010). Loss-oriented coping refers to engagement with the emotional and relational consequences of the death, including confrontation with grief, yearning, guilt, or questions of meaning. Restoration-oriented coping concerns adaptation to life after the loss, such as reorganizing everyday routines, assuming new roles, and adjusting social relationships.

A central contribution of the DPM is its understanding of oscillation as an adaptive process. Rather than assuming a linear progression through stages, the model highlights the movement between confrontation with the loss and temporary engagement with everyday life. From an analytical perspective, this framework enables the interpretation of interview material in terms of flexibility and regulation in coping processes, as well as the contextual conditions that may facilitate or constrain such movement.

While the DPM captures coping dynamics, Worden's task model provides a complementary structure for interpreting domains of adjustment. Worden conceptualizes grieving as involving four central tasks: accepting the reality of the loss, processing the pain of grief, adjusting to a world without the deceased, and developing an enduring connection with the deceased while continuing life (Worden, 2009). These tasks are not understood as linear stages but as domains that may be revisited and negotiated over time.

Analytically, the task framework helps identify which adjustment domains are foregrounded or challenged within interview narratives and professional accounts. It supports the interpretation of emotional processing, identity and role reconfiguration, and

the development of continuing bonds without imposing normative assumptions about “successful” grieving.

Viewed collectively, the Dual Process Model and Worden’s task framework provide complementary conceptual tools. The DPM captures the movement and regulation of coping processes, whereas Worden’s model highlights key domains of adjustment. Using both models allows the empirical material to be interpreted in a way that acknowledges variability and contextual influence while maintaining a clear analytical structure for comparing cases and perspectives.

3.3 Trauma-Informed Care as Analytical Framework

Trauma-informed care is integrated into the present study not as a clinical intervention model but as an analytical framework for interpreting interactions, support experiences, and institutional responses in the context of suicide bereavement. Suicide often involves suddenness, shock, intrusive imagery, police presence, forensic procedures, and abrupt disruption of everyday life, all of which may increase vulnerability to traumatic stress reactions (O’Connor, 2019; Shear, 2015). A trauma-informed perspective therefore sensitizes the analysis to how institutional encounters and support structures either stabilize or inadvertently intensify distress.

Conceptually, trauma-informed approaches are grounded in a set of principles designed to reduce the risk of retraumatization and strengthen perceived stability and control. Widely cited frameworks emphasize safety, transparency, empowerment, and autonomy as central pillars. In this study, these principles function as interpretive categories for examining both bereaved individuals’ experiences and professionals’ practices.

Safety refers to the creation of emotional and relational conditions in which affected persons feel protected from further harm. In the aftermath of suicide, this includes predictable communication, emotional containment, and the avoidance of overwhelming confrontation with distressing stimuli (Shear, 2015).

Transparency concerns clarity and consistency in communication and institutional procedures. Bereaved individuals are often confronted with unfamiliar bureaucratic or investigative processes, and unclear information channels may increase anxiety and mistrust (Toffol et al., 2022).

Empowerment refers to strengthening perceived agency and coping capacities in situations characterized by helplessness and loss of control. Analytically, this principle

draws attention to whether survivors are positioned as passive recipients of support or as participants in shaping their support trajectory (O'Connor, 2019).

Closely related is the principle of autonomy, which emphasizes respect for individual coping rhythms and freedom of choice. Bereaved individuals frequently oscillate between withdrawal and engagement; trauma-informed approaches therefore highlight the importance of allowing individualized coping pathways rather than imposing normative expectations about how grief should unfold.

Taken together, these principles form a trauma-sensitive interpretive matrix that allows the empirical material to be examined in terms of stabilization versus destabilization, control versus loss of control, and recognition versus marginalization. In this dissertation, trauma-informed perspectives complement grief-theoretical and sociocultural approaches by adding sensitivity to the institutional and relational conditions that shape vulnerability after suicide loss.

3.4 Sociocultural Theories of Stigma and Recognition

Suicide bereavement is shaped not only by psychological reactions to loss but also by social meanings, moral attributions, and culturally embedded norms. Sociocultural perspectives are therefore essential for understanding why bereaved individuals often describe experiences of social unease, distancing, silence, or self-censorship alongside grief. These approaches emphasize that grief is socially mediated: whether and how it can be expressed depends on recognition, legitimacy, and interpretive frameworks available within a community (Goffman, 1967; Doka, 2002).

Within this perspective, suicide-related grief can be understood as a relational phenomenon negotiated in social interaction. Bereaved individuals grieve within social environments that implicitly define what can be expressed, what must remain private, and how mourning is socially interpreted. Two concepts are particularly relevant for the analytical framework of this study: Goffman's theory of stigma, including the notion of "spoiled identity," and Doka's concept of disenfranchised grief.

Goffman conceptualizes stigma as a socially produced process in which certain attributes or associations become discrediting and reduce a person's social status (Goffman, 1967). Stigma emerges through interactional norms that define what is considered normal and what is perceived as deviation. The concept of "spoiled identity" describes how individuals who anticipate or experience stigmatization may engage in

strategies of impression management, such as limiting disclosures, controlling information, or withdrawing from social situations.

Applied to suicide bereavement, stigma may arise through moral interpretations of suicide, assumptions about responsibility, or cultural narratives surrounding family failure. Survivors may therefore experience a sense of being socially marked by association with the death, which can influence self-perception, social participation, and communication about the loss.

Doka's concept of disenfranchised grief focuses on the social legitimacy of mourning. He defines disenfranchised grief as grief that is not openly acknowledged, socially validated, or publicly supported (Doka, 2002). In such cases, individuals may experience profound loss while simultaneously encountering silence, avoidance, or subtle distancing within their social environment.

This concept is particularly relevant in the context of suicide, where cultural norms and moral uncertainty may complicate collective responses to the death. Bereaved individuals may therefore experience their grief as socially restricted or insufficiently recognized, even in the absence of explicit rejection.

Analytically, the concept of disenfranchised grief helps interpret how social reactions shape the communicative space of mourning. It draws attention to processes of withdrawal, self-censorship, and isolation, while also explaining why peer-support environments are often experienced as spaces of renewed recognition and belonging.

Overall, Goffman's theory of stigma and Doka's concept of disenfranchised grief provide a sociocultural framework for interpreting suicide bereavement. They enable the analysis to link individual experiences of grief and identity disruption with broader social mechanisms of recognition, moral attribution, and belonging (Goffman, 1967; Doka, 2002).

3.5 Suicide Bereavement as Multidimensional Vulnerability Context

The preceding sections have introduced grief-theoretical, trauma-informed, and sociocultural perspectives as complementary analytical lenses. Together, they conceptualize suicide bereavement not as a singular psychological reaction but as a multidimensional vulnerability context shaped by the interaction of emotional, relational, identity-related, and social processes (Stroebe & Schut, 2010; Worden, 2009).

From this perspective, suicide bereavement emerges at the intersection of psychological coping dynamics, trauma-related vulnerability, and sociocultural recognition structures. Contemporary grief theories emphasize oscillation and adjustment processes in coping with loss (Stroebe & Schut, 2010; Worden, 2009), trauma-informed perspectives highlight the role of safety, predictability, and perceived control after highly distressing events (Im & Swan, 2020), and sociocultural approaches underline how stigma, legitimacy, and moral interpretations shape communication, identity, and help-seeking processes (Goffman, 1967; Doka, 2002; Evans & Abrahamson, 2020). Understanding suicide bereavement therefore requires attention to the interaction between individual coping processes, relational dynamics, and sociocultural environments.

This multidimensional conceptualization avoids reductionist interpretations. Rather than framing survivors exclusively in intrapsychic terms or solely through structural explanations, vulnerability is treated as relationally constituted and contextually situated, emerging through the interaction of coping processes, trauma-related dynamics, and recognition structures (Stroebe & Schut, 2010; Doka, 2002).

For the analytical strategy of this study, this synthesis provides a coherent interpretive matrix. It enables the empirical material to be examined across multiple levels: (1) as dynamic grief processes characterized by oscillation and task-related adjustments (Stroebe & Schut, 2010; Worden, 2009), (2) as experiences shaped by safety, transparency, autonomy, and the management of destabilization (Im & Swan, 2020), and (3) as socially embedded negotiations of stigma, legitimacy, and identity under culturally patterned conditions (Goffman, 1967; Doka, 2002; Evans & Abrahamson, 2020). Conceptualizing suicide bereavement as a multidimensional vulnerability context therefore creates a bridge between theoretical positioning and empirical interpretation (Jordan, 2017; Pitman et al., 2024; Levi-Belz et al., 2023).

3.6 Analytical Implications for the Present Study

The present study draws on an integrated theoretical lens to guide the interpretation of interview material and structure the analysis across cases and perspectives. Rather than applying theory as a rigid explanatory template, the framework functions as an analytical orientation that helps identify patterns in survivors' and professionals' accounts and makes interpretive decisions transparent. Four conceptual strands guide the analysis: the Dual Process Model (DPM), Worden's task model,

sociocultural stigma and recognition theories, and trauma-informed care principles (Stroebe & Schut, 2010; Worden, 2009; Goffman, 1967; Doka, 2002).

First, the Dual Process Model provides the core framework for identifying oscillation in survivors' narratives. In the interview material, the DPM is used to examine how bereaved individuals describe movement between loss-oriented confrontation (e.g., intrusive thoughts about the death, guilt, "why" questions, emotional pain) and restoration-oriented coping (e.g., managing daily responsibilities, reorganizing roles, returning to routines). This lens enables the interpretation of shifts, interruptions, and possible rigidities in coping processes without assuming a linear trajectory (Stroebe & Schut, 2010). In the context of suicide loss, it helps interpret how survivors describe alternating needs for proximity to and distance from the loss and how these movements relate to their social environment (Jordan, 2017; Murphy, 2022).

Second, Worden's task model functions as a heuristic framework for identifying domains of adjustment described in the narratives. The analysis attends to how interviewees describe challenges related to acknowledging the loss, processing emotional pain, adapting to changed roles or life circumstances, and maintaining an enduring connection with the deceased while continuing life (Worden, 2009). Rather than treating these tasks as normative stages, the framework helps identify areas of strain, interruption, or ongoing negotiation within individual and relational contexts.

Third, stigma and recognition theories provide a lens for interpreting social reactions and their implications for grief, identity, and help-seeking. The analysis therefore attends to narratives describing silence, distancing, moral attributions, or perceived scrutiny in social environments. Goffman's concept of spoiled identity helps interpret experiences of altered social status following suicide loss (Goffman, 1967), while Doka's concept of disenfranchised grief highlights situations in which grief is experienced as socially delegitimized or insufficiently recognized (Doka, 2002). These concepts are particularly relevant given empirical findings that identify stigma and lack of recognition as key contextual burdens in suicide bereavement (Pitman et al., 2024; Toffol et al., 2022; Evans & Abrahamson, 2020; Levi-Belz et al., 2023).

Fourth, trauma-informed principles inform the interpretation of institutional encounters and professional perspectives. Core dimensions such as safety, transparency, autonomy, collaboration, and empowerment are used to examine how survivors describe interactions with support systems and how professionals narrate their practices in post-suicide contexts (Im & Swan, 2020). This perspective allows the analysis to assess

whether institutional processes are experienced as stabilizing or destabilizing in the aftermath of suicide (Cerel et al., 2018; Brown et al., 2022; Bennett et al., 2022; Hawgood et al., 2023).

Collectively, these four strands connect the conceptual framework to the empirical analysis by linking (a) dynamic grief movements, (b) task-related adjustment challenges, (c) sociocultural processes of recognition and stigma, and (d) trauma-sensitive interpretations of institutional encounters. This integrated lens clarifies how the study interprets survivors' narratives and professionals' accounts while maintaining openness to emergent themes within the qualitative material (Jordan, 2017; Pitman et al., 2024; Levi-Belz et al., 2023).

3.7 Concluding Synthesis

This chapter has outlined the theoretical framework that guides the analytical approach of the present study. Rather than providing a descriptive overview of theories, the framework functions as an interpretive matrix that structures how the empirical material is read, compared, and understood. By integrating contemporary grief theory, trauma-informed perspectives, and sociocultural theories of stigma and recognition, the framework enables a multidimensional interpretation of suicide bereavement as a relationally and socially embedded phenomenon.

Within this perspective, suicide bereavement is conceptualized as a multidimensional vulnerability context in which psychological coping processes, trauma-related dynamics, identity negotiations, and sociocultural recognition structures intersect. These dimensions interact rather than operate independently. Oscillation in coping processes may be constrained by stigma or limited communicative spaces, trauma-related destabilization may intensify sensitivity to social reactions and institutional encounters, and identity disruptions may be reinforced through experiences of delegitimization or moral attribution within social environments (Stroebe & Schut, 2010; Worden, 2009; Goffman, 1967; Doka, 2002).

The integrated framework therefore provides conceptual coherence between theoretical positioning and empirical inquiry. It clarifies that the analysis attends simultaneously to individual coping dynamics, relational interactions, and sociocultural contexts. In this way, the framework does not predetermine findings but sensitizes the interpretation to patterns of movement, disruption, recognition, and stabilization across

survivors' narratives and professionals' accounts (Jordan, 2017; Pitman et al., 2024; Levi-Belz et al., 2023; Evans & Abrahamson, 2020).

By establishing this theoretical orientation, the chapter creates a bridge between abstract conceptual perspectives and the empirical investigation that follows. Building on this foundation, the next chapter outlines the methodological approach used to examine suicide bereavement and postvention experiences within the study's research context.

4 Research methodology

4.1 Summary and structure of the chapter

This chapter outlines the methodological framework used to investigate suicide bereavement and postvention in rural Lower Bavaria. The research is situated within a qualitative interpretative paradigm, which assumes that experiences of suicide loss and postvention practices are socially and contextually embedded phenomena rather than purely individual events. Such processes are shaped by cultural norms, institutional structures, and social relationships, making qualitative inquiry particularly suitable for examining the meanings and experiences associated with suicide bereavement (Andriessen et al., 2019; Feigelman et al., 2020; Maple et al., 2025; Boydell et al., 2023; Segev et al., 2020).

To address the research questions developed in the previous chapters, the study employs a qualitative multiple case study design (Yin, 2018). This approach allows the reconstruction of subjective experiences and professional perspectives while enabling comparisons across cases. Multiple case studies are particularly appropriate for complex and under-researched social phenomena because they support the identification of recurring patterns without aiming for statistical representativeness (Stake, 2006; Eisenhardt, 1989; Flick, 2018; Sastry et al., 2020).

The empirical material consists of interviews with two participant groups: individuals bereaved by suicide and professionals involved in postvention and crisis response. Participants were selected using criteria-based sampling in order to capture diverse perspectives on suicide bereavement and institutional support structures.

Data were collected primarily through semi-structured narrative interviews, which provided participants with the opportunity to describe their experiences in their own words while ensuring that central topics relevant to the research questions were addressed (Helfferich, 2011; Velardo, 2021). The interview material was recorded, transcribed, and pseudonymized in accordance with established ethical standards for qualitative health research (WHO, 2025; Dolan, 2024).

The data were analysed using thematic analysis combining deductive and inductive elements (Braun & Clarke, 2022). This approach enabled the identification of both theoretically informed themes and patterns emerging directly from the empirical material.

4.2 Research paradigm and design

The present study is grounded in a qualitative, interpretative, and constructivist research paradigm. This perspective assumes that social reality is not independent of human action but is continuously produced through interactions, meaning-making processes, and culturally shaped interpretive frameworks. In the context of suicide bereavement and postvention, this approach is particularly appropriate because grief and support practices are not only individual psychological experiences but also relational and socially embedded processes (Andriessen et al., 2019; Andriessen et al., 2022; Kaspersen et al., 2022; Nicholls et al., 2024).

From an ontological perspective, grief after suicide is understood as a dynamic phenomenon shaped by narratives, family relationships, institutional interactions, and social norms. Epistemologically, knowledge about bereavement and postvention is therefore treated as situated and co-constructed in the interaction between researcher and participants rather than as a neutral representation of an objective external reality (Manoni-Millar et al., 2022; Finlay & de la Cruz, 2023; Saunders et al., 2023). Consequently, the study does not aim for statistical representativeness but for a context-sensitive reconstruction of experiences, interpretations, and institutional practices related to suicide bereavement (Flick, 2018).

To investigate these processes, a qualitative multiple case study design was adopted (Yin, 2018). Case-oriented research allows complex social phenomena to be examined in their contextual embeddedness and enables the identification of similarities and differences across cases without claiming statistical generalizability (Stake, 2006; Eisenhardt, 1989; Flick, 2018; Sastry et al., 2020). Such an approach is particularly suitable for the study of postvention, where institutional routines, informal networks, and regional resources significantly shape support processes (OECD, 2021; Hill & Robinson, 2022; Clements et al., 2022).

The design integrates two complementary perspectives. First, interviews with bereaved individuals provide insights into personal coping processes, social relationships, and experiences with formal and informal support structures. Second, professionals involved in psychosocial support, crisis services, and related institutions contribute perspectives on institutional routines, cooperation structures, and systemic challenges in postvention practice. Considering both perspectives within a multiple case study design enables an analysis of how individual experiences and institutional conditions interact

within the regional postvention landscape (Maple et al., 2020; Griffin et al., 2022; Higgins et al., 2022).

This research design also reflects the relational and context-dependent nature of suicide bereavement. Rather than treating experiences of loss as isolated psychological events, the study approaches them as socially embedded processes that unfold within specific institutional, cultural, and spatial conditions. In the rural context of Lower Bavaria, these conditions include limited anonymity, dense social networks, and overlapping institutional responsibilities. The qualitative design therefore allows for the examination of how meanings are constructed not only individually, but also in relation to local structures, expectations, and interactional dynamics. This perspective is particularly important when analyzing postvention, which operates at the intersection of personal experience and institutional practice.

Furthermore, the chosen design makes it possible to capture the interaction between different actor perspectives without reducing them to a single analytical framework. By integrating accounts from bereaved individuals and professionals, the study does not assume a unified or coherent understanding of postvention, but instead explores how different interpretations, expectations, and constraints coexist and sometimes conflict. This multi-perspective approach enables the identification of structural tensions and interface problems that would remain less visible in designs focusing on a single group. In this sense, the research design is not only exploratory but also relational, as it seeks to understand how postvention emerges through interactions between individuals, institutions, and regional contexts.

4.3 Objectives and research questions

The overarching aim of this study is to examine how suicide bereavement and postvention are experienced and organized in the rural region of Lower Bavaria. The study seeks to reconstruct both the subjective experiences of bereaved individuals and the institutional perspectives of professionals involved in postvention in order to understand how individual coping processes, social reactions, and support structures intersect.

The study is based on the assumption that grief after suicide cannot be understood as a purely individual phenomenon. Rather, it unfolds within social, cultural, and institutional contexts that shape how loss is interpreted, communicated, and responded to (Andriessen et al., 2019; Pitman et al., 2024; Oexle et al., 2022). This is particularly relevant in rural settings, where informal networks, social visibility, and limited

psychosocial infrastructures may influence both the experience of bereavement and access to support (Bayerisches Landesamt für Statistik, 2023; OECD, 2021; Cvinar, 2005).

The study therefore combines two analytical perspectives. First, it examines the experiences of bereaved individuals, including grief processes, meaning-making, social reactions, and encounters with formal and informal support. Second, it examines the perspectives of professionals in order to analyse institutional routines, structural conditions, and challenges of cooperation in postvention practice. Bringing these perspectives together makes it possible to identify areas of fit and misfit between individual needs and available support structures (Maple et al., 2025; Xanthopoulou et al., 2022; Bailey et al., 2020).

Against this background, the empirical investigation operationalizes the guiding research questions through a set of more specific analytical questions. These questions structure the data collection and analysis and allow the broader research questions to be examined through the narratives of bereaved individuals and the perspectives of professionals involved in postvention.

The study is therefore guided by the following analytical questions:

1. How do bereaved individuals in Lower Bavaria interpret and cope with the suicide loss of a close relative?
2. What social reactions, forms of recognition or non-recognition, and experiences of stigma shape their bereavement process?
3. What forms of formal and informal support are used, avoided, or experienced as helpful or unhelpful?
4. How do professionals describe their routines, responsibilities, and structural challenges in postvention practice?
5. Where do the experiences and needs of bereaved individuals converge with, or diverge from, the institutional logics and support structures described by professionals?

Together, these analytical questions translate the broader research questions into empirically observable dimensions. They make it possible to examine how individual experiences of grief, social reactions, and support practices intersect with the institutional organization of postvention in the rural region of Lower Bavaria. In doing so, the study

links subjective narratives of bereavement with the structural conditions and professional practices that shape post-suicide support.

These questions provide the analytical framework for the empirical chapters. They connect individual narratives with institutional conditions and make it possible to examine postvention not only as a matter of personal coping, but also as a socially and structurally embedded process.

4.4 Selection of participants

Participant selection is a central methodological component of this study because it determines which experiential perspectives and institutional contexts can be included in the analysis. Given the complexity and sensitivity of suicide bereavement, the study followed a purposive sampling strategy aimed at identifying information-rich cases that reflect diverse relationship roles, experiences of grief, and interactions with support systems (Flick, 2018). Such heterogeneous case constellations are considered particularly suitable for examining complex social phenomena such as grief, stigmatization, and institutional interaction (Rodríguez-Torres et al., 2021; Witham et al., 2024).

In line with this approach, the sampling process was guided by the principle of contextual diversity rather than numerical variation. For the group of bereaved participants, particular attention was paid to including individuals with different forms of relational proximity to the deceased, including close family members as well as individuals connected through broader social ties. This differentiation reflects contemporary bereavement research, which emphasizes that the impact of suicide extends beyond narrowly defined family structures and affects a wider relational network. In addition, efforts were made to include participants at different stages of the bereavement process, in order to capture variations in meaning-making, coping strategies, and engagement with support systems over time.

For the group of professionals, participant selection aimed to reflect the institutional heterogeneity of postvention practices in rural Lower Bavaria. The sample therefore included actors from different sectors involved in the aftermath of suicide, such as emergency services, psychosocial counseling, pastoral care, and public administration. This diversity was not only intended to provide a broad overview of professional perspectives, but also to examine how postvention is shaped by differing institutional logics, resource constraints, and role expectations. By including professionals operating

at different points within the postvention process, the study is able to reconstruct how support is organized, coordinated, or fragmented across institutional boundaries.

At the same time, the recruitment of participants was shaped by specific challenges associated with conducting research on suicide in rural areas. Potential participants often expressed concerns regarding anonymity, particularly in small communities where social networks are dense and individuals may be easily identifiable even through indirect contextual information. This was especially relevant for both bereaved individuals and professionals, as participation could be perceived as exposing personal experiences or institutional practices to external scrutiny. As a result, access to the field required a high degree of trust-building, transparency about the aims of the study, and clear communication of data protection measures.

These conditions also influenced the composition of the sample. Participation was necessarily based on voluntary engagement, which implies that individuals willing to share their experiences may differ from those who chose not to participate. In the context of suicide bereavement, this may relate to factors such as emotional readiness, previous experiences with support systems, or personal attitudes toward discussing the loss. Rather than treating this as a methodological deficit, the study acknowledges it as an inherent characteristic of research with vulnerable populations. The sample therefore reflects not only structural diversity but also the conditions under which participation becomes possible in a sensitive and socially regulated field.

In research on suicide bereavement, sampling cannot be fully planned in advance. Access to participants is shaped by ethical considerations, personal willingness to participate, and the emotional vulnerability of potential interviewees. For this reason, the sampling process developed as a flexible and context-sensitive negotiation between theoretical criteria and practical access conditions. The aim was not statistical representativeness but analytical depth and contextual richness.

A total of thirteen narrative interviews with bereaved individuals were conducted. Participants represented different relationship roles to the deceased, including parents, partners, siblings, adult children, and close friends. This diversity reflects varying forms of emotional attachment, responsibility, and social expectations that influence grief processes (Feigelman et al., 2020; Portz et al., 2020). Including different relationship types made it possible to capture the multidimensional character of suicide bereavement within its socio-ecological context.

In addition, thirteen professionals were interviewed in order to reconstruct the institutional framework of postvention support. Participants included professionals from psychosocial counselling services, healthcare and nursing, crisis and social psychiatric services, emergency medicine, police, emergency pastoral care, and community support systems. Postvention practice typically involves multiple actors whose communication and coordination significantly influence how support is experienced by bereaved individuals (Freeman & Hughes, 2010; Haggerty et al., 2013; OECD, 2021). Including professionals from different institutional contexts therefore allowed the study to examine structural cooperation patterns and potential discontinuities in care chains.

Bereaved participants were recruited primarily through informal and peer-based networks, often via personal recommendations from other bereaved individuals. Institutional mediation was rare, as many organizations reported limited direct contact with bereaved families or declined to forward the study request for ethical reasons. These recruitment pathways reflect the realities of research access in suicide bereavement, where formal sampling frames are often unavailable.

Given the high social visibility typical of rural regions, particular attention was paid to protecting participants' anonymity and privacy. Recruitment procedures were designed to minimize the risk of indirect identification, which can be especially pronounced in small communities (Kaiser, 2009). Participation was voluntary, and potential participants were clearly informed about the aims of the study, the option to withdraw at any time, and the confidential handling of all data (Dyregrov, 2004; Bailey et al., 2020).

The sample aimed to reflect diversity in relationship roles, social contexts, and institutional perspectives. However, not all forms of diversity described in the literature could be represented equally. Research indicates that certain groups—such as men, older individuals, or people with migration backgrounds—often face barriers to participation in psychosocial research and support services (Ferlatte et al., 2022; Sanchez et al., 2024). Although not all of these groups were represented in the empirical material, their relevance is acknowledged in the discussion of existing research and future research needs (Charles-Rodriguez et al., 2025).

The selection of professionals followed the question of which occupational groups regularly encounter bereaved individuals after a suicide. In rural regions such as Lower Bavaria, responsibilities are often concentrated among a limited number of actors, including crisis services, healthcare providers, pastoral care, and emergency services

(Abbott et al., 2023). Professionals were recruited through institutional contacts, professional networks, and recommendations from colleagues.

Data collection continued until the material reached conceptual sufficiency, meaning that additional interviews no longer substantially expanded the central analytical themes (Saunders et al., 2023). In qualitative research, this threshold is typically reached when recurring patterns and contrasts become analytically stable rather than when no new statements appear.

Overall, the participant selection process combined purposive sampling, ethical sensitivity, and practical access strategies. By including both bereaved individuals and professionals, the study captures the interaction between personal experiences and institutional structures that shape postvention support in Lower Bavaria. This dual perspective provides the empirical basis for analysing how grief processes, social responses, and support systems intersect within a specific regional context.

4.5 Data collection methods

Data collection was based on a qualitative, interpretative approach designed to capture the complexity, emotional intensity, and contextual embeddedness of suicide bereavement and postvention experiences. In line with qualitative social research, subjectivity was treated not as a source of distortion but as an important resource for understanding how grief, support, and institutional encounters are experienced and interpreted (Kvale & Brinkmann, 2009; Helfferich, 2011).

The core method of data collection consisted of semi-structured interviews with narrative elements. This format made it possible to combine thematic comparability across cases with openness to individual meanings, biographical turning points, and emotionally significant experiences (Flick, 2018; Witzel & Reiter, 2012). Such an approach is particularly suitable for research on suicide bereavement, where experiences are often fragmented, ambivalent, and difficult to capture through standardized methods (Braun & Clarke, 2022; Patterson et al., 2022).

Although the interviews were guided by a semi-structured framework, their actual course was deliberately kept flexible in order to accommodate the individual pace, emotional state, and communicative preferences of the participants. In practice, this meant that the sequence and depth of topics were adapted situationally, and participants were given the opportunity to introduce themes that were not explicitly anticipated in the interview guide. This openness was particularly important in the context of suicide

bereavement, where rigid questioning structures may inhibit narrative expression or intensify emotional distress. As a result, the interviews often followed a non-linear trajectory, moving between different temporal and thematic layers of experience.

At the same time, the use of an interview guide ensured that key areas relevant to the research questions were addressed across interviews, enabling a degree of comparability without imposing uniformity. This balance between structure and openness reflects a central methodological consideration of the study: to create a space in which participants could articulate their experiences in their own terms, while still allowing for systematic analysis. In this sense, data collection was not understood as a purely technical procedure, but as an interactional process shaped by the relationship between researcher and participant, as well as by the broader social and cultural context in which the interviews took place.

For bereaved participants, interviews were conducted primarily in settings perceived as safe and manageable by the interviewees, including in-person conversations and, in some cases, telephone or other distance-based formats. The interview process was designed to be flexible and trauma-sensitive, allowing participants to regulate the pace and depth of disclosure, interrupt the conversation, skip topics, or take breaks when needed (EFPA, 2007; Blaze & Roberts, 2023). This approach reflected the particular vulnerability of suicide-bereaved individuals and the methodological importance of trust, autonomy, and emotional safety in sensitive interview contexts (O'Connell et al., 2022).

The use of different interview formats also had methodological implications for the character of the data collected. Face-to-face interviews generally allowed for a richer perception of non-verbal communication, situational context, and emotional expression, which is particularly relevant in research on sensitive topics such as suicide bereavement. In contrast, telephone and written formats offered participants a greater degree of distance and control over the disclosure of personal experiences. Some participants explicitly preferred these formats, as they enabled them to articulate difficult experiences without immediate interpersonal exposure. Rather than treating these differences as methodological inconsistencies, the study considers them as part of the empirical reality of researching vulnerable populations in rural settings.

Accordingly, the variation in data collection formats was approached reflexively, with attention to how different communicative settings might shape the content, depth, and form of participants' narratives. This included an awareness that written responses may be more structured and reflective, while spoken interviews often contain more

spontaneous and emotionally nuanced expressions. By acknowledging these differences, the study aims to avoid homogenizing the data and instead treats variation as analytically relevant, particularly when interpreting how individuals position themselves in relation to their experiences of loss and to institutional support structures.

The professionals' perspectives were collected in written form after prior contact and information about the study. This procedure proved suitable because it allowed participants to respond flexibly and reflectively within the constraints of their professional routines (Fraser et al., 2023; Joyce et al., 2025). The use of different data collection formats was therefore not a methodological inconsistency but an adaptation to the differing access conditions and vulnerability profiles of the two participant groups.

No formal pilot interviews were conducted. Instead, the interview guide was developed and refined through an iterative, theory- and literature-informed process. It was designed as a flexible framework rather than a rigid instrument, allowing the order and emphasis of questions to be adapted to the course of the conversation and the participant's situation (Radbron et al., 2022; Attila et al., 2024). The interviews typically began with an open narrative prompt and were followed by thematic modules focusing on grief experiences, social reactions, support processes, and institutional encounters.

All interviews were documented and prepared for analysis through transcription or structured written submission. The collection process was accompanied by ongoing reflexive attention to the role of the researcher, the situational dynamics of the interview, and the influence of context on what could be articulated. In this sense, data collection was understood not as a purely technical step but as part of the interpretative production of knowledge (Finlay & de la Cruz, 2023; Byrne, 2022).

Overall, data collection was designed as a flexible, ethically sensitive, and context-aware process. The combination of semi-structured interviewing, narrative openness, adaptive guide design, and trauma-sensitive implementation ensured a data corpus suitable for reconstructing grief, support, and institutional experiences after suicide in rural Lower Bavaria. For transparency, further documentation of the empirical basis, including interview guides and selected anonymized excerpts, is provided in the appendix.

4.6 Data analysis

The empirical material was analysed using reflexive thematic analysis as developed by Braun and Clarke (2021). This approach was chosen because it allows

themes to be understood not as objectively “found” in the data, but as interpretively developed patterns of meaning. Such an approach is particularly suitable for the present study, as it enables the analysis of complex, emotionally dense, and contextually embedded experiences of suicide bereavement and postvention without reducing them to linear or standardized categories (Braun & Clarke, 2021; Hanna et al., 2021; Andriessen et al., 2020; Genest et al., 2021; Hafford-Letchfield et al., 2022).

The analytical process followed a stepwise and iterative procedure that combined both deductive and inductive elements. In an initial phase, all transcripts were read repeatedly in order to gain a comprehensive understanding of the material and to identify preliminary patterns of meaning. During this stage, analytical notes were developed alongside the readings, focusing on recurrent themes, emotionally salient passages, and variations in how participants described their experiences of bereavement and postvention. This early familiarization with the data was essential for grounding subsequent coding decisions in the empirical material rather than in pre-existing assumptions.

Building on this phase, a first cycle of coding was conducted using a set of sensitizing concepts derived from the research questions, such as experiences of support, barriers to access, institutional interactions, and processes of meaning-making. At the same time, the analysis remained open to inductively emerging codes that captured unexpected aspects of the data, including situational dynamics specific to rural contexts, forms of implicit social regulation, or ambivalent perceptions of support structures. This combination of deductive and inductive coding allowed the analysis to remain both theoretically informed and empirically responsive.

In a subsequent phase, the initial codes were systematically reviewed, compared, and grouped into broader thematic categories. This process involved examining relationships between codes, identifying overlaps and distinctions, and refining category boundaries to ensure internal coherence and analytical clarity. Particular attention was paid to patterns that recurred across different interviews, as well as to variations and contradictions that pointed to differing experiences or interpretations. Rather than seeking to eliminate such differences, the analysis treated them as analytically relevant, especially in relation to the heterogeneous conditions of postvention in rural contexts.

The development of themes was closely linked to the aim of reconstructing both individual experiences and structural dimensions of postvention. Accordingly, thematic categories were not only organized around personal narratives of grief and coping, but

also around institutional processes, interactional dynamics, and perceived gaps in support systems. Throughout this process, the perspectives of bereaved individuals and professionals were analysed both separately and in relation to each other. This comparative approach made it possible to identify points of convergence, divergence, and tension between experiential and institutional accounts, which later informed the structure of the empirical findings presented in Chapter 6.

To enhance the analytical rigor of the study, particular attention was paid to the consistency and transparency of the coding process. Categories were developed and refined through multiple coding cycles, during which earlier interpretations were continuously revisited and, where necessary, revised in light of new insights from the data. This iterative approach helped to avoid premature closure of the analysis and ensured that the final thematic structure remained closely grounded in the empirical material. At the same time, care was taken not to over-standardize participants' accounts, but to preserve variations in meaning, tone, and perspective.

Reflexivity played an important role throughout the analytical process. Given the researcher's professional background in the field, there was a continuous need to critically examine how prior knowledge, expectations, and experiential proximity might influence the interpretation of the data. This was addressed through ongoing analytical reflection and by deliberately considering alternative readings of the material. Rather than striving for a detached or purely objective stance, the study adopts a reflexive position that acknowledges the co-constructed nature of qualitative data while maintaining a clear commitment to methodological transparency and interpretative accountability.

4.7 Ethical considerations

Research on suicide bereavement is ethically demanding because it involves highly vulnerable participants and addresses experiences that are often associated with stigma, shame, family conflict, and institutional distress. Ethical sensitivity was therefore treated as a central foundation of the study rather than as an additional procedural requirement. All stages of the research process were designed to protect participants' autonomy, dignity, and safety while enabling the generation of scientifically relevant knowledge (Werdin & Wyss, 2024; Maple et al., 2023; Sommerlad et al., 2021; Freak-Poli et al., 2021; Feigelman et al., 2020; Levi-Belz & Andriessen, 2023; Andriessen et al., 2022).

The study was conducted in Germany, where ethical review procedures in the social sciences are not uniformly regulated and do not necessarily require formal approval by an institutional ethics committee for non-clinical, qualitative research involving adult participants. In contrast to standardized review systems in some other countries, the German research context is characterized by a combination of institutional responsibility, researcher self-assessment, and adherence to professional ethical guidelines (KonsortSWD, 2023; DFG, 2023; Crawford et al., 2025). At several German universities, ethics committees in the social sciences operate on a voluntary or advisory basis, and formal approval is typically required primarily for biomedical, clinical, or experimentally invasive studies. (e.g., Ludwig-Maximilians-Universität München; Humboldt University Berlin Research Ethics Guidelines).

In the present study, all participants were adults, and no minors or legally dependent individuals were included. Participation was based on voluntary, informed consent, and the study did not involve any form of intervention, manipulation, or experimental procedure. The project was discussed in advance with the doctoral supervisor, and the question of whether formal ethical approval was required was carefully considered in relation to the specific characteristics and risk profile of the study. Based on this assessment and the applicable institutional framework, the study was classified as not requiring formal review by an ethics committee.

In addition, the research project received formal academic approval within the doctoral framework. It was approved on 17 July 2025 in Dąbrowa Górnicza by the Recommendation of the Committee on Science in the Discipline of Family Studies at WSB University. This institutional approval confirms that the study design, including its ethical considerations, was reviewed and accepted within the relevant academic governance structures. Against this background, ethical responsibility in the present study was not limited to formal procedures but was implemented continuously throughout the research process in accordance with established international standards.

Participation in the study was voluntary throughout. Potential participants received written and verbal information about the aims of the study, the procedures involved, possible emotional burdens, data protection, and their right to withdraw at any time without negative consequences (Wainwright et al., 2020; Todorova et al., 2020). Informed consent was understood as an ongoing process rather than a single formal act, in line with current recommendations for research with vulnerable groups (EFPA, 2007; Xu et al., 2020; Kögel et al., 2020). Individuals showing signs of acute psychological

crisis or suicidal symptoms were not included, following international guidance that research must not replace crisis intervention or treatment (WHO, 2025; APA, 2022; Weijer et al., 2021).

This process-oriented understanding of consent was particularly important in the context of emotionally sensitive interviews, where participants' willingness to engage could fluctuate during the conversation. Participants were therefore repeatedly reminded of their right to pause, skip questions, or terminate the interview at any point without providing a reason. This ongoing negotiation of consent was intended to reduce potential pressure to continue participation and to support participants in maintaining control over the depth and direction of their disclosures.

Special attention was paid to emotional safety during data collection. Interviews were conducted according to trauma-sensitive principles, including clear framing of the conversation, the option to pause or stop at any time, respect for silence and emotional ambivalence, and the avoidance of suggestive or judgmental formulations (SAMHSA, 2025; Isobel, 2021; Gueta & Klar-Chalamish, 2022; Matthie et al., 2022).

Particular attention was also paid to recognizing signs of emotional overload during the interviews. This included both verbal and non-verbal indicators, such as changes in tone, pauses, or difficulties in continuing the narrative. In such cases, the interview situation was adapted immediately by offering breaks, shifting to less demanding topics, or, if necessary, discontinuing the conversation. The aim was not to avoid emotionally relevant content, but to ensure that participants were not placed in a situation of uncontrolled distress during the research process.

In addition, clear procedures were defined in advance for situations in which participants might express acute distress or suicidal ideation during the interview. These procedures included immediate termination of the research interaction if necessary, the provision of appropriate support contacts, and, where appropriate and with the participant's consent, guidance toward professional help services. Although such situations did not constitute the primary focus of the research, their possibility was explicitly considered as part of the ethical responsibility inherent in studying suicide-related experiences.

After participation, all respondents received information on crisis and counselling services as a form of ethical aftercare and referral where needed (WHO, 2025; O'Brien et al., 2022; Savage et al., 2022; Ford et al., 2023; Patterson et al., 2022). This measure was intended not only as a precaution, but also as an acknowledgment that participation

in the study might evoke delayed emotional reactions. Providing access to support resources after the interview therefore formed part of a broader ethical commitment to accompany participants beyond the immediate research interaction and to mitigate potential longer-term effects of engaging with sensitive material.

Confidentiality and data protection were especially important because the study was conducted in rural Lower Bavaria, where the risk of indirect identifiability is comparatively high. All materials were pseudonymized, contextual details were selectively generalized where necessary, and digital data were stored in encrypted and password-protected form (Kaiser, 2009; Karhulahti, 2023). The procedures followed the requirements of the General Data Protection Regulation (Regulation [EU] 2016/679) as well as relevant professional and ethical standards, including those of the DGPs (2016), APA (2022), EFPA (2007), and the WHO (2025). Audio recordings were deleted after transcription, and research data were stored separately from identifying information.

These measures were particularly important given the sensitivity of the research topic and the increased risk of indirect identification in rural settings. Data protection was therefore not treated as a purely technical requirement, but as an integral part of the ethical framework of the study. All stages of data handling, from recording and transcription to storage and analysis, were designed to minimize risks to participants while preserving the analytical value of the material.

The role of the researcher required continuous ethical reflection. Because professional experience in psychosocial work may facilitate trust but also create risks of role confusion or over-identification, reflexivity was treated as an ongoing part of the research process (McDermott & Marzetti, 2023; Kim et al., 2024; Finlay & de la Cruz, 2023). The boundary between research and counselling was made explicit throughout, and the study did not aim to provide therapeutic intervention. At the same time, care was taken to use respectful, non-stigmatizing language, both in interviews and in the presentation of findings (Wolfersdorf & Etzersdorfer, 2022; Niederkrotenthaler et al., 2025; Pirkis, 2019).

These potential role overlaps required a careful and explicit differentiation between the position of the researcher and that of a practitioner or support provider. Maintaining this distinction was essential to avoid creating expectations of assistance that could not be fulfilled within the research context. At the same time, the researcher remained attentive to the relational dynamics of the interview situation, recognizing that participants might attribute meanings to the interaction that extend beyond a purely

scientific encounter. Addressing these dynamics transparently formed part of the ethical responsibility of the study.

This perspective acknowledges that professionals are not only providers of support but may also be indirectly affected by repeated exposure to suicide-related situations. Their participation in the study could therefore involve revisiting emotionally demanding experiences or reflecting critically on institutional limitations. Ethical considerations in this context included creating a space in which professionals could articulate such experiences without fear of professional repercussions and ensuring that participation did not interfere with their organizational roles or responsibilities.

Throughout the study, ethical decision-making involved balancing the aim of generating in-depth knowledge about suicide bereavement with the responsibility to avoid harm to participants. This required continuous situational judgement rather than the mechanical application of predefined rules. In particular, the study acknowledges that qualitative research on sensitive topics inevitably involves entering emotionally significant domains of participants' lives. Ethical practice therefore consisted not in eliminating all potential discomfort, but in ensuring that participation remained voluntary, controlled, and meaningful for those involved.

Finally, ethical responsibility also shaped the presentation of results. Quotations were selected and anonymized in ways that preserved participants' voices without exposing them, sensationalizing their experiences, or increasing the risk of recognition in small communities (Woolf & Silver, 2018; Karhulahti, 2023). Ethical practice in this study was therefore understood as a continuous principle guiding recruitment, interviewing, analysis, storage, and dissemination. In this sense, ethics was not an appendix to the methodology but a core condition of responsible research in the field of suicide bereavement and postvention.

5 Context of the intervention in Lower Bavaria

Against this ethical and methodological backdrop, it is necessary to take a differentiated view of the regional context in which post-ventive interventions take place.

The analysis of postventive care processes in Lower Bavaria requires a more comprehensive and context-sensitive consideration of the structural, cultural, and institutional conditions in which interventions arise and take effect.

Lower Bavaria is a historically developed, politically and administratively independent district within the Free State of Bavaria. The Bavarian administrative districts were established during early 19th-century reforms as a middle level of government and are specifically protected in the Bavarian Constitution as subdivisions of the state's territory (Mages, 2006).

In the federal system of the Federal Republic of Germany, the states, including the Free State of Bavaria, have their own scope for action in key areas of health, social, and prevention policy within the framework of concurrent legislation and the implementation of federal laws (Bundesrepublik Deutschland, 2025).

This autonomy allows strategies to be adapted to regional characteristics, but it also means that local administrations, church-run institutions, and civil society organizations are highly dependent on one another and must coordinate their intervention services. This circumstance is particularly relevant for post-ventive services aimed at people who have attempted suicide, as these services do not arise in isolation but are embedded in a structure comprising community psychiatry, social counseling, crisis services, outpatient care, voluntary support structures, and municipal responsibilities.

With a population of around 13.25 million, Bavaria is one of the largest and most demographically dynamic states in the Federal Republic of Germany (Bayerisches Landesamt für Statistik, 2025). Ongoing population growth is mainly driven by immigration, while the number of births has lagged behind deaths for years. This demographic shift is leading to a significant aging of the population, which is affecting both the demand for social services and the capacity to provide them.

The aging of the population, the exodus of young, well-educated people, and the increasingly heterogeneous composition of the resident population due to migration directly affect the composition of social networks, which in turn play a central role in coping with crises and losses. Research findings from the international literature show, particularly for aging rural regions, that social structures are changing and family

networks are often thinning out, while at the same time expectations of social support within neighborhoods are increasing (Bélangier et al., 2025). Postventive services must operate in this area of tension and ensure that those who cannot rely on professional or neighborhood networks alone receive support.

Economically, Bavaria is one of Germany's strongest regions, supported by core industrial sectors such as mechanical engineering, automotive manufacturing, electrical engineering, and chemicals, as well as by new knowledge-intensive services in technology, digitalization, and health (Bayerisches Landesamt für Statistik, 2025). However, despite this economic strength, there are considerable regional differences. While urban centers such as Munich, Nuremberg, and Augsburg have a high density of infrastructure, medical services, and social services, the picture is very different in rural areas. Lower Bavaria, a structurally rural administrative district with around 1.25 million inhabitants (IHK Niederbayern, 2025), is characterized by lower densities of specialized services, longer distances, lower population density per square kilometer, and limited availability of therapeutic, psychosocial, and psychiatric services compared to urban areas. These differences are not only geographical but also reflect a complex interplay of economic, infrastructural, and socio-political factors.

In addition, rural regions in Bavaria, and thus also in Lower Bavaria, have specific cultural characteristics that are crucial for understanding the course of crises and coping processes. Approximately 55 percent of the Bavarian population lives in rural communities (Bayerisches Landesamt für Statistik, 2024).

These areas are characterized by a high density of associations, strong integration into neighborhood networks, long traditions of church affiliation, and a pronounced importance of informal social structures. On the one hand, these social networks offer stability and closeness. However, on the other hand, they can make access to professional psychosocial support more difficult due to limited anonymity and high social visibility. In the context of suicide loss, this means that shame, stigmatization, and fear of social judgment can be greater barriers than in urban areas, where discretion is easier to maintain (Niederkrotenthaler et al., 2025). At the same time, dense rural networks can also serve as resources for bearing and sharing grief.

This ambivalence between closeness and limited anonymity is particularly important for postvention, understood as structured support for people who have experienced suicide in their immediate environment. In rural communities, a person's suicide affects not only the family concerned, but spreads like ripples in a pond into the

social fabric to neighbors, clubs, work colleagues, church groups, or informal support networks. This shifts the boundaries between private and public concern. The death becomes a social event that triggers collective reactions and often leaves people speechless. Studies on suicide-related communication and stigmatization processes show that people in rural areas are often confronted with more intense social control and, at the same time, talk less about suicide-related topics (Traher & Breen, 2024; Hofmann et al., 2025).

Cultural, religious, and regional traditions strongly influence the social interpretation of suicide. In Catholic regions, such as Lower Bavaria, this interpretation has historically been closely linked to notions of moral guilt and sin, even though these assessments are more pluralistic today. Nevertheless, traditional narratives have an impact across generations and influence not only the experiences of the bereaved but also their willingness to seek support.

To understand the significance of this context, this work draws on Bronfenbrenner's socio-ecological model, which has been further developed in social space-oriented research (Grundmann & Kunze, 2008). This model understands individual life courses as the result of interlocking social, institutional, and societal structures. For postvention, this means that individual grief management at the micro level is inextricably linked to institutional support structures at the meso level and to social patterns of interpretation and normative frameworks at the macro level. Postvention is therefore not merely a professional support service, but a relational, organizational, and cultural process that takes place in the field of tension between social expectations, institutional possibilities, and individual needs.

Individual coping processes focus on the emotional, psychological, and social reactions of the bereaved. These include feelings of guilt, searching for meaning, dealing with trauma, changes in family roles, and the challenge of restructuring everyday life (Whitebrook et al., 2025; Goodall et al., 2022). In addition, institutional constellations in which actors such as social counseling centers, churches, health services, crisis intervention teams, police, or schools shape the nature and way support is organized, coordinated, and provided. At a higher societal level, normative patterns of interpretation, political frameworks, financing systems, and structural inequalities influence the conditions of postvention care.

For Lower Bavaria, this means that postvention must always be understood as an expression of regional social ecology. It is not a standardized service that would function

in the same way regardless of location and context, but rather a hybrid system that combines social practices, institutional routines, and cultural orientations. Against this background, the analyses in this work follow a context-sensitive qualitative approach that uses theoretical triangulation and contrasting case studies to highlight regional conditions, differences, and challenges (Andriessen et al., 2019, 2022; Goodall et al., 2022; Werdin & Wyss, 2024).

The regional characteristics of Lower Bavaria deserve closer consideration. The administrative district comprises nine counties, including Passau, Deggendorf, Straubing-Bogen, Regen, Rottal-Inn, Dingolfing-Landau, and Freyung-Grafenau, as well as three independent cities: Passau, Landshut, and Straubing. In terms of social structure, it is one of the most rural regions in southern Germany. The population density is well below the Bavarian average, and many communities are small, with only a few thousand inhabitants. For many people, specialized care services such as psychiatric clinics, trauma counseling, specialized grief counseling, or crisis services are located far away. This situation is critical, as studies have shown that post-ventive interventions should be carried out promptly to promote mental stability and reduce secondary risks (Abbate et al., 2022; Jackson et al., 2025).

However, it is not only the physical distances that pose a particular challenge for the work of post-ventive actors, but also the combination of geographical remoteness, limited public mobility, a shortage of skilled workers, and a lack of specialization in psychosocial services in rural areas. Many communities in Lower Bavaria have limited technological and logistical connectivity, which affects both coordination with medical and social service providers and the accessibility of digital services. Although the digital infrastructure is being expanded, it still lags that of urban regions. This also applies to telemedical counseling services, which have been shown in recent studies to be potentially very effective for people in rural areas (Finucane et al., 2024).

Large-scale care patterns indicate that access to specialized services in rural regions is limited. Statistical data show significant differences between urban and rural regions in Bavaria in the density of psychiatric, psychotherapeutic, and psychosocial facilities. As a result, general social counseling centers, social psychiatric services, or church institutions in Lower Bavaria often fulfill a "catch-all" function that specialized agencies in urban regions would perform. The treatment pathways in the event of a suicide are correspondingly complex. The police, emergency services, crisis services, and local authorities are directly involved, often earlier than psychosocial services. Such situations

are often complex in rural regions, as incident locations are often discovered late, emergency services must travel long distances, and incidents often occur in private or agricultural settings. For the bereaved, this also means being confronted with clearly visible external elements of death, which can be traumatic and increase the importance of structured post-ventive processes.

Key findings from the literature on crisis intervention show the importance of low-threshold services available around the clock (Weiß et al., 2014). Although there are individual crisis services in Lower Bavaria, they are often concentrated in larger cities, such as Passau or Landshut. They are not available in a comparable manner throughout the entire region. The gaps in care are striking in rural areas.

Compared to urban regions with established, round-the-clock psychosocial crisis services, acute care after a suicide in Lower Bavaria is more strongly influenced by general hazard prevention structures. In the immediate aftermath of the event, the police, fire department, and emergency services often play central roles. In contrast, specialized psychosocial services are involved only after a delay or not at all. This situation means that in a highly vulnerable phase, the bereaved primarily encounter actors whose mandate is not geared toward suicide-related crisis intervention.

This is a crucial factor in postvention, because the way bereaved relatives are cared for or left to their own devices in the first few hours after the event influences their subsequent experience.

In addition, research shows that regional deprivation is a relevant risk factor for increased suicide rates. A recent analysis from Germany confirms that rural and socioeconomically disadvantaged regions, such as parts of Lower Bavaria, have higher suicide rates (Belau & Gerstner, 2024). The rate in the most deprived rural regions is up to twice that in urban, more affluent areas. This finding underscores the need for regionally adapted prevention and postvention strategies that account for structural risk factors.

The evaluation of supraregional studies on suicide prevention also shows that a more coordinated approach is necessary. Werdin and Wyss (2024) point out that structural gaps, a shortage of skilled workers, stigmatization, and insufficient cross-sectoral cooperation are key challenges. These findings are very much in line with the conditions in Lower Bavaria. The segmentation of the structure she describes in Germany is particularly pronounced in rural areas such as Lower Bavaria, as local services are often unevenly distributed and key players do not systematically cooperate. For postvention,

this means that the path of bereaved relatives through the support system in Lower Bavaria is not clearly defined and often depends on factors such as individual professionals' commitment.

The cultural component plays another central role. The close ties to church communities that are common in rural Bavaria can be an ambivalent factor. On the one hand, parishes have established structures for care and support in crises, but on the other hand, church interpretations of suicide have historically been linked to moral judgments. Recent studies show that religious communities provide relief for some bereaved people, while others suffer greatly from moral messages that reinforce feelings of guilt (Whitebrook et al., 2025). These ambivalences must be considered by social counseling, crisis services, and psychosocial providers.

Applying this trend to post-suicide care, it becomes clear that Lower Bavaria will face considerable structural challenges in the long term if no sustainable personnel strategy is developed.

Infrastructural conditions also shape post-ventive care. Studies such as Finucane et al. (2024) have shown that digital services can be a significant addition, especially in rural areas. They make it possible to bridge waiting times, overcome geographical distances, and promote low-threshold exchange. However, without stable internet connections and appropriate professional training, this potential remains untapped.

At the level of organizational culture, postventive services in Lower Bavaria cannot be provided solely by professional institutions. Rather, it is often volunteers, civil society organizations, or church groups that fill the gaps in care. This diversity of actors is both a strength and a challenge. It is a strength because they are regionally anchored, but a challenge because cooperation, quality standards, data protection, and sustainable financing are often not guaranteed. In their systematic analysis, Abbate et al. (2022) emphasize the importance of evaluating postvention services for their further development. However, rural regions lack the professional structures needed to carry out targeted evaluations.

In addition, the emotional and psychological strain on the bereaved after a suicide is considerable. Recent analyses show that the risks of traumatic reactions, depression, physical illness, and suicidality have increased (Jackson et al., 2025; Goodall et al., 2022). In rural regions such as Lower Bavaria, this means many affected people must cope with these stresses without direct access to specialized services. Mobility plays a decisive role in this. People without a car or access to public transportation find it difficult to reach

help. Older people, who constitute a growing share of the population in Lower Bavaria, are particularly affected by this.

Rural areas are also affected by specific demographic and social changes that influence the accessibility and effectiveness of postvention measures. Maretzke (2016) argues that rural areas are not homogeneous entities but consist of widely diverging types of development. Some regions are growing, others are losing population, and some benefit from their proximity to economic centers, while others are structurally disadvantaged. For Lower Bavaria, this means that postvention has different framework conditions across districts. While Landshut is growing comparatively dynamically and is more strongly networked, regions such as Regen, Rottal-Inn, and Freyung-Grafenau are structurally weaker and less densely populated. This heterogeneity means that a uniform model of postvention is not appropriate.

Finally, a central issue is the stigmatization of suicide and mental health crises. The literature emphasizes that suicide is a “disenfranchised grief” in many societies, a form of grief that is not socially recognized or is marginalized (Doka, 2002). In rural regions, this marginalization is often more pronounced due to traditional norms. Survivors report blame, taboo, and social withdrawal. In their analysis of “continuing bonds,” Goodall et al. (2022) show that survivors often feel a need to remain connected to the deceased person after a suicide and that cultural and social expectations influence these forms of expression. In rural regions, where visibility and social control are high, this can mean that certain forms of grief cannot be expressed publicly.

Thus, postvention in Lower Bavaria must be understood as a communicative, organizational, and symbolic process that combines individual coping and collective interpretation. It is not only a form of assistance but also a structure, a form of coordination, and a cultural practice, and it exists in the tension among regional, political, and social norms. These three dimensions form the basis for understanding the postvention landscape in Lower Bavaria.

Overall, it can be said that postvention care in Lower Bavaria is characterized by several key factors, including the vast geographical area, limited infrastructure, low density of specialists, demographic aging, the cultural character of rural areas, the institutional fragmentation of services, the shortage of skilled workers, and existing regional disparities. The challenges exist at several levels simultaneously, such as individual involvement, institutional care, and social interpretation.

This multitude of factors necessitates understanding postvention in rural Lower Bavaria not as a static service but as a dynamic adaptation shaped by social, economic, and cultural conditions. The following analysis of counseling and support structures and the detailed examination of the specific challenges of rural postvention build on this expanded understanding and illustrate how regional characteristics and structures are interlinked.

5.1 Counseling and support structures in Lower Bavaria

Postvention care in Lower Bavaria is embedded in a multi-layered network of professional, semi-professional, and civil society actors that has grown historically, is institutionally heterogeneous, and is highly differentiated regionally. The special structure of rural areas, as is characteristic of Lower Bavaria, shapes not only the accessibility and design of social services, but also their functional logic, patterns of cooperation, and scope for action. This chapter systematically presents the landscape of counseling and support services, highlighting regional specifics, institutional networks, existing gaps in care, and particular challenges. It becomes clear that postvention in Lower Bavaria cannot be understood in isolation from the general counseling, crisis, and support structures that form the framework for assistance and determine follow-up care in an emergency.

As an administrative district, Lower Bavaria has many institutions active in psychosocial care. These include social psychiatric services (SPDi), general social counseling centers, family counseling centers, addiction and debt counseling, youth welfare offices, health authorities, church counseling services, outpatient therapeutic services, community psychiatric associations, and inpatient and day care facilities for adult, child, and adolescent psychiatry. This landscape has developed historically and is by no means comprehensive or evenly distributed. While the urban centers of Passau, Straubing, and Landshut have relatively dense infrastructure, rural districts face significant limitations, characterized by long distances, limited mobility, a lack of specialization, and low staffing capacity.

At this point, the shortage of skilled workers in the social and psychosocial sector is central to the supply situation (IHK Niederbayern, 2025). Social educators, psychotherapists, and specialized crisis workers are difficult to recruit and retain in rural areas. As a result, counseling centers often operate with minimal staff resources, are heavily dependent on capacity utilization, and cannot avoid waiting times. For bereaved

families after a suicide, this can mean that low-threshold immediate services are lacking or only become available after weeks, which is often critical for those affected due to the high emotional stress.

The rural character of Lower Bavaria exacerbates structural fragmentation. As Maretzke (2016) points out, rural areas are by no means homogeneous, but vary considerably in terms of economic strength, population development, age structure, and infrastructural accessibility. Some districts, such as Landshut or Deggendorf, benefit from economic dynamism and a certain proximity to conurbations. Others, such as Freyung-Grafenau or Rottal-Inn, are structurally disadvantaged, sparsely populated, and far from specialized care services. These inequalities are directly reflected in post-ventive care. Survivors in structurally weak regions have significantly fewer resources, are more dependent on volunteer support, and often face mobility barriers to accessing professional help. In this context, social counseling is a central, low-threshold basic care service for people facing crises, psychosocial stress, or social law challenges. It is often the first professional, familiar, and accessible point of contact for bereaved families after a suicide. This is not only due to the regionally limited availability of specialized postvention services, but also to the fact that many of those affected initially seek out general counseling centers. Reasons for this include a lack of knowledge about specialized services and personal recommendations, geographical proximity, lower inhibitions, or the short-term availability of counseling appointments.

Within this framework, social counseling fulfills several interrelated functions. On the one hand, it acts as the first point of contact immediately after a stressful event, providing guidance and addressing acute emotional and organizational overload. On the other hand, it plays an essential guiding role in the complex and fragmented support system in Lower Bavaria. Social workers refer people to social psychiatric services, trauma clinics, psychotherapy practices, self-help initiatives, outpatient crisis services, or church support services, provided these are available in the region. This referral role is particularly important in an area where the care landscape is heterogeneous, and responsibilities are often unclear.

In addition, counseling centers play an important role in case coordination and interface work. As Weiß et al. (2014) emphasize, the effectiveness of crisis intervention processes depends crucially on the ability to coordinate institutional transitions and secure communication channels between the actors involved. In Lower Bavaria, general social counseling centers often take on this coordinating function, as central structural

authorities, which are more common in urban areas, are hardly available. At the same time, they offer practical support in a phase in which the loss of a loved one to suicide is often accompanied by overwhelming stress. Questions about financing, dealing with authorities, or uncertainties about social welfare law can significantly increase the psychological strain already present. Low-threshold social work support therefore contributes significantly to restoring structural stability, which is an important factor in psychological stabilization and coping with stressful life events (Goodall et al., 2022).

In addition, current literature increasingly points to the potential of digital support services. Finucane et al. (2024) show in their rapid review that digital forms of grief and suicide aftercare can be an important addition to existing care, especially in rural areas.

However, this potential has so far only been exploited to a limited extent in Lower Bavaria. The reasons for this lie in the ongoing heterogeneity of broadband coverage, the partial lack of digital communication systems in counseling centers, the limited digital skills of professionals, and the reservations of some bereaved people toward digital counseling formats. The findings are consistent with general research results on digital mental health care in rural areas, which identify structural and infrastructural deficits as key barriers (Landesmedienzentrum Baden-Württemberg, 2024; Fraunhofer ISI, 2022).

This makes it clear that basic social work services in Lower Bavaria play a key role in the post-ventive support system, but at the same time face considerable structural challenges. These relate both to the analog care landscape and to the digital infrastructure, which has not yet been sufficiently developed. Against this backdrop, it can be assumed, particularly in structurally weak regions, that bereaved persons have fewer resources at their disposal, are more dependent on voluntary structures, and often must overcome additional mobility barriers to receive professional help. Social psychiatric services (SPDi) play a key role. SPDi are services enshrined in Bavarian law that offer counseling and support to people with mental illnesses and their relatives. Even though suicide aftercare is not explicitly one of their original tasks, SPDi in Lower Bavaria plays an essential role in post-ventive care, not least because there is a lack of specialized suicide aftercare services (Bezirk Niederbayern, 2024; Krisendienst Psychiatrie Niederbayern, 2024).

In Lower Bavaria, social psychiatric services (SPDi) exist in Passau, Straubing, Landshut, and Deggendorf, among other places. Nevertheless, their regional reach remains limited. Often, a single SPDi serves several districts, leading to significant gaps

in care, especially in peripheral areas such as Freyung-Grafenau, Regen, or Rottal-Inn. For people in acute stress, this means timely support cannot always be guaranteed.

The SPD_i performs various key tasks for those left behind after a suicide. They offer crisis intervention, provided the necessary capacity is available; provide psychosocial counseling; refer people to psychiatric treatment; offer support with social law issues; and provide accompaniment. Depending on the qualifications of the staff, they also provide support for trauma-related stress. This makes them an essential part of basic psychosocial care, especially in rural areas.

However, their effectiveness is limited by structural factors. The ongoing shortage of skilled workers, a high caseload, and a lack of outreach care structures mean that many bereaved people cannot be reached to the extent that would be necessary from a professional point of view. Outreach work, which is of central importance for families and relatives affected by suicide, is often only carried out to a limited extent in the context of SPD_i, highlighting the structural challenges of care provision in rural Lower Bavaria.

A central element of any post-ventive care is the crisis service. However, the design and accessibility of such services vary by region. While crisis services are available around the clock in densely populated urban areas, the situation in rural Lower Bavaria is more complex.

In practice, this can mean that after a suicide or suicide attempt, it is often the police or emergency services who make the first contact with those affected. At the same time, psychosocial professionals are only involved in the process after some time has passed. Psychosocial emergency intervention teams, which are part of the regular structure in some other federal states, such as Thuringia or North Rhine-Westphalia, are largely absent in Lower Bavaria.

Current research underscores the importance of this early phase particularly clearly. The study “The First 72 Hours. Suicide Loss Survivor Experiences with Early Responders” shows that the first hours and days after a suicide have a decisive influence on how survivors process the event emotionally and what consequences of stress may develop later (Duval et al., 2023). According to the study, a lack of initial psychosocial intervention often leads to an intensification of shock, disorientation, and distressing images.

Against this background, the insufficient availability of a comprehensive crisis service in Lower Bavaria means that bereaved individuals often remain without

professional psychosocial support during a highly vulnerable phase, which can significantly increase the risk of long-term psychological consequences.

Church services and religious frameworks traditionally play an important role in Lower Bavaria, as both church counseling centers, particularly Caritas and Diakonie, and local parishes are deeply rooted in the region's social structures. They contribute significantly to grief counseling, pastoral support, and social stabilization. At the same time, their involvement in postvention processes is ambivalent. On the one hand, church actors have a strong regional presence, are considered trusted contacts by many people, offer culturally anchored rituals, and provide low-threshold access. On the other hand, religious interpretive frameworks can reinforce feelings of guilt, especially if the bereaved themselves have a tense relationship with religion or do not feel affiliated with the church. In addition, there is often a lack of specific expertise in postvention and structured cooperation with government agencies. The meta-ethnography by Whitebrook et al. (2025) shows that religious interpretations can be a source of relief for some bereaved people but can also exert considerable psychological pressure on others. This is particularly important in Catholic-influenced Lower Bavaria.

Self-help groups, peer support formats, and civil society initiatives are also important elements of care after a suicide but are only available to a limited extent in Lower Bavaria. Where self-help groups do exist, they perform key functions that institutional services cannot fully cover. As Goodall et al. (2022) emphasize, the exchange between those affected provides a unique form of validation, understanding, and relief that professional support alone cannot provide. Nevertheless, self-help in rural areas faces considerable structural challenges. Low population density makes it difficult to establish stable groups, long distances hinder regular participation, digital platforms are often lacking, and the stigma surrounding suicide inhibits public visibility. Civil society actors, such as associations, bereavement initiatives, and local support networks, can fill gaps in specific areas. However, these structures are unevenly distributed and often depend on committed individuals, making their sustainability fragile.

However, the structural undersupply is most evident in the complete lack of a specialized postvention center in Lower Bavaria. The existing support structures are unspecific and only partially cover the demand. Social counseling is generalist in nature. The SPD primarily offers psychiatric and psychosocial support. Crisis services are not available across the board. Church services focus on pastoral care. Self-help initiatives are sporadic, and psychotherapeutic care is hardly accessible on short notice due to long

waiting times. Abbate et al. (2022) emphasize that specialized postvention services can provide a qualitatively different form of support that is structured, trauma-informed, multi-professional, timely, case-managed, and cross-sectoral. These characteristics described in the literature have so far been observed only to a limited extent, or not systematically, in Lower Bavaria.

As a result, many bereaved people do not receive appropriate support. Coping with acute crises, therefore, does not depend on a systematically organized care process, but often on chance factors, such as which agency they contact first, how well the respective specialist is networked, or how quickly an appointment becomes available.

5.2 Specific conditions and challenges of aftercare in rural Lower Bavaria

Aftercare following a suicide in rural Lower Bavaria is characterized by an interplay of structural, social, cultural, and institutional factors that differ fundamentally from urban contexts in terms of their density, quality, and effectiveness. Postvention is a highly sensitive process that requires timely, tailored, and coordinated support. At the same time, it is a field of activity that places special demands on the systems involved, as those affected are at maximum vulnerability. In rural areas such as Lower Bavaria, these demands are exacerbated by geographical distances, infrastructural bottlenecks, disparities in care provision, cultural peculiarities, and systemic fragmentation. The analysis shows that these factors do not act additively, but are interwoven, creating a specific regional psychological dynamic that is indispensable for understanding post-ventive care.

The geographical structure of Lower Bavaria, with its large, sparsely populated communities, is a central challenge. The distances between places of residence, counseling centers, and specialized services are often long, public transportation is inadequate, and travel times are considerable. In many communities, there are only a few bus connections, which also operate on a seasonal or limited schedule. Survivors who do not own a car or who are unable to drive immediately after the suicide due to shock and emotional dysregulation face considerable mobility barriers. This situation particularly affects older people, people on low incomes, and young people who rely on relatives for transportation.

In rural areas, it is a crucial structural factor in access to social care. In regions where both digital and physical accessibility are limited, a “double infrastructure

bottleneck” arises. People in rural areas cannot simply drive to counseling sessions, and there is a lack of digital alternatives.

Finucane et al. (2024) emphasize that digital grief and psychosocial interventions are well-suited to compensate for geographical distance. In Lower Bavaria, however, the potential described in the literature has so far remained largely untapped, due in part to insufficient broadband availability, a lack of digital counseling structures, and technical uncertainties among many professionals.

Mobility barriers have a particularly significant impact in the first few weeks after a suicide, a phase in which those affected are in a state of increased suicidality, stress, and disorientation. If professional support is delayed or unavailable, the risk of reactive traumatization, social isolation, or maladaptive coping strategies increases. International guidelines emphasize that rapid access to support after a suicide is essential to reduce acute risks and prevent long-term psychological consequences (World Health Organization [WHO], 2014; Duval et al., 2023). In Lower Bavaria, however, the sparse population density creates a gap in care provision that only partially meets these time-critical requirements for post-ventive interventions.

Another key finding concerns the lower density of specialized psychosocial services in Lower Bavaria compared to urban areas. While urban contexts often have specialized crisis services, trauma counseling centers, psychiatric outpatient clinics, grief counseling services, and multi-professional teams, the services available in Lower Bavaria are predominantly generalist in nature and not primarily specialized in suicide aftercare. Social psychiatric services, general social counseling centers, and church institutions perform important tasks, but do not systematically have specific postvention expertise or corresponding training structures.

In their systematic analysis of international postvention services, Abbate et al. (2022) show that such support is particularly effective when it is specialized, multi-professional, and standardized. These conditions are not met across Lower Bavaria.

The SPDs are overburdened, especially in structurally weak districts. The supply gaps are large, the number of cases is high, and there is a shortage of skilled personnel. In Lower Bavaria, an SPD can sometimes cover entire regions, making outreach work practically impossible. This eliminates an essential component of trauma-informed postvention. Namely, the ability to visit bereaved relatives in their immediate environment, accompany them at the scene of the event or shortly thereafter, and help them stabilize. In urban regions, this task is often performed by crisis teams. Weiß et al.

(2014) impressively document that outreach crisis assistance significantly improves the quality of care and is a central prerequisite for coping with acute traumatic stress.

In Lower Bavaria, on the other hand, the police and emergency services are often the only actors on site immediately after a suicide. These services respond professionally, but are primarily focused on hazard prevention, documentation, and operational management. Immediate psychosocial assistance is not one of their core tasks.

The lack of specialization also means that bereaved relatives are more likely to fall through the gaps in care or be referred and forth between institutions. While those grieving after natural deaths often receive guidance from hospice associations or palliative care teams, there is no comparable structure in cases of suicide. Goodall et al. (2022) show that suicide grief differs from other forms of grief in many ways. It is more intense, more contradictory, and more trauma-related, and is often characterized by guilt, shame, and stigmatization. These particularities require specific skills that generalist counseling centers can hardly impart without targeted training.

The social dynamics of rural areas are ambivalent. On the one hand, close networks, mutual support, and long-term acquaintances shape everyday life. On the other hand, this gives rise to specific forms of social control and reduced anonymity, which can have a massive impact on the behavior of those seeking help after a suicide. In Lower Bavaria, this is particularly pronounced due to the strong social integration in clubs, parishes, neighborhoods, and work environments. Survivors repeatedly report that "everyone knows" or that there is speculation about the suicide in the community. Many fears judgment, pity, or moral condemnation, especially in traditionally Catholic areas.

Whitebrook et al. (2025) show that bereaved people often oscillate between the need for openness and the need for protection. This tension is particularly complex in rural areas. Silence protects against social control but also increases the risk of isolation and psychological stress. Doka (2002) describes suicide grief as a form of "disenfranchised grief," i.e., grief that is not socially legitimized. In a rural context, this form of grief can be further exacerbated by pronounced social expectations of restraint, self-control, and "silent coping".

Many of those affected do not feel safe enough in their communities to talk openly about their situation. Counseling centers report that bereaved individuals often call anonymously, use pseudonymous email addresses, or only make appointments in cities so as not to be recognized. These forms of emotional protection strategies show that

stigma in Lower Bavaria is not only experienced individually but is also structurally anchored.

Stigmatization also affects the institutional level. Research by Werdin & Wyss (2024) shows that employees in social institutions themselves exhibit uncertainties in dealing with suicide losses, for example, out of fear of retraumatizing those affected or because they perceive the topic as “sensitive”. A lack of specialization exacerbates these uncertainties. When professionals internalize stigma, the issue's visibility is further reduced, creating a classic vicious circle.

While the requirements for post-ventive care are clearly described in international literature as timely, multi-professional, network-oriented, and trauma-informed (Abbate et al., 2022), Lower Bavaria has a highly fragmented system that is structurally unable to meet these requirements. This fragmentation is pronounced both horizontally (between institutions at the same level) and vertically (between the municipal, district, and regional levels).

The horizontal structures of care after a suicide in Lower Bavaria are often characterized by fragmentation. Cooperation among key players such as social psychiatric services, general social counseling, crisis services, hospitals, family doctors, psychotherapeutic practices, the police, emergency services, and church institutions is often person-dependent, poorly standardized, and, in many cases, random. Binding interface regulations, established emergency chains, joint training, clear reporting channels, and clearly defined responsibilities are largely lacking.

This is exemplified by the fact that police information about a suicide is not systematically forwarded to psychosocial specialist services in all cases. In some cases, bereaved relatives receive only general information material and must organize access to further support. This practice conflicts with international recommendations that emphasize early, coordinated psychosocial aftercare following suicide events (World Health Organization [WHO], 2014; Duval et al., 2023; Abbate et al., 2022).

There are also significant gaps at the vertical level. There are no consistent cooperation structures between municipalities, counties, district social administrations, the district of Lower Bavaria, and independent agencies. Particularly in the case of suicides in the agricultural sector, a frequent phenomenon in Lower Bavaria, it is unclear which institutions should be involved. The responsibilities of agricultural professional associations, veterinary offices, social insurance agencies, and health authorities are not

clearly defined. This lack of clarity leads to organizational inefficiency and increases the risk that families in highly stressful situations will be left without adequate support.

The emotional and intimate stress associated with suicide further reinforces the importance of structured support. Suicide is an experience of extraordinary emotional intensity, characterized by shock, guilt, shame, anger, confusion, and a profound upheaval of one's world. Confrontation with the scene of the event, the body, or distressing visual impressions is particularly stressful. In rural areas, the bereaved are particularly likely to be the first to discover the body, as professional services must travel longer distances. Emergencies following suicides illustrate this reality. The typical scene of blue lights, barrier tape, and technical equipment leaves a deep impression and, in the silence and remoteness of rural locations, often reinforces the event's traumatic nature. Whitebrook et al. (2025) show that such traumatic exposures are a key risk factor for complicated grief processes, which is further exacerbated in Lower Bavaria by structural conditions.

The region's digitalization deficits act as an additional systemic bottleneck. While telepsychological services are increasingly established in urban regions, their potential remains largely untapped in Lower Bavaria (Finucane et al., 2024). Finucane identifies key advantages of digital support services, including bridging geographical distances, lowering barriers to access, complementing face-to-face formats, relieving overburdened services, and increasing accessibility for vulnerable groups. In practice, however, unreliable internet connections, a lack of video technology in counseling centers, a lack of secure platforms, insufficient digital training, and low public visibility of digital services make effective use difficult. Especially when it comes to shameful topics such as suicide, trust in stable digital access is crucial and breaks down carelessly when the technical requirements are unreliable.

The cultural framework of Lower Bavaria also significantly influences post-ventive care. Traditional Catholic interpretations, family loyalty norms, gender-specific role expectations, and expectations of self-control and restraint shape how suffering and crises are dealt with.

The great importance of work, duty, and family in rural contexts means that many bereaved people experience both support and pressure. Men in agricultural family businesses are often under implicit pressure to continue functioning and not show weakness. This can make seeking psychosocial help appear to be a "social risk". As Niederkrotenthaler et al. (2025) show, regional masculinity norms can contribute to

delayed or non-existent help-seeking. This finding is also observed in rural Lower Bavaria in the present analysis.

In addition, care provision is significantly affected by a shortage of skilled workers and structural underfunding. Reports from the social economy and regional institutions show a low number of applicants, high turnover, low attractiveness of rural working environments, high psychological stress on employees, and inadequate remuneration. For postvention, this means long wait times, limited appointment availability, a lack of specialized training, and significant overload for the few skilled workers available. Many services are operating at their limits, increasing quality risks and making it difficult to further develop the services offered.

In addition, there are pronounced inequalities in care and social disparities. Belau and Gerstner (2024) show that rural and socioeconomically disadvantaged regions have higher suicide rates. These findings are also relevant for the context of Lower Bavaria, especially for structurally weaker districts such as Regen, Rottal-Inn, and Freyung-Grafenau. These areas are characterized by a lower density of doctors, lower incomes, limited educational opportunities, higher unemployment, and increased migration of young people. These factors increase the burden on the psychosocial care system by increasing the demand for support while reducing the available resources.

Another key shortcoming is the lack of systematic evaluation and quality development of existing services. Although many services are committed to their work, they often lack the necessary resources and methodological expertise to conduct continuous scientific monitoring. However, the importance of systematic outcome measurements to highlight effectiveness, needs, and burdens is explicitly emphasized in the international literature (Jackson et al., 2025).

At the same time, such procedures are methodologically demanding and require continuous data collection, documentation, and training. In Lower Bavaria, binding quality standards, standardized documentation processes, regional data exchange systems, and sustainable training structures have so far been established only to a limited extent. Werdin and Wyss (2024) point out that there are considerable gaps in quality assurance for suicide prevention in Germany as a whole, especially in rural areas.

Overall, the picture is complex, with geographical distances, digital bottlenecks, low specialization, social control and stigma, cultural norms, a shortage of skilled workers, structural decoupling, social disparities, and a lack of evaluation all interconnected. Postvention in Lower Bavaria therefore occurs within a complex tension

field characterized by individual vulnerability, institutional limitations, and regional cultural patterns. It demands a lot from professionals, organizations, and political structures and extends well beyond traditional psychosocial care in rural areas. Against this background, the following chapter presents the empirical findings of the study and explores how these structural conditions are experienced and understood by bereaved individuals and professionals involved in postvention.

6 Empirical Findings: Suicide Bereavement and Postvention

This chapter presents the empirical findings of a qualitative study on grief counseling and aftercare following a suicide in rural Lower Bavaria. The results are based on interviews and written questionnaires with bereaved individuals and professionals providing postvention support. The aim of this chapter is to systematically present the participants' experiences, perceptions, and needs and to ground them directly in the empirical data.

The analysis follows a reflexive-thematic approach. The focus is on participants' narratives, meanings, and subjective interpretations, rather than predefined theoretical categories. Accordingly, the results section emphasizes the participants' voices and grounds analytical statements in concrete interview material. Wherever individual experiences are described, the corresponding interview codes (e.g., H07, B04) are provided to ensure transparency and traceability.

This chapter is divided into two main parts. The first part describes the experiences of bereaved individuals with postvention support, including how they access help, the perceived usefulness of different forms of support, their emotional and social needs, and the temporal aspects of grief. The second part addresses professionals' perspectives and focuses on their understanding of the observed challenges of postvention and the structural conditions of care provision in rural areas. A separate section addresses perceived barriers to access, followed by a section summarizing suggestions for improvement from both bereaved individuals and professionals.

The tables summarizing the characteristics of the bereaved participants (Table 1) and the professional participants (Table 2) provide an overview of the empirical material and serve as a frame of reference for all subsequent analyses.

The aim of this chapter is not to interpret the results theoretically, but to present the empirical patterns and variations that emerged from the data. The theoretical discussion and integration will follow in a separate chapter.

Table 1**Overview of interviews with bereaved persons (empirical material)****Source. The author's own research****Table prepared by the author of the dissertation**

Inter- view ID	Relati- onshi- p to the decea- sed	Sociode- mographi- c characte- ristics	Character- istics of the suicide	Mode of interview admini- stration	Use of profession- al support (postven- tion)	Key themes / central experie- nces	Relevance for postventio- n	Raw materi- al referen- ce
H01	Son / cousin / nephew	Male, 46 years old	three suicides in the family. mother (02/2000) , cousin (09/1993) , uncle or father of cousin (03/1979)	Questio- nnaire- based; written	Professi- onal support decades later (hospital stay 2 years ago)	Guilt, stigma, lack of services , faith- based coping	Need for long-term, accessible postventio- n; addressin- g guilt and societal responsibi- lity	Appen- dix H01, questi- onnair- e
H02	Daugh- ter	Female, 55 years old	Suicide of the mother in February 2000 (hanging) ; history of depressio- n; repeated suicide threats; one prior non- lethal attempt with sleeping pills; death experien- ced as unexpect- ed after a period of apparent improve- ment	Questio- nnaire- based; written	Several free counseli- ng sessions (approx. 6) at a psycholo- gical counseli- ng center of Diakonie Regensb- urg in a rural area, initiated after recomm- endation by a member of a church- based Bible group	Initial shock and disbelie- f; intense grief and physica- l pain; long- standin- g parentif- ication and worry for the mother; loss of the parental home as “refuge- ” and subsequ- ent loneline	Importanc- e of low- threshold counselin- g and church- related networks in rural areas; need for proactive encourage- ment to seek help by trusted persons; value of profession- ally accompa- nied self- help groups for suicide- bereaved with attention to	Appen- dix H02, questi- onnair- e

						ss; weeken ds spent crying and feeling purpose less; gradual buildin g of a new social networ k via church, Bible group and Catholi c women 's associat ion; support from faith and religiou s ritual; perceiv ed “liberat ion” and increas ed fearless ness after survivi ng the loss; no persona l guilt; little perceiv ed stigma, but awaren ess of Christia n	possible guilt feelings; need for more open societal discourse on death, suicide and grief; need for guidance on how to approach and support grieving persons	
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						framing of suicide as sin		
H03	Mother	Female, 53 years old	Suicide of son in June 2020; in context of psychiatric/clinical treatment ; experienced as pervasive rupture making all aspects of daily life challenging	Questionnaire-based; written	No own professional support used; reports many offers in Frankfurt but no suitable services for adolescent siblings; initial flyer from police, further help left to family; data protection cited as barrier to proactive follow-up	Everything as challenge (daily functioning, social contact, organizing funeral and family events); simultaneous need to comfort and support others (family, school, professionals); alternation between inability to act and better days; getting a dog as emotional support and new perspective; search for missed signs to help others	Gaps in tailored support for adolescent siblings even in urban areas; need for proactive, follow-up oriented postvention beyond one-time information; importance of peer support and ritualization; need for long-term accompaniment acknowledging persistent grief; addressing stigma, social avoidance and blame; promoting open societal dialogue on suicide and grief	Appendix H03, questionnaire

						avoid similar mistakes; exchange with other bereaved; creation of rituals for birthdays and Christmas; strong social speechlessness; feeling judged and isolated; perception of stigma (fear of imitation, search for someone to blame)		
H04	Wife	Adult female; freelance socio-therapeutic professional (approx. age not stated)	Suicide of husband on 30 June 2024; bipolar disorder (depressive and manic phases); severe depression after moving	Interview-based; narrative notes	Ongoing professional support since suicide; follow-up contact from psychiatric institution (doctor and social	Shock and disbelief despite professional expertise; guilt about not recognizing suicidality; burden	Illustrates good postvention practice in psychiatric care; highlights need to involve partners in treatment of bipolar disorder; need to recognize	Appendix H04, interview / notes

			and clinic stay; suicide by medication at home; no farewell letter; suicide experienced as unexpected		worker); pastoral care; psychotherapy with external therapist ; informal support from friends, neighbors, church and hospice network; AGUS group considered but not attended	of police, emergency services and crime-scene flat; additional strain through very ill father and distressed in laws; emphasis is on “functioning” rather than rebuilding; family conflicts and ruptures; stabilization through broad social and church network and meaningful funeral; nature and activities with friends as key resources; positive evaluation of	and support the “functioning mode” and instability of bereaved; importance of distinguishing grief from depression; value of empathy training and mental health first aid; need to address suicide as violent, radical loss and to provide low threshold, non-stigmatizing support in rural, periurban areas	
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						clinic's postvention; stronger professional attention to suicidality; refusal to accompany assisted suicide requests		
H05	Father of eldest daughter / friend (ex-partner)	Female, 64 years old (current), 27 years old at time of suicide	Suicide of male partner in October 1987; history of severe mental illness/psychosis; prior inpatient treatment; voiced suicidality yet discharged; relationship separation 2,3 months before suicide; strong conflict with his family; no police offered support	Interview-based; narrative notes	No professional support at the time; later training as psychological counsellor or as part of personal processing; informal support from friends, later partner, daughter and son in law	Strong guilt feelings (towards deceased and child); accusation and rejection by deceased's family; fear of others and social withdrawal; early lack of any support offers; long-term difficulty in relationship with daughter who grew up	Need for visible, low-threshold and specialized offers for suicide-bereaved (especially in rural regions); importance of addressing guilt as central theme; necessity of empathetic, individualized counselling rather than schematic approaches or moralizing/religious talk; role of postvention	Appendix H05, interview / notes

						in paternal family; work experienced as liberating and stabilizing; gradual improvement through “step by step” coping and a lot of talking; importance of conversations with other suicide-bereaved; perception that depression and suicidality were inadequately treated; emphasis is on experiential knowledge, empathy, honesty and non-schematic counseling	n as both processing and prevention for further life; importance of making counselling centers and self-help groups better known and accessible ; need for societal openness and honesty about suicide and grief	
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H06	Mother	Female, 65 years old	Suicide of adult son in March 2025 by hanging from balcony; long-standing severe physical illness (Morbus Scheuer mann) and later paranoid schizophrenia after polytoxic substance use; repeated suicide threats and attempts; conspicuous behaviour, police contacts, short compulsory admissions; suicide long anticipated by mother	Case report written by counsellor (client declined direct interview due to recent loss)	Long-term prior and ongoing counselling at social psychiatric service (SPDI) as relatives' support; approx. 4 weekly sessions plus phone contacts during acute crises; focus on relief from responsibility, preparation for possible suicide, prevention of relapse of own depression; after suicide continuation of same counselling relationship; did not seek other offers; AGUS recommended but refused	Long phase of anticipatory grief and "tightrope walk" between support and autonomy; mother as main carer and contact person, intensive practical support in everyday life; initial functioning mode around funeral with delayed access to grief; strong need to cognitively grasp and accept the death; disruption of daily and weekly structure	Illustrates value of early, long-term relatives' counselling before and after suicide; importance of continuous, trusted one to one setting for highly burdened relatives with own suicidality history; need to support carers in balancing responsibility and autonomy; shows how pre-existing support can enable access to help after suicide; highlights impact of secrecy and religious stigmatization on grief and family dynamics; relevance of specialized offers (e.g. hospice associations, AGUS)	Appendix H06, counsellor's case report
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					in favour of trusted individual counselling	e after loss of caregiving role; gradual reorientation after about three months (visiting friends, travelling, focusing more on daughter); search for positive memories to avoid being overwhelmed by grief; strong influence of family conflict around disclosure of suicide to grandson	being adapted to preferences for individual vs. group support	
H07	Father	Male, 83 years old	Two suicides in the family. biological daughter Anna (born	Interview-based; narrative notes	Long-term psychotherapy with female therapist (approx. two	Different affective impact of the two suicides (emotio	Highlights need for competent suicide risk assessment and open discussion of	Appendix H07, interview / notes

			1965, suicide 1999) with limited contact since parents' divorce; adoptive son Hans (age 22, suicide 2018) with close relationship; Hans had genetic risk (schizophrenic mother), developed depression and suicidality in young adulthood, died by jumping from roof of Passau clinic where he was in treatment		years, first with wife then separately); therapeutic focus on processing own life story and both suicides; no mention of other formal postvention offers	nal distance to Anna, deep attachment to Hans); long struggle with son's illness, crises and coercive admissions; perception of grave failures in clinical suicide risk assessment and management; ongoing inner dialogue and gratitude towards Hans; strong awareness of genetic loading and adoption risks, yet affirmation of the adoption decision;	suicidality in psychiatric settings; calls for specialized, accessible counselling for suicide-bereaved families; underlines importance of integrating suicidology and grief after suicide into medical, psychological and social work education; stresses necessity of destigmatizing suicide at societal and church levels and of developing broader, well-funded support structures for relatives	
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						continuing bonds through objects and nature; initial isolation and shame, later wish for public discourse; view of suicide as widespread but hidden issue		
H08	Mother	Female, 69 years old (43 at Elvira's suicide in 1999; 62 at Jona's suicide in 2018)	Two suicides in the family. Elvira (stepdaughter, suicide 1999); Jonas (adopted son, suicide 2018, died in hospital after jumping from clinic roof); long-standing mental health problems and suicidality in	Interview-based; narrative notes	After Elvira's suicide, psychodrama group for foster/adoptive parents (Bavaria level, approx. four times per year); after Jona's suicide. intensive support and trauma therapy by GP who is also psychoth	Deep shock and paralysis after Jona's death in hospital; perception of missing crisis intervention and support for relatives in the clinic; critical view of professionals' risk assessment and defensiveness	Highlights serious gaps in hospital-based crisis intervention and systematic support for relatives after suicide; underlines importance of trauma-informed, long-term GP/psychotherapy care; value of specialized groups for adoptive/foster	Appendix H08, interview / notes

			Jonas, treated at hospital before death		erapist and had treated Jona before; additional informal support from friends (including doctors and psychotherapists) and foster/adoptive parents' group	ve reaction s; strong help from empathic GP, friends and peer group who "simply grieved with her"; difficulties of mutual support within the couple due to different grieving styles; experience of limited local offers for (suicide -)bereaved in Passau; importance of time, talking and shared grief for coping	parents; need for transparent, non-defensive communication by clinicians after a suicide; indicates necessity of expanding and making visible local grief and suicide-bereavement services	
H09	Ex wife (moth	Female, 56 years old; 20	Suicide of ex husband	Interview-based;	Support for son and	Major challenge of	Highlights need for structured	Appendix H09,

	er of his son)	year relations hip, 16 years married; one son (6 at separation, 9 at time of suicide)	in March 2013; occurred about two years after divorce; ongoing conflicts, financial problems and “terror” reported; suicide experienced as both burden and partial relief (end of conflict and dual parenting styles)	narrative notes	family from SBZ Passau psychologist, child and adolescent psychotherapist, youth welfare office and paediatrician; guidance on how to tell the child the truth; own needs and fears largely unsupported; later contact with BKH Passau	truth-telling to the child and pressure from ex husband’s family to conceal suicide; construction of “complex web of lies” vs. recommended openness; initial self blame and questioning of marital responsibility; ongoing up and down grief course over years; change and partial loss of social network; perceived stigma in the environment; simulta	guidance to surviving parents on communicating suicide to children; importance of addressing ex partners’ guilt and own support needs, not only those of the child; shows scarcity of specialized postvention offers and trained staff; underlines role of youth services and school/child services; raises issue of structural discrimination when family suicide history restricts children’s career options	interview / notes
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						neous feeling of liberation from ex husband's control; ongoing impact on son's processing of the loss		
H10	Daughter	Female, 27 years old; 6 years old at time of father's suicide	Suicide of father by hanging on 14 June 2005 in a psychosomatic clinic in Simbach; father lived in same household, had schizophrenia, depression and severe heart disease with poor prognosis ; mother planned separation during his clinic stay out of fear of escalation	Interview-based; narrative notes	No specific professional support after father's suicide; mother in psychotherapy (not only because of suicide); many years later own search for therapy after death of "replacement father," with difficulties finding a therapist in rural area; occasion	Limited attachment to father and rapid "closure" of the topic in childhood; later renewed confrontation through belongings and creating a memory box (letters, documents, photos) ; no anger towards father, view of suicide as	Points to lack of child-focused postvention and follow-up when a parent dies by suicide; highlights long-term, delayed processing of childhood suicide loss; underlines gaps in acute, easily accessible counselling in rural regions; stresses importance of neutral, empathetic, non pathologizing	Appendix H10, interview / notes

					al support via workplace PSNV service in Munich	individual decision; protective amnesia around hospital events and time after; important role of later “replacement fathers” and current fear of losing remaining family (mother); experience of scarce acute help and long waits for therapy in rural areas; professional perspective on suicidality and need to take threats seriously while distinguishing attentio	contact persons; suggests offering diverse, creative grief rituals and individualized approaches instead of standardized “one size fits all” therapy paths	
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						n seeking from acute intent; emphasis is on low threshold, empathic conversations and flexible, non dogmatic support rather than only inpatient or classical psychotherapy		
H11	Husband	Male, 58 years old at time of suicide; widowed since March 1999	Suicide of wife in March 1999 (details of method not specified); shared flat became emotionally difficult space, constant sense of her presence; moved to a new flat within about	Questionnaire-based; written	Psychotherapy; participation in a grief café with professional and volunteer facilitators, all bereaved by partner loss (not always through suicide)	Relief at not having to identify the body; importance of funeral and grave (300 km away) as farewell ritual and place to visit; returning to shared	Importance of timely access to psychotherapy and serious grief support offers in urban settings; value of rituals and spatial changes (funeral, grave, moving flat) for grief processing; need to address	Appendix H11, questionnaire

			three months as part of grief work			home as major challenge (feeling wife's presence, difficulty touching her belongings); change of flat as helpful step to start grief work; focus on rebuilding life, especially through work; no wish for quick new partnership, feeling "fulfilled" for about five years by past relationship; long term impact on ability to enter new partnerships,	long term relational consequences and fears in widowed persons after suicide; caution against superficial or commercialized grief offers ("turbo grief seminars") and emphasis on credible, helpful services	
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						with recurrent loss and failure anxieties		
H12	Long term close friend	Female, 65 years old	Suicide of long standing very good friend on 01 March 2023; repeated prior suicide attempts; progressive social withdrawal and explicit wish to be left alone; refusal of conversations and help; perceived role of alcohol and loneliness; bereaved experienced the funeral as very loveless	Questionnaire-based; written	No formal postvention offers used; intensive supportive conversations with a friend who is a mediator	Helplessness in face of rejected help offers; need to accept the friend's wish for peace and self-determination despite pain; conviction that no one should judge the decision; coping through belief that the deceased found peace; hurtful experience of an unloving funeral; perception that societal reactions did	Need to address guilt relief and clarify boundaries between self-determination and perceived responsibility; importance of respecting autonomous decisions while supporting survivors; attention to the design of farewell rituals; recognition of highly individual grief processes and the necessity of respect and acceptance rather than normative expectations	Appendix H12, questionnaire

						not shape her grief; strong emphasis is on individuality of grief		
H13	Cousin	Female, 43 years old	Suicide of cousin in April 1993; later disclosure of gambling addiction, high debts, intense shame and perceived hopelessness, unknown to family beforehand	Questionnaire-based; written	No professional support used; no search for specific postvention offers	Strong emotional turmoil (self-blame, helplessness, grief, pain, anger and perceived egoism. “why is she doing this to us”); need to understand and subsequent learning about hidden addiction and desperation; sense of cousin’s extreme shame and isolation	Importance of relieving guilt and working through difference between self-determination and external determination; need for respectful, accepting attitudes toward the deceased’s decision while supporting bereaved; postvention should help families understand hidden problems such as addiction and associated shame	Appendix H13, questionnaire

Table 2**Overview of interviews with professionals (empirical material)****Source. The author's own research****Table prepared by the author of the dissertation**

Inter view ID	Professi onal role / instituti on	Sociode mographi c & professio nal backgrou nd	Definiti on of postven tion	Profess ional field / setting	Key challeng es observed	Approac hes and practices	Relevanc e for postventi on structure s	Raw materi al referen ce
B01	Freelan ce funeral speaker / counsel or	Male; many years of experien ce working with bereaved persons	Support during farewell and narratio n of life story	Freelan ce counsel ing / funeral context	Guilt, shame, lack of clear responsi bilities in aftercare	Non- judgmen tal space, individu al rituals	Need for clearly structure d and coordinat ed postventi on	Appen dix B01, questi onnair e
B02	Represe ntative, (nation al self- help associat ion)	Male; long- standing experien ce in counselin g and supportin g suicide- bereaved on a nationwi de level; self-help and coordinat ion role	Early, active and network ed aftercar e followi ng suicide; support aimed at reducin g isolatio n, stigma and complic ated grief	Self- help organiz ation; advisor y and coordin ation work at nationa l level	Guilt, stigma, social isolation of bereaved ; lack of clear responsi bilities; highly uneven availabili ty of support across regions	Peer support groups; counseli ng for relatives; networki ng with professio nal services; advocac y for suicide- bereaved	Emphasi zes the need for formalize d postventi on chains, clear responsib ilities and systemati c cooperati on between self-help and professio nal services	Appen dix B02, written statem ent / letter
B03	Social worker, counsel ing center for mental	Female; approx. 2.5 years of experien ce in the counselin	Aftercar e followi ng suicide and suicide	Outpati ent counsel ing center for mental	Guilt, anxiety, anger, grief, shame; strong social	Trust- building relations hip; careful attention to body	Highlight s the importan ce of low- threshold , locally	Appen dix B03, questi onnair e

	health and refugee counseling; facilitator of a group for suicide-bereaved	g center at the time of data collection ; additional work in refugee counseling	attempts, embedded in general psychosocial counseling	health (Caritas); group offer for suicide-bereaved in a rural area	taboo around suicide; delayed help-seeking and reluctance to talk	language ; trauma-informed stance; use of supervision and further training; group offer for bereaved	accessible services and group formats; criticizes poor public transport and limited reachability in rural areas	
B04	Diploma social pedagogue (FH), Social Psychiatric Service (SPDi); leader of open group for suicide-bereaved and trauma group	Female; experienced SPDi staff member; runs a monthly open group “Hinterbliebene nach Suizid” and a yearly trauma group (6 sessions)	Support and stabilization after suicide, aiming to prevent or reduce mental disorders and suicidality among bereaved	Social psychiatric service (SPDi) in a rural Bavarian region; group and individual counseling	Everyday triggers (places, dates, objects), social withdrawal, intense guilt and shame, negative self- and future concepts	Trauma-informed psychoeducation (PTSD, flashbacks, hyper-/hypoarousal, constriction); teaching concrete coping skills; work on allowing emotions and joy again; use of rituals and explicit naming of guilt and shame	Demonstrates the value of specialized group offers within SPDi structures; underlines the need to anchor trauma-informed postvention as a regular task, not as an add-on	Appendix B04, questionnaire
B05	Social pedagogue, Social Psychiatric	Female; several years of experience in SPDi	Part of general SPDi counseling.	Social psychiatric service in a	Guilt and shame; existential quest	Relationship- and resource-oriented counseling	Calls for better networking, clearer	Appendix B05, questionnaire

	tric Service	work including contacts with relatives after suicide	support and aftercare for suicide-bereaved within existing psychosocial services	mid-sized town	for meaning; organizational overload (formalities, everyday functioning) after the suicide	ng; support with practical issues; team support and supervision; integrating postvention into routine SPD work	responsibilities and more specific postvention offers in rural areas	onnaire
B06	Social pedagogy, counseling center for mental health; also involved in crisis service	Female; around eight years of experience in the counseling center (with a break for parental leave); crisis intervention experience	Aftercare following suicide and an opportunity to “learn from experience” without getting trapped in endless guilt	Outpatient counseling center for mental health in a rural Bavarian district	Difficulties finding low-threshold help; organizational and bureaucratic overload; persistent search for reasons; self-blame and blaming others	Individual counseling at the office, by phone and in home visits; crisis service; group formats; referrals; open, non-judgmental attitude; use of supervision and further education; partial normalization (“suicide not always preventable, sometimes subjectively felt	Points to gaps in visibility and accessibility of support; underscores the need for systematic, easily findable postvention services	Appendix B06, questionnaire

						as necessar y”)		
B07	Diplom a social pedago gue (FH), Social Psychia tric Service (SPDi); leader of open group for suicide- bereave d and yearly trauma group	Male; experien ced SPD staff member; since almost 8 years	Support , accomp animent and stabiliza tion after suicide with explicit suicide- preventi ve aim for bereave d	Social psychia tric service in rural Lower Bavari a with both group and outreac h crisis work	Everyda y triggers, marked social withdra wal, pervasiv e guilt and shame, very negative self- and outlook	Trauma- focused psychoe ducation ; teaching concrete skills for dealing with flashbac ks, arousal and constrict ion; working with rituals and explicit addressi ng of guilt/sha me; fostering new relationa l experien ces	Shows that structure d SPD based postventi on groups can be a key element of regional care; argues for clearer anchorin g of postventi on in service mandates	Appen dix B07, questi onnair e
B08	Diplom a social pedago gue (FH), counsel ing center for mental health / SPDi- type service	Male; works in a psychoso cial counselin g setting in rural Lower Bavaria; postventi on cases are described as rare	Concise . “afterca re” followi ng suicide	Outpati ent mental health counsel ing (SPDi- like); individ ual counsel ing; rural context	Broad range of emotions . grief, pain, speechle ssness, powerles sness, anger, helplessn ess, shame and guilt; central	Individu al counseli ng; trauma- sensitive attitude by letting clients determin e depth and pace; explicit permissi	Points to limited frequenc y but high intensity of cases; stresses problems of reachabil ity and service accessibi lity in	Appen dix B08, questi onnair e

		exceptions			questions “Why?” and “Could I have prevented it?”; strong need for relief from self-blame	on to talk about taboo feelings; team exchange and supervision	rural areas	
B09	Registered nurse and practical trainer, psychiatric hospital	Female; works in the nursing and educational service of a psychiatric hospital; regular contact with relatives after suicide attempts and suicides	Counseling relatives about their own feelings and ways of coping after a suicide of a loved one	Inpatient psychiatric care); nursing perspective	Persistent “Why?”-questions; strong guilt feelings; existential uncertainty about how to continue living; low acceptance of suicidality as a manifestation of mental illness; blaming in the social environment	Informal conversations with relatives; emotional support during hospitalization; attempts to normalize reactions; use of team supervision for self-care	Identifies structural deficits. time pressure, lack of systematic information, no formalized postvention processes; stresses potential value of structured family and relative groups	Appendix B09, nursing questionnaire
B10	Nurse in ambulatory home care service	Female; works in home care in the Landshut region with elderly and severely ill patients;	Initially unfamiliar with the term; understands it as aftercare for patients and relative	Ambulatory nursing in a predominantly rural, Catholic region	Mixture of grief, guilt, shame and sometimes relief after long-term caregiving; difficulty	Conversations before and during care; information about the dying process; addressing	Criticizes that psychosocial conversations occur “on the side” under time pressure and are	Appendix B10, nursing questionnaire

		experience with suicide-related deaths (e.g. medication, refusal of food)	s around the time of dying, including in cases of self-determined death		to speak openly about ambivalent feelings; strong taboo around suicide in old age; limited palliative/hospice resources	ambivalences (“letting go” vs. “not ready”); inclusion of relatives and children in care of the deceased; informal “to-go counseling” with colleagues from mental health services	not structurally backed; calls for better integration of psychosocial postvention and clear referral options from nursing services	
B11	Social pedagogue, social psychiatric counseling service (SPDi context)	Male (likely; not explicitly stated); works in a rural SPDi/mental health counseling setting; data collected via handwritten “Postvention Beratung” form	“Support and aftercare” following suicide; accompaniment of bereaved in coping with the loss	Social psychiatric counseling in rural Bavaria; low-threshold individual counseling	Guilt, shame, bewilderment, helplessness; strong need for answers to “Why?”; perception of societal reactions as weakness, anger, incomprehension and failure	Creating space without “digging” into details; client-led depth and pace; emphasis on low-threshold access; use of supervision and organizational structures for self-care	Underlines the necessity of low-threshold, easily recognizable postvention offers; points to deficits in psychotherapeutic care and stigma in rural settings	Appendix B11, handwritten questionnaire
B12	Head psychologist,	Male, diplom-psycholo	Abstractly. adaptati	Social Psychiatric	Reports that suicide	Occasional integrati	Illustrates that in some	Appendix B12,

	Social Psychiatric Service,	gist; head of SPD in a rural district	on to the loss after suicide; integration of the event into one's life course	Service (SPDi) in a rural region; management perspective	of relatives is a very rare and marginal topic in his caseload; where present, mainly sadness about being left behind; no robust empirical basis for generalizations	on of suicide losses in general biographical and illness-history work; no specialized postvention concept due to low case numbers	rural SPD settings suicide-bereavement is barely visible as a distinct field; indicates potential under-detection and lack of targeted offers	written response
B13	Dipl. psychologist; counselor and therapist for children, adolescents, young adults and parents, Counseling Center for Children, Adolescents and Parents	Male; Dipl.-Psychologe; systemic therapist / family therapist (DGSF); head of the Counseling Center for Children, Adolescents and Parents. Has occasional experience with families affected by suicide, mostly after the suicide of	The term "postvention" was previously unknown to him; he understands it as interventions following ("post") a (suicidal) event	Outpatient counseling and (systemic) family therapy for children, adolescents, young adults and their parents in a rural Bavarian district; sessions scheduled in an individually	Acute shock, especially when the suicide is completely unexpected; questions of subjective involvement and guilt ("Did I do something wrong? Would it not have happened if I had...?"); coping with loss	Systemic counseling and therapy for all family members who are open to external support; basic trauma-sensitive principles without formal trauma training, especially concrete stabilization in the initial shock and grief phase rather	Highlights that specialized postvention services would likely face difficulties in rural areas due to lower case numbers and shame-related barriers (clients fearing to be seen entering such a service); no known	Appendix B13, questionnaire

		a parent, once after the suicide of a brother.		agreed rhythm, initially more frequent when the suicide is recent.	and the associated emotions; communicating about the event to the outside world; dealing with how the environment evaluates and views the suicide.	than deep processing; open addressing of taboo topics, guilt and shame; encouraging open communication; careful pacing and sensitivity regarding how much open exchange a person can cope with in each phase.	local initiatives or cooperations in the field of postvention; underline the importance of general family counseling centers as low-threshold points of contact.	
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6.1 Experiences of bereaved individuals with postvention

The interviews reveal that bereaved individuals do not experience grief support as a clearly structured or consistently accessible support system. Instead, it is perceived as a fragmented, situation-dependent, and highly person-dependent network of encounters, resources, and obstacles. In all cases, grief support is described not as a coordinated system, but rather as a series of individual contacts that may not occur at the right time.

For most participants, access to support was not through systematic referral channels but rather by chance or through third-party intermediaries.

A 55-year-old woman who lost her mother to suicide in 2000 reported that she only sought psychological counseling on the recommendation of a member of her church Bible study group (H02). Similarly, a 53-year-old mother whose son committed suicide in 2020 reported that she received only a flyer from the police and that further assistance

was left entirely to the family's own initiative (H03). She emphasized that despite living in a large city, she was offered neither proactive aftercare nor coordinated support.

A 46-year-old man who had experienced three suicides in his family stated that he only gained access to professional help decades later, during a hospital stay unrelated to bereavement following a suicide (H01). Seeking help had previously been "unthinkable" in his family, and access was only made possible by the later medical context.

Several participants described similar, indirect pathways. A 27-year-old woman who had lost her father as a child reported that she was not offered any specific support after his suicide and that her subsequent attempts to find therapy were hampered by long waiting lists in rural areas (H10). A 65-year-old friend of a woman who had committed suicide reported that she never sought formal aftercare services and relied solely on conversations with a friend as an intermediary (H12).

These reports show that access to aftercare was not anchored in standardized institutional procedures but depended primarily on personal networks, chance recommendations, or later-life circumstances.

The forms of support used by the participants varied greatly. These included individual psychotherapy, counseling centers, pastoral care, social psychiatric services, peer discussions, and self-help groups.

Some participants rated the structured professional support positively. One woman, whose husband committed suicide in 2024, reported ongoing psychotherapy, pastoral care, and supportive aftercare contact through the psychiatric facility. She described this combination as stabilizing and helpful in coping with shock, guilt, and family stress (H04).

A widowed man who lost his wife in 1999 described psychotherapy and participation in a bereavement café as important resources that helped him to gradually resume his daily life and professional activities (H11).

Others emphasized the importance of informal or interpersonal support. A 64-year-old woman whose former partner committed suicide in 1987 described conversations with friends, her later partner, and her children as central to coping with the loss in the long term, while no professional support was available at the time of the loss (H05).

A 69-year-old mother who had lost two children to suicide highlighted the role of her family doctor, who was also a psychotherapist, as well as that of a foster/adoptive

parent group, and described them as crucial for processing the trauma and for emotional stabilization (H08).

Participants did not primarily evaluate the support based on its professional status, but rather on the quality of the relationship, its continuity, and its emotional security.

The same emotional themes repeatedly emerged in the interviews concerning the experiences following the death of the child. Guilt was described as a dominant and persistent feeling. A 64-year-old woman reported intense guilt towards both the deceased and her child, coupled with rejection by the deceased's family (H05). A 46-year-old man described guilt as closely linked to stigmatization and a lack of support (H01). A 53-year-old mother reported constantly searching for overlooked signs and experiencing self-doubt (H03).

Shame and social withdrawal also played a significant role. Participants reported fear of judgment, speechlessness in social situations, and avoidance of conversations about suicide (H03, H07, H09). A 65-year-old friend emphasized the loneliness resulting from the deceased's wish to be left alone before death and the lack of affection in the funeral arrangements (H12).

Several participants described a pronounced "functioning mode" in the early phase after the suicide, in which they focused on organizational tasks, while emotional access to grief was delayed (H04, H06). A 65-year-old mother whose son had long anticipated his suicide reported a prolonged period of anticipatory grief, followed by disruption of her daily routine after losing her caregiving role (H06).

At the same time, participants described gradual processes of reorientation, such as traveling, focusing on remaining family members, creating rituals, or searching for positive memories to avoid being overwhelmed by grief (H03, H06, H10).

A 43-year-old woman who lost her cousin to suicide described the initial period after the death as a "violent emotional rollercoaster" of self-reproach, disbelief, helplessness, grief, pain, and anger ("Why is she doing this to us...?"). Only when she later learned that her cousin had been a gambling addict, had accumulated significant debts, and had apparently felt immense shame, was she able to understand the act more as an expression of despair and loneliness (H13).

A key finding concerns the temporal dimension of postvention. Many participants reported that their need for support did not arise immediately after the suicide.

Parents who had lost their daughter and later their adopted son reported that they only sought support later and were only open to therapeutic and spiritual support later on

(H07, H08). A 27-year-old woman stated that coming to terms with her father's suicide only began many years later with sorting through personal belongings and creating a memory box (H10).

A widowed man reported that although he rebuilt his professional life relatively early, the fear of new relationships and repeated losses persisted for many years (H11).

These narratives suggest that postvention is experienced more as a long-term process with changing needs than as a short-term intervention.

The participants unanimously emphasized that the social recognition of their role in grieving strongly influenced their experiences after the intervention.

Former partners and friends often felt that their grief received less social recognition (H09). Parents felt understood in their grief by those close to them, but were disappointed by institutional responses (H07, H08). Adult children reported a lack of child- and youth-appropriate support after the suicide of a parent (H10).

Several participants highlighted conflicts within families regarding the disclosure of suicides, particularly when religious or moral stigma was present (H06). These conflicts not only affected the grieving process but also access to external support.

From the perspective of the bereaved, aftercare was experienced not only as a matter of service availability but also as a question of affirming the relationship, fostering communicative openness, and granting social permission to grieve.

In all the interviews, coping with grief emerges as a fragile, uneven, and highly individual experience. Access to support depends on chance and mediation, and the quality of help follows personal rather than institutional rhythms, shaped by relationship building and timing. The narratives of the bereaved illustrate that coping with grief is experienced less as a coherent system and more as a patchwork of encounters that can support, delay, or complicate the grieving process.

6.2 Perceived barriers to accessing aftercare services

The interviews show that bereaved individuals encountered numerous, interconnected obstacles when accessing postvention. These obstacles were described as informational, structural, geographical, social, and emotional. Participants frequently described access to postvention not as a clearly defined path, but as something that had to be actively "found," negotiated, or postponed due to shock and being overwhelmed (H01, H03, H06, H10, H11).

A recurring obstacle was the lack of clear information about who to contact and who is responsible for aftercare following a suicide. Some participants reported that no one proactively contacted them after the immediate situation had been dealt with, and that information was either completely unavailable or consisted only of very general materials (H03, H05, H10).

One mother reported that the police left a flyer but left the responsibility for further steps entirely to the family: "The police will leave a flyer. After that, it's up to you to take care of it."

A participant who had experienced several suicide losses explained similarly that he had not known that external support existed, and that due to his upbringing, he had coped with everything alone for years: "I didn't even know that there was support available from external agencies." ["I didn't even know there was support from external bodies..."] (H01)

In other cases, the lack of information was exacerbated by the fact that the death occurred when the participant was still a child; later in life, the issue remained "unspoken", and no services specifically tailored to children were reported (H10).

Participants repeatedly described structural bottlenecks in services, particularly in rural areas. These bottlenecks manifested themselves both in a general lack of services and in long waiting times, which posed a practical obstacle to accessing help (H01, H10, H11).

One participant explicitly linked the problem to waiting times and resource scarcity in rural areas: "There are enough options available – if you disregard waiting times of up to two years... in rural areas, there are far from enough options." ["...if the waiting time of up to 2 years is not taken into account... There are nowhere near enough options in rural areas."] (H01)

In contrast, a widowed participant described comparatively quick access in an urban environment and explicitly linked this to the availability of services, not to a fundamentally different need (H11).

Another major obstacle was the perceived stigma and fear of social judgment. Some participants reported direct social avoidance (e.g., being shunned by others), while others described more subtle pressure to remain silent or to address the issue in a socially acceptable way. One mother put it very clearly: "Yes and yes – there are still people crossing the street." ["Yes & yes, there are still people who cross the street."] (H03)

Another participant described stigmatization as a persistent feeling of being considered abnormal or socially stigmatized after a suicide loss (H01).

Furthermore, a case report described how stigmatization affected communication within the family: The grieving grandmother was not allowed to mention the cause of death, which the participant found very distressing and a blockage to the grieving process (H06).

Many participants described the period following the suicide as characterized by functional demands, organizational tasks, and emotional overload. During this phase, seeking support was often not possible, even if participants later considered it important or benefited from follow-up contact (H03, H06).

One participant used a particularly vivid formulation: "I just functioned." ["...she said she was just functioning."] (H06)

A working, grieving participant described a similar dynamic and emphasized the importance of recognizing this "functioning mode" in aftercare work. "It is important to recognize the respective mode of functioning of people... and to allow this instability." ["...that one recognizes the mode of operation in which the bereaved are then... and that one allows this instability to be part of it."] (H04)

In this context, the mother in case H03 emphasized that grief does not end quickly and that continued contact beyond the first few days is beneficial: "Grief doesn't end after three days. Stay with them." Grief doesn't end after 3 days. Stay tuned. (H03)

Several reports indicated that contact with institutions often ends after the acute phase – after police action, medical interventions, or the organization of the funeral – without a structured bridge to psychosocial aftercare being established (H03, H06, H07/H08, as mentioned in the family narratives).

In one case, the participant explicitly described how data protection was cited as an argument against further contact – something she personally could have accepted and which she had heard had helped others: "Data protection is the argument for why they cannot get in touch again after a few days." ["Data protection is the argument for why one cannot ask again after a few days of pastoral care."] (H03)

Another participant described that helpful support required a trusting relationship bridge that had already existed before the suicide – implying that it would probably have been too difficult to seek help after the suicide (H06).

The interviews show that the barriers to accessing aftercare are not isolated but interconnected. Limited information, unclear responsibilities, supply shortages, long

waiting times in rural areas, fear of stigmatization, the emotional strain during the acute phase, and the discontinuity of institutional systems all interact and reinforce one another. As a result, aftercare is often delayed, fragmented, or unavailable altogether.

The interviews show that the obstacles to accessing aftercare do not occur in isolation but are closely intertwined and mutually reinforcing. Limited information about available services, unclear institutional responsibilities, the low availability of support services in rural areas, long waiting times, fear of stigmatization, and the emotional "functioning mode" in the acute phase form a complex network of obstacles, not separate problems.

Participants rarely described a single, decisive obstacle. Instead, they described a cumulative process in which several difficulties arose simultaneously or sequentially. Emotional paralysis in the initial phase often prevented active help-seeking, while the lack of proactive follow-up further reduced the likelihood of later access. At the same time, stigma and fear of social embarrassment deterred many from utilizing visible or local support services, particularly in small communities.

Geographical distance and limited service availability exacerbated these dynamics, particularly in rural areas where long commutes, inadequate public transportation, and a lack of anonymity created additional practical and emotional burdens. Institutional fragmentation further contributed to discontinuity, as participants experienced abrupt breaks in contact due to police, medical, or funeral arrangements, without structured transitions to psychosocial aftercare.

As a result, support after a suicide was frequently delayed, interrupted, or not used at all. When support was available, it often depended on chance, individual referrals, or existing relationships of trust, rather than on systematic referral channels. The interviews, therefore, paint a picture of post-suicide support not as a stable, easily accessible service structure, but as a fragile resource in the lives of the bereaved, highly dependent on availability.

6.3 Professional Perspectives on Postvention

Interviews with professionals reveal that postvention is understood as an important, yet insufficiently structured, field of activity. Although all participants acknowledged the relevance of postvention for those bereaved by suicide, their descriptions differed considerably about definitions, institutional integration, practical implementation, and perceived responsibility. Postvention is primarily practiced within

existing professional roles rather than as a clearly defined, independent field. Several professionals explicitly stated that the term "postvention" itself was unfamiliar to them, even though they support those bereaved by suicide as part of their daily work (B10, B13).

A nurse working in outpatient care explained, "I am not familiar with the word. Aftercare for patients also means aftercare for relatives" (B10).

A child and adolescent psychotherapist explained similarly that although the term was unknown to her, its meaning was intuitively understandable, as it referred to support after a suicide attempt (B13).

Despite differing terminology, the experts described postvention primarily as support, stabilization, and accompaniment of grieving individuals.

One social worker defined postvention as aftercare that begins after the acute crisis ends, to help those affected cope with irreversible circumstances (B05).

Another social worker defined postvention as aftercare for "affected survivors and bereaved in the narrower and broader sense," aiming to learn from experiences and process what has happened (B07).

A funeral speaker emphasized that he had little use for abstract, technical terms like "postvention" and understood his role pragmatically, accompanying conversations surrounding the funeral service and walking together (B01).

Another social worker also succinctly defined postvention as "support and aftercare" aimed at those left behind after a suicide (B11).

Another expert described postvention as helping grieving people "to learn to live with irreversible circumstances" (B06).

Another psychologist understood postvention primarily as support in adjusting to loss (B12).

One consultant summarized the postvention as follows: "Support and aftercare." ["Support and aftercare."] (B11)

In the interviews, postvention was therefore understood less as a formalized intervention model and more as a relationship-oriented support process.

Experts cited feelings of guilt, shame, and the persistent question of "why" as key problems for the bereaved.

A social psychiatrist described the following: "Guilt and shame – I didn't look closely enough; I didn't act." ["Guilt and shame – I didn't pay enough attention or act properly."] (B04)

A social worker emphasized that bereaved individuals often struggle with a complex mix of guilt, fear, anger, grief, and shame, while simultaneously suffering from the taboo surrounding the topic because few are willing to speak openly about it (B03).

A social pedagogue highlighted that many bereaved individuals carry "massive feelings of guilt" and are further burdened by blame from their social circles, leaving some temporarily unsure how to go on living (B06).

A counselor described a similar spectrum of reactions—grief, pain, speechlessness, powerlessness, anger, helplessness, shame, and guilt—and emphasized that many bereaved individuals grapple primarily with the question of why the suicide occurred and whether they could have prevented it, while simultaneously seeking relief (B08).

A social pedagogue described how these reactions often manifest as a mixture of guilt, shame, bewilderment, and powerlessness, accompanied by the persistent question "why" and a need for relief in a safe, supportive environment (B11).

In the few cases where suicide losses were discussed, one psychologist reported primarily a profound sadness about the feeling of having been abandoned (B12).

A child and adolescent psychologist reported great confusion and many unanswered questions among the bereaved, as well as a strong need to be relieved of feelings of guilt – but only in a way that felt internally coherent and credible to them (B13).

Another social worker observed that many bereaved individuals intensively search for reasons for the suicide, grappling with both their own self-recrimination and accusations from those around them (B07).

Another professional highlighted the constant triggers and withdrawal from daily life (B04).

A child and adolescent therapist described frequent reactions as confusion, many unanswered questions, and a strong need to alleviate feelings of guilt (B13).

Similarly, a nurse reported that relatives often fluctuate between anger, self-doubt, and a need for responsibility (B10).

Another nurse described how bereaved individuals frequently look for someone else to blame, are characterized by anger and incomprehension, and simultaneously develop intense self-doubt that can significantly impair their daily lives (B09).

A nurse from outpatient care reported that many relatives after a suicide waver between feelings of guilt, shame that they are not allowed to talk about it, and a specific

relief because the often long-term, exhausting care is over and the deceased person no longer must suffer (B10).

Experts also highlighted the complexity of the emotions, including ambivalence, relief, anger, and longing, which often coexist and are difficult for grieving people to express (B10, B06).

In all professional contexts, experts emphasized relational attitudes over specific techniques.

Several experts emphasized the importance of listening, allowing feelings to surface, and creating a safe space for their expression. One consultant explained: "Listening is the most important thing." ["Listening is the most important thing."] (B13)

A social worker described how many bereaved individuals primarily need to talk to someone who "simply listens and bears their feelings," and that it is beneficial for them to have an outside, non-judgmental person who creates a space where, in the initial conversation, everything except destruction and physical violence is explicitly permitted (B05).

Another professional reported that she openly addresses potential taboos and distressing feelings and incorporates her own hypothetical reactions ("how I would feel if...") into the conversation to create space for difficult emotions (B06).

Another counselor emphasized that clients should decide for themselves how deeply they want to delve into the process and which topics they want to address, and that feelings of guilt and shame, as well as potential taboos, may be explicitly acknowledged (B08). A social worker stressed that the primary goal of counseling is to give bereaved individuals space without probing and to enable them to speak at their own pace (B11).

A child and adolescent psychologist reported that he directly addresses feelings of guilt and shame and encourages bereaved individuals to talk about them as openly as possible (B13).

A nurse described how she addresses feelings of guilt and shame, as well as potential taboos, openly and objectively, giving them space in conversation and making them manageable (B09).

Another social worker described her approach as follows: in these conversations, "everything is allowed," and it is crucial to listen, openly address complex topics, and work together to destigmatize them to "learn for the future" from the experiences (B07). Another social worker emphasized the importance of explicitly naming guilt and shame as symptoms, rather than moral failings (B04).

Several experts emphasized that time, flexibility, and emotional openness were crucial: "Time is helpful – giving yourself and the consultation process time." ["Give yourself time – but also time for advice."] (B02).

Most professionals stated that they applied trauma-sensitive principles, even if they had not completed any formal training.

These principles included stabilization, psychoeducation, careful pacing, validation of emotions, and normalization of stress responses (B04, B06, B13).

A social worker also emphasized the importance of establishing a solid foundation of trust at the outset, paying close attention to clients' body language during conversations, and utilizing regular training, supervision, and team meetings to meet the needs of bereaved individuals who have experienced suicidal thoughts or deaths (B03).

Another social pedagogue highlighted that, for her, trauma-informed work primarily involves building and maintaining trusting relationships, a high degree of understanding, flexibility, and openness, as well as ongoing training and team meetings (B07).

Another professional described how she initially categorizes symptoms of acute stress as normal reactions, provides those affected with easily accessible crisis contact information – for example, the telephone number of the crisis service "for the refrigerator" – and takes self-recrimination seriously, while simultaneously placing it in a temporal perspective ("Back then they didn't know what they know today," "at that time, it was the best choice for them") (B05).

A nursing professional described how, in conversations, she specifically addresses the emotional level and subjective experience of the bereaved person and actively perceives this to create a safe, trauma-sensitive atmosphere (B09).

A nurse in outpatient care described how she informs bereaved relatives and family members about the physical process of dying and about existing support services even during the dying process, discusses with them the ambivalence between "letting go" and "not yet ready for saying goodbye," addresses questions about the "right to a self-determined death," and provides dignified care for the deceased together with the relatives. Children are also involved when needed, and their questions are answered in an age-appropriate manner (B10).

A child and adolescent psychologist without formal trauma training described how, in the initial shock and grief phase, he consciously focuses on very concrete stabilization and support rather than on a deep processing of the events (B13).

An expert explained that clients are constantly reminded of this: "Back then, you didn't know what you know today." ["Back then, they didn't know what they know today."] (B05)

Another emphasized that clients should decide for themselves how deeply they want to delve into the topic (B08).

Experts unanimously described the societal stigma surrounding suicide as a significant burden. One counselor stated that suicide remains a taboo subject and that bereaved individuals often withdraw due to this stigma, as suicide is sometimes associated with personal "failure" in their social circles (B08).

A social worker confirmed that the persistent societal stigma frequently leads to social withdrawal among the bereaved (B06).

Another social worker pointed to a general lack of openness regarding the topic of suicide, as well as towards those affected and their families, and described death as a highly personal issue that many people find difficult to cope with (B07).

A social worker reported that bereaved individuals are not only confronted with their own pain, but also with attributions such as weakness, failure, anger, and a lack of understanding from their social environment (B11).

A psychologist added that suicide—like many mental health issues—is generally one of the topics that are rarely discussed openly (B12).

Another psychologist described the experience of stigma as rather diffuse and presumptive, yet highly unsettling for the bereaved (B13).

A nurse from outpatient care reported that suicide at the end of life, particularly in predominantly Catholic regions, continues to be experienced as taboo and often remains within the home environment, so that neither neighbors nor the wider social circle learns of the specific cause of death (B10).

A nursing professional pointed out that suicidal thoughts are often not understood by society as an expression of illness. Instead, blame is placed on the surrounding environment, which can manifest as overt or covert accusations against the bereaved (B09). Another expert remarked: "Society is unsure how to deal with it." "Society's uncertainty in dealing with it" (B04).

A child and adolescent therapist described stigmatization as often diffuse, vague, and perceived more emotionally than clearly articulated, yet nonetheless destabilizing (B13).

A social worker pointed out that significant uncertainties and myths still surround suicide—for example, the assumptions that talking about it can actually drive people to suicide, or that those who talk about it won't do it—and that many affected individuals, out of fear of doing something wrong or opening up too much, try to cope alone for a long time, often seeking professional help only belatedly (B03).

Another professional described how suicide is not openly discussed in some families for years, while individual family members consciously deal with a suicide attempt very openly to raise awareness among their social circle, but this remains the exception rather than the rule. She also pointed to significant ignorance and reluctance to engage in counseling services in institutions such as schools, where, although information about counseling centers is provided, little is known about their work, and information events are only minimally attended by parents (B05).

Experts emphasized the overall need for public education.

The participants described rural Lower Bavaria as a region with limited opportunities for postventive care.

Long travel distances, inadequate public transport, and the fear of being recognized in small communities were repeatedly cited as obstacles (B03, B04, B08). A social worker emphasized, for example, that public transport in her district was “very poorly developed” and that while those affected could, in principle, use existing services, accessibility remained difficult (B03). A nationwide professional association for suicide survivors added that the distribution of services in Germany was very uneven and that Lower Bavaria was among the most underserved regions. There was only one AGUS self-help group in all of Lower Bavaria, while there were 25 in Bavaria as a whole (B02). An expert summarized: “Accessibility is the main problem.” [“Accessibility.”] (B09).

Another expert highlighted that people in rural areas often know each other, which can both facilitate and hinder access to help (B12, B07).

A child and adolescent psychologist also suggested that specialized counseling centers exclusively for suicide bereavement would be complicated to establish in rural areas due to the low number of cases and the shame associated with being seen there (B13).

A nurse emphasized that outpatient care often lacks the necessary prior knowledge of available support services, and that caregivers themselves must cultivate networks to provide bereaved individuals with appropriate contact information when needed; at the same time, many services in rural areas are hardly visible to the public (B10).

A nursing professional added that there are generally fewer services available in rural areas and, at the same time, less social acceptance of mental health crises and suicide (B09). A social worker pointed out that the travel distances frequently encountered in Lower Bavaria can pose a barrier to direct contact and that it therefore makes sense to integrate support services into existing, easily accessible structures to make use of professional resources (B05).

Several experts suggested integrating postvention into existing services rather than establishing a separate structure, given limited financial and human resources (B05).

Many professionals reported an awareness of the emotional strain involved in aftercare work.

Strategies included supervision, team discussions, clear boundaries, structured workflows, and personal rituals for emotional detachment after work (B06, B04, B10, B08, B05, B09, B11).

One professional described: “After work, I change my clothes, wash my hands, and consciously close my notes.” [“I change my clothes after work, wash my hands, and carefully lock away my notes.”] (B06)

Another social worker reported that she relieves stress through team meetings, supervision, and peer case discussions, and consciously uses several boundary-setting rituals – such as changing clothes after work, washing and airing out her hands after each conversation, carefully locking away notes and calendars, listening to music on the way home, and exercising regularly (B05).

Another person emphasized that compassion fatigue can occur when professionals constantly have to project optimism while also serving as the only confidant for lonely clients (B10).

Interviews with professionals reveal that while the need for aftercare following a suicide is generally recognized, it remains inadequately structured, inconsistently termed, and only weakly anchored in institutional systems. Although professionals in various contexts encounter bereaved individuals after a suicide, aftercare is rarely described as a clearly defined field with standardized processes, responsibilities, or formalized procedures. Instead, it is primarily practiced as an extension of existing professional roles and personal commitments.

Experts agree that bereaved individuals primarily struggle with feelings of guilt, shame, stigmatization, social withdrawal, and persistent, unanswered questions. These emotional burdens are understood as long-lasting and recurring, not as short-term

reactions. Accordingly, aftercare practices rely less on standardized intervention models and more on relationship-oriented approaches, active listening, appreciation, sensitivity, and the creation of emotionally safe spaces.

At the same time, experts emphasize that structural conditions significantly influence what support can be offered. Limited resources, time constraints, insufficient service integration, and unclear responsibilities diminish the continuity and visibility of aftercare. These limitations are particularly pronounced in rural areas, where geographic distance, concerns about anonymity, and limited service availability further complicate access and aftercare.

Despite these challenges, professionals demonstrate a high degree of self-reflection regarding their roles, emotional boundaries, and responsibility for self-care. Supervision, team exchange, and the conscious separation of professional and private life are described as essential strategies for remaining emotionally present without becoming overwhelmed. In this sense, grief counseling proves to be not only a task for the bereaved but also a practice that requires continuous reflection, boundary setting, and institutional support for the professionals involved.

6.4 Structural gaps and systemic challenges in postvention

The expert interviews reveal that significant structural gaps and systemic inconsistencies characterize aftercare. These challenges concern the distribution of responsibility, institutional anchoring, service networking, the visibility of available resources, and the long-term continuity of care. A nationwide professional association also emphasized that the availability of specialized services for those bereaved by suicide varies considerably from region to region, and that Lower Bavaria has significantly fewer resources compared to the other areas (B02).

Experts have repeatedly emphasized that aftercare following a suicide is rarely defined as a central institutional task. Instead, it is often practiced as an additional, informal, or marginal activity within existing care structures (B04, B06, B12).

As a result, the responsibility for bereaved individuals after a suicide remains inconsistent and inadequately regulated.

Several professionals described aftercare as a task that "belongs to everyone and therefore to no one alone" (B02, paraphrased). It is neither assigned to psychiatric care, counseling services, nor community-based systems. One professional summarized: "There are no clear lines of responsibility." ["There are no clear responsibilities."] (B02).

Another expert in social psychiatry emphasized that postvention is not mandated as part of the service but depends on staff participation (B04).

A psychologist at the management level reported that grief following a suicide rarely appears as a separate topic in official documents or case statistics, which further limits institutional visibility (B12).

Experts described the inadequate cooperation between hospitals, outpatient services, self-help organizations, and counseling centers. The transitions between the systems were portrayed as particularly fragile. One expert explained: "Everyone works in their own area, but there is no chain." ["Everyone works in their own area, but there is no chain."] (B02).

Another expert emphasized that relatives are often transferred without clear instructions: "They are sent somewhere else, but without any guidance."

["They are sent on, but without guidance."] (B06).

This fragmentation was perceived as a factor contributing to interruptions in care and repeated loss of contact with the bereaved. The low visibility of aftercare services was described as a significant structural deficit.

Several experts reported not always being informed about all existing services in their region (B03, B08). A nurse emphasized that in outpatient care, often only those bereaved individuals whose caregivers have relevant prior knowledge and network contacts benefit from existing services, and that at the same time, the balancing act between protecting privacy and data protection on the one hand and actively referring individuals to existing services on the other presents a structural challenge (B10).

An expert explained: "You really have to search to find something." ["You really have to search to find something."] (B08).

Another expert emphasized that many bereaved people do not actively seek help due to shame, exhaustion, or disorientation, which is why passive information strategies are insufficient (B06).

Experts unanimously highlighted the conditions in rural areas as a structural challenge. This included:

- long distances and limited transport options (B03, B04, B08),
- Fear of being recognized in small communities (B10, B13),
- lower numbers, which reduce political and institutional attention (B12).

A funeral speaker from a rural area also emphasized that "everyone knows everyone" and that many prejudices about family backgrounds circulate, making it

difficult for bereaved people to find trustworthy conversation partners in their own circles of acquaintances, because there is a strong concern that something “will leak out” (B01).

An expert explained: “In rural areas, you can't simply offer a specialized service.” [“You can't just open a specialized service in a rural area.”] (B13)

Another person added that shame-related barriers are more pronounced in rural areas due to social proximity and lack of anonymity (B13).

Experts have repeatedly emphasized that follow-up consultations often take place “alongside” other tasks. One nurse explained: “These discussions are taking place under time pressure.” [“These conversations take place under time pressure.”] (B10).

A counselor reported that long-term support is rarely possible due to high caseloads and limited session capacity (B06).

Therefore, aftercare is often limited to short-term crisis stabilization rather than long-term relationship support.

Despite these limitations, experts made straightforward suggestions for improvement. These included:

- clearer transfer methods,
- better networking of services,
- visible contact points for bereaved people,
- Training for professionals in grief counseling after a suicide,
- Formal recognition of follow-up as a regular service task (B04, B07).

From the perspective of a nationwide professional association for bereaved individuals of suicide, there is a clear need for expansion, particularly in Lower Bavaria: In addition to more counseling centers offering short-term consultations, additional self-help groups are needed, as there are very few points of contact compared to other regions (B02). A social worker emphasized that, due to pronounced anxieties surrounding suicide, specific training would be desirable in many institutions, and that all psychiatric, psychological, and social psychiatric services, as well as educational and school counseling centers, should consider postvention as a core task (B05).

One expert summarized this need as follows: “Postvention must become a normal part of the system.” [“Postvention must become a normal part of the system.”] (B07).

The expert interviews reveal that aftercare is currently embedded in a fragmented, poorly coordinated, and insufficiently transparent system. Responsibilities are unclear, cooperation between sectors is limited, and the long-term continuity of care is structurally

restricted. Rural conditions, time constraints, and limited resources further exacerbate these problems.

At the same time, experts demonstrate a strong awareness of these shortcomings and formulate concrete needs for structural development. Postvention is therefore understood not only as a relational task, but also as a systemic challenge requiring institutional recognition, coordination, and a sustainable allocation of resources.

6.5 Suggestion for improvement from the participants' point of view

Both family members and professionals formulated concrete, sometimes overlapping, proposals for improving aftercare structures. These proposals address accessibility, continuity, visibility, professional conduct, and systemic organization. Overall, the proposals do not primarily focus on creating entirely new institutions, but rather on improving coordination, transparency, and the quality of relationships within existing structures.

The bereaved participants repeatedly emphasized the need for proactive contact after a suicide, instead of being left alone with the responsibility of seeking help.

Several participants stated that a simple phone call or letter after a few days or weeks would already be a helpful form of support (H03, H06). One mother explained: "Grief doesn't end after three days. Stay with them." Grief doesn't end after three days. Stay tuned (H03).

Experts expressed similar views: postvention should include active follow-up and should not rely solely on the initiative of the bereaved (B02, B06).

Participants from both groups emphasized the importance of clearly identifiable contact points.

Survivors indicated that a single, clearly named institution or contact person responsible for aftercare would have helped them (H03, H10).

Professionals emphasized the need to establish formalized referral chains between the police, hospitals, counseling centers, and self-help organizations (B02, B04).

One expert summarized this need as follows: "There must be a chain." ["There must be a chain."] (B02).

Accessibility was highlighted as a key requirement. The bereaved individuals interviewed emphasized the importance of easily accessible services without long waiting times, complicated registration procedures, or strict diagnostic requirements (H01, H10, H12).

Professionals confirmed that many potential clients avoid using services if access seems overly bureaucratic or complex (B08, B11).

One social worker highlighted that the low-threshold nature of her facility, short waiting times, flexible appointment scheduling, and good telephone accessibility was particularly helpful because they gave those affected the feeling that “something is finally happening” and that they regain control (B05).

Several professionals suggested integrating aftercare more closely into existing easily accessible services such as social psychiatric services, family counseling centers, or primary care physician networks (B06, B13).

The participants emphasized that aftercare should respect the individuality of the grieving process.

The bereaved emphasized that grief can encompass very different and sometimes contradictory feelings and therefore does not follow a fixed emotional pattern (H05, H12, H13).

One participant also highlighted the importance of relieving feelings of guilt, distinguishing between external and self-determination, and placing great value on respecting and accepting the deceased's decisions (H13).

Experts also emphasized the importance of avoiding schematic approaches and tailoring support to individual needs (B04, B06).

One participant expressed this clearly: “Everyone grieves differently” [“Everyone grieves differently.”] (H12).

Both groups emphasized that postvention should not be limited to the acute phase. Bereaved individuals reported that their need for support often resurfaced months or years later (H07, H10, H11).

Professionals confirmed that grief following a suicide frequently has long-term consequences and requires repeated support services (B06).

Postvention was therefore described as long-term support rather than short-term intervention.

Experts highlighted the need for improved training and continuing education in bereavement support after suicide for medical, nursing, psychological, and social work professionals (B07).

In this context, a social worker emphasized the importance of ongoing professional development and regular team meetings to adequately address the complex concerns of those bereaved by suicide (B07).

They stressed that even basic knowledge about grief after suicide, stigmatization, and appropriate communication could significantly improve initial contact with bereaved individuals. Bereaved individuals indirectly confirmed this by describing both very helpful and very insensitive encounters with professionals (H04, H05, H09).

Participants from both groups emphasized the importance of better cooperation between the services.

Experts called for regular communication between hospitals, outpatient services, self-help organizations, and counseling centers (B02, B04).

Those affected emphasized that continuous contact had reduced their feelings of abandonment (H03, H06). Networking was therefore seen as a key factor for sustainable aftercare structures.

6.6 Summary of the empirical results

The empirical findings regarding bereaved relatives and professionals paint a coherent but complex picture of bereavement support in rural areas. Both groups experience and describe bereavement support as an important, yet inadequately structured, poorly coordinated, and inconsistently accessible field of care.

Bereaved individuals predominantly experience aftercare as a fragile and unreliable resource. Access to support is rarely systematic and often depends on chance, referrals from trusted individuals, or pre-existing relationships. Emotional overload and the “functioning mode” of the acute phase, combined with limited information, unclear responsibilities, stigma, inadequate services in rural areas, and a lack of institutional connections, frequently delay or prevent access to support. Aftercare is therefore experienced less as a stable support structure and more as a patchwork of individual encounters.

Experts confirm these observations from a systemic perspective. They acknowledge the need for aftercare but describe it as weakly anchored in institutional systems, inconsistently named, and lacking formalized pathways and responsibilities. Professional practice relies primarily on relationship-building skills, listening, flexibility, and emotional support rather than standardized aftercare models. Structural limitations, particularly in rural areas, further restrict the accessibility, visibility, and continuity of care.

Both groups identify guilt, shame, stigmatization, unanswered questions, and social withdrawal as central experiences of grief after a suicide. At the same time, both

emphasize that grief after a suicide is a long-term, non-linear, and highly individual process that requires flexible and continuously available support rather than short-term crisis interventions.

Regarding improvements, bereaved individuals and professionals formulate consistent demands: proactive aftercare, clearly defined contact persons, low-threshold access, respect for individual grieving processes, long-term support, further training for professionals, and improved networking of services. Instead of calling for isolated new institutions, participants emphasize that bereavement support must become a visible, coordinated, and relationship-oriented component of existing support structures.

Taken together, the empirical findings show that aftercare is a relational and systemic task currently characterized by high individual commitment but limited structural support. The results underscore that effective aftercare depends not only on professional attitudes and skills, but equally on institutional recognition, coordination, and sustainable integration into regional care systems. These findings require further analytical interpretation and contextualization within existing theoretical perspectives and the broader field of suicide bereavement research. The following chapter therefore discusses the results in greater depth and situates them within relevant theoretical and professional debates.

6.7 Conceptual synthesis: the postvention interface misalignment model

The empirical findings presented in this chapter indicate that the limitations of postvention in rural Lower Bavaria cannot be explained adequately by resource scarcity alone. Rather, the material points to a more complex pattern in which difficulties arise through the interaction of individual needs, institutional arrangements, and sociocultural conditions.

To capture this pattern more precisely, the findings can be synthesized in the form of a postvention interface misalignment model. This model does not claim to offer a universal theory of suicide bereavement. Instead, it provides a context-sensitive analytical framework for understanding why postvention may remain fragmented or ineffective even where support services formally exist.

The model distinguishes three analytically interconnected levels, whose misalignment generates postvention gaps:

1. Individual needs and coping dynamics of the bereaved, including the need for recognition, flexibility, emotional safety, comprehensible communication, and support that is responsive to changing grief trajectories.
2. Institutional logics and professional constraints, including procedural requirements, role boundaries, unclear responsibilities, limited service coordination, and restricted access to specialized support.
3. Sociocultural conditions of the rural context, including high social visibility, low anonymity, local norms of discretion, and stigma-related barriers to help-seeking.

The central argument emerging from the data is that postvention gaps often arise not only at one of these levels, but in the misalignment between them. Support may formally exist, yet still fail to become accessible, acceptable, or effective when institutional routines do not correspond to the lived realities of bereaved individuals, or when both are constrained by the sociocultural conditions of the rural environment.

In this sense, the empirical material points to postvention as a relational and multi-level process rather than as a discrete intervention. What becomes visible is not merely a shortage of services, but a structural interface problem: bereaved individuals, professional actors, and regional support conditions are connected, yet insufficiently synchronized.

The following discussion chapter builds on this conceptual synthesis and examines how this pattern relates to existing theoretical approaches and international research.

7 Discussion

7.1 Purpose and function of the discussion chapter

This chapter aims to analytically deepen the study's empirical findings, situate them within relevant theoretical frameworks, and place them within a broader professional and societal context. I deliberately distinguish this chapter from the results section, which presents the experiences of bereaved individuals and professionals as closely as possible to the empirical material. In contrast, my focus here is not on description but on interpretation.

I structured the discussion around the guiding question. What do the present findings contribute to the understanding of bereavement after suicide and postvention? In addressing this question, I did not aim merely to confirm existing concepts. Instead, I critically examined established assumptions, models, and approaches to care, considering the empirical material. For this reason, I did not treat the findings in isolation but systematically related them to the study's theoretical framework and the specific regional context of rural Lower Bavaria.

Based on the qualitative design of this study, I was able to approach bereavement after suicide not as an abstract category, but as a biographically embedded, relational, and socially framed process. I consider this to be a central insight of the present work. In analyzing the perspectives of those affected, I noticed how grief after suicide is lived, regulated, concealed, or processed in everyday life, and how postvention is experienced as a support system that is often shaped less by clear structures than by coincidence, personal relationships, and individual capacities for connection.

I therefore deliberately chose not to organize the discussion according to a linear logic of "problem, intervention, and solution". Instead, I took the complexity, ambivalence, and temporal openness of grief seriously as analytical starting points. I connected the empirically reconstructed experiences with theoretical concepts of grief, stigmatization, social recognition, and support in rural contexts. In doing so, I examined where the findings confirm existing research, where they extend it, and where they challenge implicit assumptions that often remain unquestioned.

From a methodological perspective, I consciously avoided generalizations in the statistical sense. I realized early on that the aim of this discussion could not be representativeness, but analytical depth. The strength of the findings lies precisely in identifying structural patterns across individual case histories and interpreting these

patterns within their social, institutional, and cultural contexts. Against this background, I do not present the discussion as a final evaluation, but rather as a contribution to a more differentiated and context-sensitive understanding of suicide bereavement and postvention.

7.2 Classification of the key findings within the international state of research

The synthesis of the empirical findings presented in the previous chapter suggests that the limitations of postvention in rural contexts cannot be fully explained by resource constraints or individual factors alone. Rather, the data point to a structural pattern in which difficulties emerge through the interaction of individual needs, institutional logics, and sociocultural conditions.

Building on this observation, the study proposes a postvention interface misalignment model as a context-sensitive analytical framework. This model conceptualizes postvention not as a set of isolated interventions, but as a relational system in which support outcomes depend on the degree of alignment between these three levels. From this perspective, postvention gaps are understood less as isolated failures and more as the result of systematic mismatches between the lived realities of bereaved individuals, the operational logic of institutions, and the conditions of the rural social environment.

In the following sections, this perspective is used to situate the empirical findings within the international state of research and to examine how existing theoretical approaches account for — or fail to account for — these relational dynamics.

The results of this study confirm key aspects of the international research on grief after suicide. In particular, the high emotional complexity, the dominance of feelings of guilt and shame, and the ongoing search for explanations are among the most frequently described characteristics of suicide grief (Andriessen et al., 2020; Feigelman et al., 2021; Levi-Belz et al., 2023; Wagner et al., 2021; Westerlund et al., 2020) and are strikingly reflected in the present empirical findings. The experiences of the bereaved illustrate that grief after suicide is often experienced not only as the pain of loss, but also as an existential questioning of one's own responsibility, moral integrity, and social belonging.

It is striking that feelings of guilt and shame do not arise solely from intrapsychic processes but are closely intertwined with social reactions and societal interpretive frameworks. Those interviewed frequently describe guilt not only as self-reproach but as a feeling reinforced by implicit or explicit attributions from their environment. These findings correspond with research that describes suicide as a particularly socially normed

form of death, in which bereaved individuals are confronted with expectations, pressure to explain, and moral judgments (Cvinar, 2005; Evans & Abrahamson, 2020; Goulah-Pabst, 2021; Pitman et al., 2016; Scourfield, 2012; Sajan et al., 2021; Westerlund et al., 2020).

Social isolation and a lack of communication also prove to be central components of suicide grief. Several participants describe tendencies toward withdrawal, avoidance of social contact, or the experience that their social circle avoids conversations about suicide. These experiences confirm international studies that describe suicide grief as a form of grief that often receives less social support than other experiences of loss (Cvinar, 2005; Evans & Abrahamson, 2020; Goulah-Pabst, 2021; Pitman et al., 2017; Sajan et al., 2021; Spillane et al., 2017). At the same time, it becomes clear that this isolation is not necessarily due to a lack of willingness to offer support, but instead to uncertainty, fear of saying the “wrong thing”, and socially ingrained taboos.

Furthermore, the results underscore the increased vulnerability associated with prolonged or complicated bereavement. Several biographical accounts demonstrate that the effects of suicide do not simply “fade away” over time but rather resurface in different phases of life over years or decades. This long-term impact confirms key assumptions in suicide bereavement research (Chen & Laitila, 2023; Entilli et al., 2021; Hybholt et al., 2020; Lunderoff et al., 2017; Shear, 2015; Spillane et al., 2017) but is made particularly tangible in the biographical depth of the present data. Grief does not appear to be a completed process but rather a recurring point of reference throughout the life course.

Beyond confirming known findings, the results of this study make an independent contribution to the further development of research by reconstructing postvention from the lived reality of those affected. Postvention thus appears less as a clearly structured care system and more as a fragmented experiential space characterized by randomness, time delays, and personal mediation.

Access to support is rarely achieved through systematic or standardized channels. Many bereaved individuals report obtaining information indirectly, such as through personal recommendations, church networks, or chance encounters. These experiences contrast with postvention models (Andriessen et al., 2019; Geležėlytė et al., 2020; Kaspersen et al., 2022; Sax Institute, 2024), which assume clear responsibilities, defined intervention chains, and seamless transitions between acute care and follow-up.

These results point to a discrepancy between normative conceptions of care and lived experience (Geležėlytė et al., 2020; Hofmann et al., 2025; Kaspersen et al., 2022;

Nicholls et al., 2024). While postvention is often conceived as a clearly defined intervention (Abbate et al., 2024; Andriessen et al., 2019; Clements et al., 2022; Kryszyska & Andriessen, 2022; Khalid et al., 2022; Szumilas & Kutcher, 2011), in the lived experience of those affected, it appears as a loose network of individual contacts whose timing and quality vary considerably. Support is not experienced as a continuous process, but rather as something that must be actively sought, “found”, or reconstructed afterward.

When interpreted through the lens of the postvention interface misalignment model proposed in this study, this discrepancy can be understood more precisely as a systematic misalignment between institutional logics and the situational and dynamic needs of bereaved individuals. While formal care models assume linear pathways, clearly defined responsibilities, and predictable intervention sequences, the empirical findings show that bereavement trajectories are non-linear, temporally fragmented, and highly dependent on relational and contextual factors.

From this perspective, the problem is not simply that support is lacking, but that existing structures are not aligned with how grief unfolds in lived reality. Institutional arrangements operate according to organizational and procedural logics, whereas bereaved individuals navigate fluctuating needs, delayed readiness for support, and socially constrained help-seeking. The resulting gap is therefore not only a matter of availability, but of structural incompatibility between different levels of the postvention system.

This discrepancy between conceptual care models and lived care trajectories is also highlighted in research on suicide prevention at the health-system level. Studies examining national prevention strategies emphasize that sustainable suicide prevention requires coordinated, multi-sectoral structures and continuity of support across institutional boundaries. Fragmented care pathways and insufficient coordination between services are repeatedly identified as central structural risk factors (Lewitzka et al., 2019). The present findings extend this perspective by demonstrating how such structural discontinuities are experienced concretely by bereaved individuals within postvention processes.

It is also important to note that the evaluation of support is more focused on its relational quality than on its professionalism. Help is perceived as helpful when it is emotionally relatable, respectful, and continuous, regardless of whether it occurs in a formal or informal setting. This shifts the focus of intervention research from the question

of “effective measures” (Ali & Lucock, 2020; Adshead & Runacres, 2022; Freeman & Hughes, 2010; Geleželytė et al., 2020; Higgins et al., 2022; Sweeney et al., 2018; Wainwright et al., 2020) to the question of under which relational and structural conditions support is experienced as relieving.

Another key finding of this study concerns the temporal dimension of postvention. The empirical findings suggest that the need for support among many bereaved individuals does not primarily arise in the immediate acute phase after the suicide but instead emerges later. Several participants reported that they became open to support, or first recognized a need for it, only months, years, or even decades later.

These findings challenge acute-oriented postvention logics that assume early interventions are sufficient to reduce long-term distress (Andriessen et al., 2017, 2019; Hofmann et al., 2025; Linde et al., 2017; Nicholls et al., 2024; Spillane et al., 2017; Szumilas & Kutcher, 2011). While the data show that support in the acute phase can have a stabilizing effect, they also make it clear that grief after suicide is a long-term process whose dynamics change over time. Support needs often only arise when external demands decrease or new life phases are reached.

Theoretically, this finding can be interpreted considering dualistic grief models (Andriessen et al., 2017; Chen & Laitila, 2023; Entilli et al., 2021; Hybholt et al., 2020; Spillane et al., 2017), which describe grief as an oscillating process between loss orientation and recovery. However, the present results demonstrate that this oscillation not only occurs within a limited timeframe but also extends across the entire lifespan. Against this backdrop, postvention should be considered less as a time-limited measure and more as a long-term, available resource.

This study contributes to broadening the perspective of postventive research, moving away from short-term intervention windows towards an understanding of grief after suicide as a life-history-embedded process that may require repeated support without being pathologized.

A more in-depth analysis of the findings within the context of international research reveals that grief over suicide is often treated in a highly individualized manner across many theoretical and practical approaches (Jordan, 2020; Levi-Belz et al., 2023; Linde et al., 2017; McCarthy et al., 2023). Grief is frequently conceived as an intrapsychic coping process whose course depends primarily on individual resources, coping strategies, or psychological vulnerability. Concepts of complicated grief also predominantly focus on symptoms and trajectories. While the present findings confirm

the relevance of individual burdens, they also highlight the limitations of such an individualized approach.

The empirical findings of this study suggest that the key burdens for bereaved individuals do not stem solely from the loss itself but also from social and institutional frameworks. Feelings of guilt and shame, social isolation, or delayed access to support do not primarily reflect individual dysfunction but rather reflect reactions to societal interpretations, implicit norms, and structural gaps in services. This highlights factors that are often neglected in individualizing models of grief.

Internationally, there is a growing awareness of the social aspects of bereavement from suicide (Evans & Abrahamson, 2020; Goulah-Pabst, 2021; McCarthy et al., 2023; Scourfield, 2012; Wray et al., 2011), yet concepts that understand postvention as a targeted intervention for individuals experiencing distress still dominate (Andriessen et al., 2019; Clements et al., 2022; Kryszka & Andriessen, 2022; Szumilas & Kutcher, 2011). The findings of this study broaden this discourse by demonstrating that bereavement from suicide is not only dealt with individually but also negotiated socially. Those grieving navigate a field of societal expectations, moral attributions, and institutional responsibilities that significantly shape their options.

Against this backdrop, postvention appears less as an individual form of support and more as an expression of societal responsibility. The fragmentation of postvention, as revealed in empirical findings, can be attributed to the widespread privatization of grief. Dealing with the long-term consequences of suicide is primarily left to the bereaved themselves, while institutional responsibility remains limited to the acute phase (Geleželytė et al., 2020; Kaspersen et al., 2022; Linde et al., 2017; McDonnell et al., 2022; Nicholls et al., 2024). The results of this study thus stand in sharp contrast to research approaches that primarily conceptualize grief as a deviation from the norm (Boelen & Lenferink, 2020; Lundorff et al., 2017; Shear, 2015). They suggest that the question of complicated grief cannot be posed in isolation from the social conditions under which grief occurs. What appears “complicated” can, under certain circumstances, also be understood as a reasonable response to a lack of recognition, insufficient support, and persistent stigmatization.

This perspective offers a broader view of postvention within the international discourse. Postvention is relevant not only as a means of reducing individual burden but also as a societal practice that enables recognition, makes responsibility visible, and counteracts social isolation (Jordan, 2017; Levi-Belz et al., 2023; Levi-Belz & Feigelman,

2022; Feigelman et al., 2024; Honneth, 1992). The present findings thus contribute to a shift in focus. Away from the question of how bereaved individuals “cope” with their grief, and toward the question of under what social and institutional conditions grief after suicide can even be addressed. The results, therefore, point to fundamental theoretical tensions that will be examined in greater depth in the following section using key empirical categories.

7.3 Theoretical Interpretation of Central Empirical Categories

The theoretical interpretation of the empirical material can be further specified by drawing on the postvention interface misalignment model proposed in this study. While the theoretical frameworks outlined in Chapter 3 — including contemporary grief theories, trauma-informed perspectives, and sociocultural approaches to stigma and recognition — provide important conceptual tools, the empirical findings suggest that their explanatory power remains limited if applied in isolation.

The model introduced in this study makes it possible to integrate these perspectives by conceptualizing suicide bereavement as a relational and multi-level process shaped by the interaction between individual coping dynamics, institutional structures, and sociocultural conditions. From this perspective, grief after suicide cannot be understood solely as an intrapsychic or even relational process but must be interpreted within a broader system in which support, recognition, and meaning-making are structurally mediated.

This integrative approach allows for a more differentiated interpretation of the empirical categories identified in the analysis. Rather than assigning them exclusively to psychological, social, or institutional domains, they can be understood as emerging at the intersections between these levels. In the following sections, this perspective is used to reinterpret key theoretical approaches and to examine how they account for — or overlook — the relational dynamics identified in the empirical material.

The empirical categories reconstructed in Chapter 6 should not be understood as isolated findings, but as an interwoven constellation of meanings in which individual coping processes, institutional logics, and socio-cultural interpretive frameworks continuously interact.

In this section, I interpret the central empirical categories explicitly and systematically, considering the theoretical perspectives developed in Chapter 3. Rather than re-describing the results, I show how the empirical material can be read through (a)

contemporary grief theories (Chapter 3.2), (b) a trauma-informed approach to postvention (Chapter 3.3), and (c) socio-cultural theories of stigma, recognition, and socially regulated grief (Chapter 3.4).

I aim to clarify where my findings confirm existing frameworks, where they specify or extend them, and where theoretical models reach their limits in a rural context.

A central interpretive anchor for my findings is the Dual Process Model (DPM) of Stroebe and Schut, which conceptualizes grieving as an oscillation between loss-oriented and restoration-oriented coping (Stroebe & Schut, 2010). Across cases, I found recurring movements between phases of intense emotional confrontation with the suicide and phases of everyday functioning, role adaptation, and administrative problem-solving. I interpret this pattern as empirical evidence of oscillation as an adaptive mechanism in suicide bereavement (Stroebe & Schut, 2010).

From a theoretical perspective, the fragmentation of postvention reconstructed in this study constitutes a structural disruption of adaptive grief processes. Within the Dual Process Model, adaptive coping depends on the possibility to oscillate flexibly between loss-oriented and restoration-oriented modes (Stroebe & Schut, 2010). Fragmented support structures, however, tend to privilege short-term functioning while failing to provide sustained relational spaces for loss-oriented processing. As a result, bereaved individuals are often pushed into a prolonged “functioning mode” without adequate opportunities to articulate grief, integrate traumatic experiences, or engage in meaning reconstruction.

Fragmentation, therefore, does not merely describe an organizational deficit but represents a theoretically relevant mechanism that constrains oscillation itself. In this sense, fragmentation can be understood as a structural condition that increases the risk of chronic imbalance, either by enforcing premature restoration-oriented adaptation or by leaving loss-oriented distress uncontained. The empirical findings thus specify the Dual Process Model by showing how institutional logics and care structures actively shape the conditions under which oscillation can remain adaptive. From the perspective of the postvention interface misalignment model, this means that oscillation is not only a psychological process but also depends on the degree of alignment between individual needs, institutional arrangements, and sociocultural conditions.

These dynamics become particularly visible when examining the specific conditions under which oscillation is constrained or blocked. Fragmentation of postvention, understood here as discontinuous access, delayed entry points, and

premature endings of support, appears to be an external condition that shifts bereaved individuals into a prolonged “functioning mode” without sufficient opportunities for loss-oriented processing (Stroebe & Schut, 2010). Conversely, trauma-related overload, stigma-related withdrawal, and moralized interpretations of suicide can lock individuals into sustained loss orientation. In DPM terms, I argue that these empirical patterns indicate reduced flexibility. The adaptive pendulum movement is impeded by structural and socio-cultural barriers rather than by individual deficits (Stroebe & Schut, 2010). This is particularly visible in the temporal dimension of support. My material shows that help remains sporadic, begins late, or breaks off, while grief-related crises re-emerge across the life course, precisely the kind of long-term oscillatory dynamic the DPM predicts, but which requires continuity and recognition to remain adaptive (Stroebe & Schut, 2010).

Worden’s Tasks of Mourning provide a second, complementary lens that allows a more fine-grained theoretical mapping of the empirical categories (Worden, 2009). Based on my analysis, the material permits a precise allocation of central findings to typical task-related challenges and reveals where these tasks are socially and structurally obstructed (Worden, 2009).

Building on Worden’s Tasks of Mourning, I develop a differentiated theoretical interpretation of the empirical findings.

About Task I, the acceptance of the reality of the loss, I found that this process is repeatedly complicated by the nature of suicide as an abrupt, morally charged, and often procedurally “managed” death. Forensic procedures, administrative sequences, and the early institutional focus on acute crisis management frequently leave bereaved individuals with insufficient space to integrate the reality of the death into a coherent personal narrative. I therefore interpret the fragmentation of postvention as a structural obstacle to Task I, as institutional attention tends to end precisely at the point at which narrative integration and meaning reconstruction would require stable, sustained support (Worden, 2009).

About Task II, the processing of the pain of grief, my findings indicate that grief-related suffering is not only intrapsychic but also deeply socially conditioned. I found that silence, avoidance, and implicit expectations not to speak openly about suicide restrict emotional expression and thereby hinder the processing of feelings such as guilt, shame, anger, and ambivalence. In this sense, I understand Task II not merely as emotionally demanding but as actively constrained by socio-cultural norms that regulate which forms of grief may be expressed and socially recognized (Worden, 2009).

With respect to Task III, the adjustment to a world without the deceased is clear in my empirical material. However, my analysis shows that their manageability depends strongly on structural conditions. In rural contexts, I found that limited access to specialized services, long distances, and reduced anonymity increase the practical and emotional costs of help-seeking and intensify the everyday workload placed on bereaved families. This suggests that Task III is shaped not only by individual coping capacities but also by institutional accessibility and social geography (Worden, 2009).

Finally, regarding Task IV, finding an enduring connection with the deceased while continuing life, I found persistent ambivalences surrounding continuing bonds. Maintaining an inner relationship with the deceased can be stabilizing and meaningful; however, I observed that this process may be problematized by moral narratives that frame suicide as deviant or blameworthy. I therefore interpret Task IV not as an individual endpoint to be achieved, but as a relational and socially regulated process that unfolds within broader normative and cultural frameworks (Worden, 2009).

Overall, I show that the explicit linkage to DPM and Worden renders the empirical categories theoretically coherent. Fragmentation and structural barriers constrain restoration-oriented coping and task progression; stigma and social silence restrict loss-oriented articulation and narrative work; and relationally reliable support functions as a key enabling condition for adaptive oscillation and task-related movement (Stroebe & Schut, 2010; Worden, 2009).

A second major interpretive frame is the trauma-informed approach developed in Chapter 2.2. My findings align with evidence that suicide bereavement is associated with elevated risks for depression, prolonged grief disorder, posttraumatic stress symptoms, and suicidal crises (Linde et al., 2017). Against this backdrop, I interpret the empirically reconstructed ambivalence toward support and help experienced as both relieving and intrusive, through trauma-informed principles such as safety, predictability, transparency, cooperation, and choice, as well as the explicit aim of avoiding retraumatization (SAMHSA, 2025).

I found that postvention is experienced as trauma-sensitive when it creates psychological safety, communicates procedures clearly, and preserves bereaved individuals' autonomy in decision-making (SAMHSA, 2025). Conversely, my material shows that support becomes burdensome when it is perceived as standardized, rushed, or normatively prescriptive, thereby intensifying feelings of helplessness and vulnerability (SAMHSA, 2025).

From a trauma-informed perspective, I argue that fragmentation is not merely an organizational gap but functions as a cumulative stressor. When institutional attention ends with the acute phase, responsibility for navigating longer-term needs is tacitly shifted to bereaved individuals at precisely the time when trauma-related symptoms and exhaustion may be strongest (SAMHSA, 2025). I therefore conclude that continuity, reliable pathways, and clearly identifiable points of contact are structural prerequisites for trauma-sensitive postvention.

Stigmatization emerged as a cross-cutting category in my findings, shaping both emotional processing and access to support. Drawing on the literature reviewed in Chapter 2 and the theoretical framework presented in Chapter 3, these findings are interpreted through Goffman's (1967) stigma theory and Doka's (2002) concept of disenfranchised grief.

My analysis shows that suicide bereavement often produces a socially marked status in which bereaved individuals anticipate evaluation and regulate their own visibility. Courtesy stigma plays a central role, as relatives become socially implicated through association with the suicide (Goffman, 1967). At the same time, I found that grief after suicide is frequently not fully recognized as legitimate. In Doka's terms, it is disenfranchised. Grief is socially delegated, morally reframed, or rendered communicatively risky (Doka, 2002).

In rural contexts, high social visibility, dense interpersonal networks, and the fear of gossip intensify these mechanisms. Stigmatization thus functions as a socially regulating force that raises thresholds for help-seeking and constrains the conditions under which adaptive oscillation, task progression, and narrative integration can occur (Goffman, 1967; Doka, 2002; Stroebe & Schut, 2010; Worden, 2009).

By bringing these perspectives together, this study demonstrates a theoretically relevant shift in how suicide bereavement and postvention can be understood. First, the findings confirm contemporary grief theories by showing bereavement as non-linear, oscillatory, and socially embedded (Stroebe & Schut, 2010; Worden, 2009). Second, they extend these frameworks by identifying institutional continuity and social recognition as structural preconditions for adaptive coping. Third, and most importantly, the findings suggest that many theoretical models reach their limits when the interaction between individual, institutional, and sociocultural dimensions is not explicitly considered.

From the perspective of the postvention interface misalignment model, postvention challenges are therefore not adequately explained by individual vulnerability

or isolated system deficits. Instead, they emerge from systematic mismatches between different levels of the support system. This highlights the need for theoretical approaches that conceptualize suicide bereavement not only as an individual or relational process, but as a structurally mediated and context-dependent phenomenon.

7.4 Postvention in the Rural Context of Lower Bavaria

The results of this study demonstrate that rural Lower Bavaria not only provides the backdrop against which suicide grief and postvention take place but also acts as an active structural and semantic framework. Rurality proves to be a multidimensional category encompassing institutional, social, and cultural conditions, the interplay of which significantly influences how support after a suicide is accessible, perceived, and effective.

The discussion of the rural context should therefore be understood not as a supplement, but as an integral analytical dimension that shapes both the experiences of bereaved individuals and the institutional conditions of postvention.

At the structural level, the results reveal significant gaps in services, particularly pronounced in rural areas. Limited service availability, long waiting times, and restricted access to specialized support services characterize postvention access. These factors are known from general research on healthcare provision in rural regions (Bell et al., 2022; Chen et al., 2022; Graves et al., 2020; Maretzke, 2016), but they take on relevance in the context of bereavement after a suicide.

Bereaved individuals are often in a phase of emotional distress, where long waiting times, complicated registration procedures, or extended travel distances present significant obstacles. My findings show that these structural barriers not only delay access but sometimes prevent it entirely. Support is then not sought because there is no need, but because the structural prerequisites for translating that need into help are lacking.

Compared to urban areas, where services are more diverse and distances are shorter, the consequences of institutional fragmentation are more pronounced in rural areas. While postvention services exist in some locations, they are not widespread or systematically integrated. My findings suggest that this structural scarcity contributes to postvention being perceived less as an independent field of action in rural areas and more as an incidental addition to other services.

In addition to structural factors, the social organization of rural areas plays a central role. Empirical findings show that social proximity, dense networks, and low

anonymity have ambivalent effects. On the one hand, familiar relationships can provide support, facilitate informal assistance, and facilitate early access to help. On the other hand, these same structures increase the fear of visibility, social judgment, and exposure.

This ambivalence is particularly pronounced in the context of suicide. Suicide represents a highly sensitive and normatively charged form of death. In small communities of Lower Bavaria, where social roles are well known, deviations are readily noticed. This can lead to additional pressure to avoid openly discussing suicide or seeking professional help locally. The findings indicate that fear of social stigma is a significant factor in delayed or absent access to help.

This makes it clear that social proximity is not automatically synonymous with social support. Instead, especially in conjunction with stigmatization, it can lead to self-regulation of grief, with those affected suppressing their feelings, adapting, or seeking support in secret. This dynamic contributes to the invisibility of postvention in rural areas, despite the need for support.

A key finding of my study is that postvention in rural Lower Bavaria is often provided implicitly by existing actors, without being explicitly designated as such or structurally secured. General practitioners, social psychiatric services, nurses, chaplains, and church volunteers frequently assume crucial roles in supporting bereaved individuals after a suicide.

This implicit form of support has several advantages. It leverages existing trust relationships, is easily accessible, and is culturally compatible. Especially in rural areas where specialized services are scarce, these actors serve as the first and sometimes only point of contact. Empirical findings show that support in such contexts is often perceived as particularly helpful when it is continuous, personal, and seamless.

At the same time, this implicit nature carries risks. Postvention depends on the individual attitude, personal commitment, and time resources of individual actors. Without precise structural anchoring, there is a risk of overload, uncertainty in professional practice, and limited networking. Furthermore, postvention remains invisible and difficult to plan in this way, which hinders systematic development.

The results suggest that rural areas do not primarily require specialized services but rather improved structural recognition and networking among existing stakeholders. Postvention could be understood here as a cross-cutting task that is explicitly defined, professionally supported, and institutionally secured.

Taken as a whole, the data show that the rural context reinforces existing dynamics of bereavement surrounding suicide without fundamentally altering them. Guilt, shame, stigmatization, and the long-term nature of grief are not exclusively rural phenomena; however, they have a more intense impact in the context of limited anonymity, scarce resources, and strong social norms.

Rural areas should not be understood as a deficit, but rather as a specific social space with its own logic. This significantly influences how postvention is conceived, organized, and experienced. Concepts that ignore these spatial logics risk contradicting the needs of those affected or unintentionally reinforcing existing obstacles.

Considering existing research, it seems sensible to understand rural and urban contexts not as hierarchically ordered, but as distinct socio-spatial logics. Many care concepts were developed within the context of urban supply structures, which are characterized by high service density, specialization, and greater anonymity. The present findings suggest that these assumptions are only partially transferable to rural regions.

While urban areas tend to offer functionally differentiated, specialized services, support here is often fragmented and time-limited.

Support in rural areas is frequently embedded in everyday social relations rather than delivered through clearly bounded professional arrangements. This embeddedness can foster reliability and continuity, yet it also heightens concerns about visibility and social control, which may discourage individuals from seeking assistance openly.

From a theoretical perspective, these differences can be interpreted as expressions of differing "spatial logics." Urban contexts favor a functional separation of responsibilities, while in rural areas, support is embedded in social relationships and locally shared norms. This ambivalence significantly shapes how bereaved individuals perceive, accept, or reject support.

Against this backdrop, it becomes clear that postvention must be designed with context in mind. Models that primarily rely on anonymous accessibility, specialization, and clearly defined intervention periods are only partially effective in rural areas. Conversely, a focus solely on informal support is insufficient, as it can obscure structural responsibility. The findings therefore support approaches that reflect the respective strengths and limitations of rural and urban contexts and understand postvention as a practice embedded in social spaces.

7.5 Practical implications for care and follow-up

I argue that the empirical findings of this study have far-reaching implications for the design of care and aftercare following a suicide. They not only affect individual professional groups and institutions, but also raise fundamental questions about responsibility, attitudes, and the structural integration of postvention. It becomes clear that the data do not so much yield concrete "catalogs of measures" as they do requirements for framework conditions that make postvention effective, accessible, and sustainable.

The results suggest that postvention should not be understood primarily as a specialized supplementary service, but rather as a cross-cutting task within existing care structures. Bereaved individuals perceive support as helpful when it is relationally coherent, temporally flexible, and continuous. Therefore, what is crucial is not so much the expansion of individual measures as the clarification of responsibilities and the design of transitions.

The data clearly show that a lack of clear responsibilities and institutional discontinuities hinders access to support. A further conclusion is to explicitly embed postvention structurally – for example, through designated responsibilities, defined transitions between acute care and follow-up, and proactive contact options that can also be offered at different times.

For the healthcare system, the results illustrate that contact with medical institutions is often limited to the acute phase. The data clearly show that bereaved individuals experience the abrupt termination of institutional contact as distressing. One conclusion drawn from this is that medical facilities, particularly psychiatric clinics and acute somatic care services, should assume a bridging function for psychosocial aftercare.

This does not necessarily mean expanding services. Instead, it entails actively facilitating access to existing support structures and sensitive follow-up after discharge or completion of acute treatment. The results suggest that even a single subsequent contact, as a sign of responsibility and recognition, can have a relieving effect.

For social work, and especially for social psychiatric services, the results show that these institutions are often de facto key providers of postvention, even if they do not explicitly acknowledge this role. The data indicate that low-threshold, relationship-oriented services with flexible scheduling are particularly well received.

A further conclusion is that social psychiatric services in rural areas should be strengthened explicitly as hubs for postvention. This does not require a fundamental reorientation, but rather an explicit recognition of postvention as part of their remit,

adequate time resources, and opportunities for networking with other stakeholders such as self-help groups, pastoral care, and medical services.

For psychotherapeutic and counseling settings, the results illustrate that bereaved individuals are often only open to therapeutic engagement after a delay. The data show that long waiting times and limited availability, particularly in rural areas, act as significant barriers.

One conclusion drawn from this is that flexible, low-threshold counseling formats can be an essential complement to traditional psychotherapy. Furthermore, the results show that a clear distinction between grief and mental illness is relieving for bereaved individuals. Therapeutic services should therefore not prematurely pathologize grief after suicide, but rather recognize it as an independent, often long-term, process of adjustment.

Perspectives from the nursing field indicate that nursing professionals are often in close contact with family members and thus play an essential role in early aftercare. The data show that conversations in nursing contexts frequently occur informally and "on the side," yet are nevertheless experienced as significant.

A further conclusion is that nursing settings should be more strongly integrated into postventive structures, for example, through clear referral options, training on bereavement after suicide, and the recognition of psychosocial counseling as part of professional nursing care. This is particularly relevant in rural areas, where caregivers often build stable relationships with families over extended periods.

The results show that pastoral care services in rural areas represent a crucial resource for many bereaved individuals, regardless of their personal religious beliefs. The data indicate that pastoral care is perceived as particularly helpful when it avoids moralizing and allows for ambivalence.

A further conclusion is that church actors can play an essential role in destigmatizing bereavement after a suicide. Through open communication, acknowledgment of grief, and cooperation with psychosocial services, they can help reduce barriers to accessing additional support.

Empirical findings show that exchanging experiences with other bereaved individuals is perceived as particularly relieving but is not equally suitable for all bereaved people. The data indicate that peer support services represent an essential complement to professional support but must be designed flexibly.

A further conclusion is that self-help services should be made more visible and integrated into regional support networks, without being standardized as a mandatory or

“correct” way of coping with grief. Diversity and freedom of choice are key principles in this context.

In summary, the need is less for isolated specialized services than for coordinated, recognized, and long-term available support structures. Postvention is a task that can be effectively carried out only if conceived relationally, structurally anchored, and implemented in a culturally sensitive manner.

The empirical findings suggest that such an approach not only helps to relieve the burden on bereaved families but also has a preventive effect by reducing social isolation, blame, and long-term stress.

The empirical findings demonstrate that postvention requires structured, reliable, and long-term support, but cannot be fully professionalized. Support is perceived as helpful when it fosters recognition, respects autonomy, and connects to the individual's life story, qualities that cannot be achieved solely through standardization.

Overly prescriptive or technocratic forms of support risk narrowing the grieving process and reproducing implicit expectations of “appropriate” mourning. Professional postvention thus exists in a tension between necessary structuring and the danger of over-professionalization.

The findings also underscore the independent significance of informal support relationships within family, neighborhood, or pastoral care contexts. These cannot be partially transferred to professional responsibilities without altering their nature. A meaningful development of postvention, therefore, lies less in the complete institutionalization of all forms of support than in recognizing their plurality.

In practice, this means that professionals should act more as companions, offering guidance, ensuring smooth transitions, and providing support as needed, without claiming the authority to interpret the grieving process. Particularly in rural areas, excessive formalization can weaken existing networks or create additional barriers. Effective postvention, therefore, requires an attitude that embraces responsibility while simultaneously reflecting on the limits of professional assistance.

7.6 Limitations of the study and perspectives for future research

Like any qualitative study, my study is subject to certain methodological and content-related limitations, which I considered when interpreting the results.

A key limitation of this study is its qualitative, context-dependent design. I am fully aware that the findings cannot be statistically generalized to a broader population.

However, this limitation is not an unintended constraint but an inherent consequence of the qualitative approach I deliberately adopted. From the outset, my aim was not to identify generalizable prevalence rates or broader statistical trends but to achieve a deeper understanding of specific processes, meanings, and interactional dynamics related to bereavement after suicide and postvention.

For this reason, the number of bereaved individuals and professionals included in the study was intentionally limited to enable in-depth engagement with individual experiences and interpretations. The analytical value of the findings, therefore, lies not in statistical generalization but in reconstructing patterns, dynamics, and areas of tension that emerge across cases. Recurring themes such as the fragmentation of postvention, experiences of stigmatization, and the long-term, non-linear nature of grief point to structural phenomena that, while grounded in the specific regional context of rural Lower Bavaria, are likely to be relevant in other contexts as well.

Another limitation lies in the retrospective nature of some data collection. Some interviews and written reports refer to suicides that occurred many years or even decades ago. In such cases, memories are inevitably shaped by later biographical experiences, interpretive processes, and re-evaluations. However, this temporal distance not only represents a limitation but also offers a unique perspective on the long-term nature of grief over a suicide. The retrospective perspective allows grief to be understood as a life-historical process and not reduced to short-term reactions.

It should also be considered that specific perspectives can be represented only to a limited extent. For example, individuals who neither sought nor found any professional support (H03, H10, H12, H13) and who partly withdrew (H05 and H07) from social and institutional contexts are only marginally visible in the sample.

Similarly, experiences of shame and stigmatization may have influenced the willingness to participate. I am aware that this selectivity has shaped the material, and I explicitly take it into account when interpreting the findings.

The regional focus on rural Lower Bavaria constitutes an additional limitation. The results are closely linked to the specific structural, social, and cultural conditions of this area. At the same time, this is a particular strength of the study, as it demonstrates how postvention is implemented in a rural context and the challenges it entails. The transferability of the results to other regions should therefore not be understood as direct comparability, but rather as an invitation to context-sensitive comparisons.

Several avenues for future research stem from the limitations. First, conducting comparative studies between rural and urban areas would help identify which dynamics depend on the context and which happen regardless of the regional setting. Second, future research could focus more on institutional transitions, such as between acute care, psychosocial aftercare, and long-term support, to systematically analyze disruptions and successful transfers.

Thirdly, a more in-depth examination of previously underrepresented groups would be desirable, such as siblings, friends, and older bereaved individuals. The perspective of children and adolescents who lose a parent to suicide also deserves further attention. Finally, longitudinal research designs could contribute to a more nuanced understanding of grief processes and support needs over more extended periods. Taken together, these reflections highlight the broader implications of the study and point to the need for further research and development in the field of suicide bereavement and postvention. The following chapter therefore brings together the central insights of the dissertation and formulates its overall conclusions and future perspectives.

8 Conclusion and Outlook

8.1 Revisiting the Research Problem and Objectives

This dissertation arose from a twofold gap, one academic and one practical. Despite growing international attention to suicide prevention and grief research, grief following suicide remains marginal in many discourses.

Building on the empirical results and the theoretical interpretations developed in Chapters 6 and 7, this final chapter synthesizes the findings and reflects on their broader implications. Rather than introducing new analytical perspectives, the focus here lies on synthesizing the central insights and outlining their implications for understanding suicide bereavement, postvention practice, and future research.

It is frequently individualized, pathologized, or implicitly delegated to existing care systems without being seriously considered as an independent phenomenon framed within social and structural contexts. At the same time, postvention, as support for bereaved individuals after a suicide, is often vaguely defined, fragmentarily organized, and conceptually underdeveloped in both research and practice. This gap is particularly evident in rural regions, where institutional responsibilities are less visible, services are limited, and social dynamics are more tightly interwoven.

Against this background, I aimed to examine grief after suicide and postvention from a qualitative-empirical, context-sensitive, and multi-perspective approach.

The starting point was the assumption that grief after suicide cannot be understood solely as an individual coping process, nor can postvention be understood primarily as a one-off intervention. Instead, it was assumed that grief after suicide arises and is processed within a complex interplay of biographical experiences, social relationships, societal interpretive frameworks, and institutional conditions.

The central research interest, therefore, focused on how bereaved individuals and professionals experience, interpret, and practice postvention, and on which structural conditions shape these experiences. In this sense, the dissertation has fulfilled its central objective: to systematically analyze the experiences of bereaved individuals after suicide and the perspectives of professional actors in rural Lower Bavaria, and to use these findings to identify structural requirements for needs-based and sustainable postvention.

The decision to focus the study on rural Lower Bavaria was not based on the idea of it being a deficient or special case, but rather on the goal of seriously examining a social context that has been under-researched. The findings confirm that rural Lower

Bavaria was not just the setting for the study, but a key factor shaping access to support, social visibility, institutional pathways, and the lived experience of postvention.

Specific support structures, dense social networks, and limited anonymity characterize rural regions. These conditions influence not only access to support, but also how grief becomes visible, can be communicated, and is socially regulated. The dissertation aimed not merely to describe these contextual conditions but also to explore their significance for suicide grief and postvention analytically.

The research objective was therefore to gain a deeper understanding of the experiences of those bereaved by suicide and to relate these to the perspectives of professionals involved in postvention in various institutional contexts. By combining these perspectives, the study aimed to reveal where perceptions, expectations, and logics of action overlap, complement, or contradict one another. At the same time, the study sought to contribute to a broader understanding of postvention, considering it not only from the perspective of institutional concepts but also from the lived reality of those affected.

In retrospect, this research objective was achieved. The empirical findings provide a nuanced insight into the complexity of bereavement after suicide and postvention and make it clear that these two phenomena cannot be considered in isolation. Bereavement after suicide proved to be a long-term, relational, socially framed, institutionally shaped, and regionally mediated process that extends far beyond the acute phase.

In this context, postvention appears less as a clearly defined service and more as a fragmented support system shaped by individual relationships, institutional transitions, and societal interpretations.

Returning to the dissertation's starting point reveals that the initial problem has not only been confirmed but also become more complex. The work shows that the question of effective postvention cannot be answered by individual measures alone. Instead, it highlights fundamental questions of jurisdiction, recognition, and societal responsibility in dealing with suicide and its aftermath. By addressing these questions empirically and with contextual sensitivity, the dissertation helps establish grief after suicide and postvention as independent, serious fields of research and practice.

8.2 Contribution to Suicide Bereavement and Postvention Research

A central contribution of this study lies in the development of a context-sensitive analytical framework for understanding postvention as a relational and multi-level

process. Based on the empirical findings, the study proposes a postvention interface misalignment model, which conceptualizes postvention gaps not primarily as a consequence of resource scarcity or individual vulnerability, but as the result of systematic misalignments between individual needs, institutional logics, and sociocultural conditions.

This model provides a structured way of interpreting postvention as a dynamic interface rather than a set of isolated interventions. It highlights that the effectiveness of support depends on the degree to which these different levels are aligned and mutually responsive. In doing so, it shifts the analytical focus from individual coping or isolated service provision toward the relational and structural conditions under which postvention becomes accessible, acceptable, and effective.

Building on the postvention interface misalignment model, a central contribution of this dissertation lies in showing how grief after suicide and postvention emerge as interconnected, socially framed, and long-term processes shaped by structural conditions.

This dissertation makes a significant contribution to broadening our understanding of grief after a suicide by moving beyond reducing it to emotional reactions or symptoms of psychological distress. Instead, it reveals grief after suicide as a process deeply embedded in social relationships, structured by societal interpretive frameworks, and evolving over extended periods. The work makes it clear that grief after a suicide is not merely an individual experience, but always also a social one, shaped by recognition or its absence, by openness or silence, by support or structural voids.

In this context, the dissertation makes a crucial contribution by consistently addressing the long-term aspect of bereavement after a suicide. Grief is not portrayed as a finite phase that can or should be moved past, but rather as a personal reference point that can develop new meanings at different life stages. This perspective helps to critically challenge common ideas of “closure” or “coping” and to view bereavement after a suicide as a dynamic, ongoing process.

Viewed collectively, the findings indicate that fragmentation of postvention is not merely an operational challenge but a central feature shaping how suicide bereavement is lived and managed over time. What becomes visible across cases is that bereaved individuals are often required to navigate their grief largely on their own once the acute phase has passed.

The significance of this finding lies less in the description of fragmented structures than in its consequences. Long-term grief trajectories unfold in contexts where continuity,

reliable points of contact, and socially legitimized spaces for mourning are scarce. Fragmentation thus emerges as a key condition that shapes how support is perceived, accessed, and sustained, particularly in rural regions where alternatives are limited.

The work demonstrates that in practice, postvention often occurs implicitly, takes effect with a time lag, and is strongly dependent on individual actors and existing relationships. This makes it clear that postvention should be understood less as a technical instrument and more as a social practice.

This perspective shifts the focus from the question of the “right” intervention to the question of under what conditions support for bereaved individuals becomes possible, accessible, and practical. The dissertation's contribution lies in highlighting postvention as a structural and relational task that cannot be addressed solely through additional services, but rather engages fundamental questions of responsibility, continuity, and recognition.

Furthermore, this work advances our understanding of suicide grief and postvention by viewing stigmatization not as a marginal issue, but as a central social structure. The dissertation shows that stigmatization isn't just about obvious labels or taboos; it often appears subtly, such as through silence, uncertainty, or social withdrawal. These subtle forms of recognition limit affect the grieving process and access to support, shaping how bereaved people experience and express their grief. By highlighting these connections, the dissertation offers a more detailed understanding of the social conditions surrounding suicide grief.

Another important contribution to the research is the consistent focus on the rural context. The dissertation shows that limited resources not only define rural areas but also reflect social logics that influence grief and postvention in particular ways. Dense social networks, low anonymity, and long-term relationships can be both helpful and hindering. The work's contribution is in not oversimplifying these contradictions but instead taking them seriously in analysis and introducing rurality as a distinct category into the discussion on suicide grief and postvention.

Taken together, the findings demonstrate that suicide bereavement and postvention cannot be adequately understood within frameworks that isolate individual coping from its social and structural context. Instead, the analysis shows that both are shaped by the interaction between personal experience, institutional arrangements, and sociocultural conditions.

From the perspective of the postvention interface misalignment model, this interaction is not always coherent. Postvention challenges emerge where these dimensions are insufficiently aligned, leading to gaps in accessibility, continuity, and recognition. This highlights the need to conceptualize postvention not only as a set of services, but as a structurally mediated and relationally organized field of practice.

In this sense, the contribution of the dissertation lies not only in individual empirical findings, but in offering an analytical perspective that makes these structural and relational dynamics visible. This perspective opens new directions for research, practice, and policy by shifting the focus from isolated interventions toward the conditions under which support can become sustainable and responsive to the lived realities of those affected.

8.3 Originality of the dissertation

The originality of this dissertation lies not in the introduction of entirely new theoretical models or normative concepts, but in the specific way in which an under-researched field is empirically explored, analytically framed, and its societal relevance is made visible. This originality becomes visible across the empirical design, the methodological approach, and the conceptual synthesis of the findings.

The empirical contribution of this dissertation lies first and foremost in its consistent focus on the perspectives of those left behind after a suicide and their systematic interweaving with the viewpoints of professionals. This multi-perspective approach avoids viewing suicide grief solely from the perspective of the affected individual or from an institutional standpoint, but rather as a relational process unfolding through the interaction of various actors.

In this study, I contribute to broadening the perspective of post-suicide research by shifting attention from predominantly short-term intervention windows to a life-history-embedded understanding of suicide bereavement, highlighting the need for recurrent, non-pathologizing forms of support across the life course.

A central element of this originality is the development of the postvention interface misalignment model, which integrates individual, institutional, and sociocultural dimensions of postvention within a single analytical framework. This model provides a novel way of conceptualizing postvention gaps as relational and structural phenomena rather than isolated deficiencies.

Additionally, a notable empirical advantage is the study's regional focus. By centering on the rural area of Lower Bavaria, the dissertation investigates a social context that has received little systematic attention in research on suicide bereavement and postvention. The work shows that regional conditions are not just background factors but actively shape the experiences of grief and support. Its unique empirical contribution is in viewing rurality not as an exception or a deficit, but as an important social space for analysis.

The methodological contribution of this work lies in the consistent implementation of a qualitative-empirical, reflective research design that does justice to the subject matter's complexity. The dissertation does not follow a schematic approach. Instead, it combines narrative perspectives with a systematic, theory-driven analysis. This approach succeeds in understanding individual experiences not by fragmenting them, but by capturing them within their biographical and social context.

A key feature of the methodological approach is the sensitive balance between closeness and analytical distance. The work takes the interviewees' narratives seriously without idealizing or instrumentalizing them. At the same time, subjective perspectives are not considered in isolation but rather embedded in relational and structural contexts. This approach enables the identification of both the uniqueness of individual experiences and overarching patterns.

Furthermore, the dissertation stands out for its reflective approach to the author's role as a researcher. It clearly reveals the ethical and emotional challenges involved in studying bereavement from suicide and addresses these with careful methodology and restraint. Its methodological contribution is more about thoughtfully designing a research process that is fair to all participants while producing scientifically valid results than about formal innovations.

Finally, this work makes a methodological contribution by demonstrating how qualitative research can help to reveal structural phenomena without prematurely quantifying or simplifying them. The dissertation clarifies that qualitative approaches are not only suitable for exploratory research questions but can also be fruitfully applied to the analysis of complex care and support structures.

The conceptual contribution of this dissertation lies in the way it reframes and relates suicide grief and postvention to one another. Instead of treating these two phenomena separately, the work demonstrates that grief after suicide and postvention can only be adequately understood in their interplay. Grief is not conceived as a purely

individual event to which postvention is subordinate, but rather as a process significantly shaped by the conditions of support or its absence.

A key conceptual advantage is making fragmentation visible as a structural issue. The dissertation shows that postvention's failure is not mainly due to individual actors' lack of commitment but instead results from unclear responsibilities, gaps in continuity, and institutional breaks. This shifts the focus from individual faults to structural problems, opening new avenues for research and practice.

Also, this work contributes to the conceptual development of the understanding of stigmatization in the context of bereavement after suicide. Stigmatization is not viewed as a marginal phenomenon or an individual experience, but rather as a social structure that shapes perceptions, interactions, and access to support. The dissertation demonstrates that stigmatization operates not only through overt labeling but also through silence, uncertainty, and implicit expectations. This perspective contributes to understanding bereavement after suicide as a socially regulated phenomenon.

Finally, a major conceptual contribution is the introduction of rural areas as an analytical category in the study of suicide bereavement and postvention. The work clearly shows that rurality not only affects the availability of services but also shapes social dynamics, relationships, and norms. This insight expands the current discussion and highlights the importance of using context-sensitive approaches in research and practice.

Overall, the originality of this dissertation lies not in isolated findings, but in the coherent integration of empirical research, methodological reflection, and conceptual development. By introducing a relational and multi-level perspective on suicide bereavement and postvention, the study offers an analytically grounded framework that makes structural and contextual dynamics visible. This contribution provides a basis for future research, practice, and policy development that takes into account the complexity of postvention in real-world settings.

8.4 Relevance of the study for science, practice, and future research

The relevance of this dissertation stems not only from its empirical findings but also from the way it illuminates grief after suicide and postvention as socially significant, scientifically under-researched, and practically challenging phenomena. The work contributes beyond the regional context under investigation and offers points of departure for action and reflection at multiple levels.

For the scientific community, the importance of this dissertation mainly lies in its integrative approach. The work combines various discourses that have often been studied separately, including grief research, suicide research, healthcare research, and socio-spatial perspectives. By viewing grief after suicide not as just an individual experience but as a socially and structurally influenced process, the dissertation expands the analytical scope of existing research methods.

A key scientific contribution lies in consistently understanding suicide grief as a long-term, dynamic process. This perspective relativizes time-limited models of grief management and opens possibilities for life-course-oriented approaches. The work demonstrates that grief after suicide does not “decrease” or conclude over time but rather changes and can take on new meanings in different phases of life. This insight is relevant both for the further development of theoretical concepts and for the interpretation of empirical findings in future studies.

Additionally, the dissertation adds to the academic discussion by viewing postvention not as a clearly defined intervention field, but as a relational and structurally shaped support space. This perspective challenges existing assumptions that mainly define postvention through measures, programs, or responsibilities. Instead, the work emphasizes transitions, ruptures, and implicit practices, uncovering aspects often missed in more formal research approaches.

Finally, the scientific relevance of this work lies in its consistent inclusion of rural areas as an analytical category. The dissertation demonstrates that socio-spatial contexts are not merely background variables, but actively participate in the generation of experiences, interpretations, and possibilities for action. This perspective opens new avenues for social science research that considers regional differences not only descriptively, but also explanatorily.

For practical purposes, the study's significance lies particularly in providing realistic, context-based insights into the experiences of bereaved individuals and professionals. The work deliberately avoids idealized models or simple recommendations for action, instead highlighting the complexity of postventive care. This approach is itself part of its practical contribution, as it helps to differentiate and alleviate expectations regarding support.

The dissertation demonstrates that effective postvention depends less on the existence of individual services than on their relational quality, timing, and structural integration. For practitioners, this means that attitude, continuity, and recognition are key

determinants of effectiveness. The work thus underscores the importance of professional reflection and interdisciplinary collaboration without devaluing or idealizing informal forms of support.

Particularly in rural areas, the study provides important insights for a more context-sensitive approach to service provision. It demonstrates that dense social networks, low anonymity, and long-term relationships can both represent resources and pose challenges. In practice, this means that support services must be integrated into existing social structures without creating additional barriers. The work contributes to a more nuanced understanding of rural service realities, rather than focusing solely on deficits.

Moreover, the dissertation can serve as a basis for reflection for various professional groups confronted with bereavement from suicide. It reveals that postvention often occurs implicitly and is not always explicitly named as such. This insight can contribute to greater awareness and appreciation of existing practices and, where appropriate, to their structural reinforcement.

The dissertation also opens diverse perspectives for future research. By presenting suicide grief and postvention in their social, relational, and structural complexity, it simultaneously reveals where further differentiation and in-depth analysis are needed. The work can serve as a starting point for comparative studies, for example, between rural and urban contexts or between different institutional settings.

Besides, the study suggests developing more life-course-oriented longitudinal research designs to capture changes in grief and to support individuals more systematically over longer periods. Investigating perspectives that have been underrepresented to date, such as those of specific groups of relatives or informal support networks, is also an important desideratum.

Finally, this work highlights the need to further research postvention not only as an individual support service but also as a societal responsibility. Questions of responsibility, recognition, and the structural integration of support remain central themes that extend beyond the scope of this dissertation.

Overall, the relevance of this work lies less in providing definitive answers than in opening a nuanced perspective on a complex field. The dissertation thus contributes in a way that is relevant to both further scientific development and practical reflection processes and sustainably enriches the discourse on suicide bereavement and postvention.

8.5 Final Reflection and Outlook

This dissertation concludes with the insight that grief after suicide and postvention defy simple answers, clear responsibilities, and definitive explanations. This, however, is a central finding of the work. Suicide grief is not an exceptional state that can be “managed” with appropriate interventions, but rather a complex, long-term, and socially framed process that continually re-engages with biography, environment, and societal interpretive frameworks. Against this backdrop, postvention appears not as a technical instrument but as an attitude that enables recognition and avoids prematurely individualizing responsibility.

Building on the empirical results and the theoretical analyses presented earlier, this study demonstrates that grief following suicide cannot be understood in isolation, but must be situated within broader social, cultural, and structural contexts that shape recognition, silence, and access to support.

It is embedded in social relationships, shaped by institutional structures, and influenced by societal norms and taboos. Dealing with suicide and its consequences always raises the question of how society handles ambivalence, guilt, powerlessness, and grief. The dissertation shows that when these issues cannot be openly discussed, grief often becomes invisible, and support tends to be fragmented.

A key finding of this study is that postvention isn't limited to situations where it's explicitly named. Instead, support often shows up in implicit ways—through relationships, silent presence, and ongoing support from individuals or institutions. These forms of support are hard to quantify and lack standardization, yet they are a vital resource for many people coping with grief. The study highlights the importance of sensitivity, time, and relationships in addressing suicide grief.

The focus on rural Lower Bavaria has also shown that social contexts not only influence access to support but also how it is perceived and its importance. Rural structures strengthen existing ambivalences. Being close can offer support but also lead to control. Existing networks can be both helpful and stigmatizing. This finding is not limited to the area studied; it more generally highlights the need to consider postvention in a way that respects regional differences and local characteristics.

The outlook presented in this dissertation is deliberately cautious. The work does not claim to offer definitive solutions to the challenges of bereavement after a suicide or postvention. Instead, it sees itself as a contribution to a more nuanced examination of a field that has long been marginalized. It demonstrates that the focus is less on developing

new concepts than on questioning existing assumptions, rethinking responsibilities, and acknowledging the multifaceted nature of grief.

For future academic discussion, this means moving away from reducing or pathologizing grief after a suicide and instead examining it within its social, temporal, and relational contexts. Practically, this means not linking support only to interventions but to attitudes that promote openness, recognition, and respect for individual grieving processes. For society, this work emphasizes the need to create spaces where grief after a suicide can be openly expressed without judgment or normalization.

The dissertation concludes with this perspective. It views bereavement and postvention not as marginal issues but as key indicators for how vulnerability, loss, and responsibility are addressed. By examining these topics empirically, sensitively, and reflectively, the work contributes to a deeper scientific, practical, and societal discussion while also creating space for further questioning, research, and understanding.

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Appendix A: Overview of Interviews

This appendix provides an overview of all empirical interviews conducted within the study. The table summarizes anonymized case identifiers, participant groups, interview period, interview format, duration (where available), and recruitment context.

In total, 26 interviews were conducted, comprising 13 with bereaved family members and 13 with professionals. Data collection took place in August following approval of the interview guides.

Table

Case ID	Participant Group	General Background	Interview Period	Interview Format	Duration	Recruitment Context
H1	Bereaved family member	Mother, Cousin, Uncle	August 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H2	Bereaved family member	Mother	September 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H3	Bereaved family member	Mother	August 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H4	Bereaved family member	Husband	September 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H5	Bereaved family member	Boyfriend	September 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H6	Bereaved family member	Son	August 2025	Written interview	Not available	Referral via counselling service
H7	Bereaved family member	Son, Daughter	August 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H8	Bereaved family member	Son, Daughter	August 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H9	Bereaved family member	Father of the Child	September 2025	Written interview	Not available	Recruited by researcher
H10	Bereaved family member	Father	August 2025	Oral interview	approx. 60 minutes	Recruited by researcher

Case ID	Participant Group	General Background	Interview Period	Interview Format	Duration	Recruitment Context
H11	Bereaved family member	Wife	August 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H12	Bereaved family member	Friend	August 2025	Oral interview	approx. 60 minutes	Recruited by researcher
H13	Bereaved family member	Cousin	August 2025	Oral interview	approx. 60 minutes	Recruited by researcher
B01	Funeral speaker		September 2025	Written interview	Not available	Recruited by researcher
B02	Chef of an organization		August 2025	Written interview	Not available	Recruited by researcher
B03	Socialworker		September 2025	Written interview	Not available	Recruited by researcher
B04	Socialworker		September 2025	Written interview	Not available	Recruited by researcher
B05	Socialworker		September 2025	Written interview	Not available	Recruited by researcher
B06	Socialworker		September 2025	Written interview	Not available	Recruited by researcher
B07	Socialworker		September 2025	Written interview	Not available	Recruited by researcher
B08	Socialworker		September 2025	Written interview	Not available	Recruited by researcher
B09	Nurse		September 2025	Written interview	Not available	Recruited by researcher
B10	Nurse		September 2025	Written interview	Not available	Recruited by researcher
B11	Socialworker		September 2025	Written interview	Not available	Recruited by researcher
B12	Socialworker		September 2025	Written interview	Not available	Recruited by researcher
B13	Psychologist		September 2025	Written interview	Not available	Recruited by researcher

Appendix B: Interview Guides and Questionnaires

This appendix contains the interview guides and questionnaires used during data collection. Separate instruments were developed for bereaved family members and professionals to capture both experiential and institutional perspectives.

The interview guides were designed to elicit narrative, open-ended responses while ensuring comparability across interviews. They served as flexible orientation tools rather than strictly standardized questionnaires, allowing participants to structure their responses according to their individual experiences.

Interview Guide: Bereaved – original version in German

Das Leben nach dem Suizidverlust fortsetzen: Die Notwendigkeit und Herausforderungen von Postvention aus Sicht der Hinterbliebenen und Fachkräfte Leitfaden für Interviews mit Suizid-Hinterbliebenen

Einleitung

Bevor wir beginnen, nehmen Sie sich bitte einen Moment Zeit, um in sich hineinzuhorchen, wie Sie sich heute fühlen. Wenn Sie sich während des Gesprächs unwohl oder überfordert fühlen, können wir jederzeit pausieren oder das Interview beenden. Sind Sie bereit, fortzufahren?

1. Hintergrundinformationen

- Alter
- Geschlecht
- Beziehung zur verstorbenen Person
- Wann fand der Suizid statt? (Monat/Jahr)
- Haben Sie seitdem professionelle Unterstützung erhalten?

2. Erfahrungen nach dem Suizid

- Mit welchen Herausforderungen waren Sie konfrontiert, um die Realität des Verlustes zu akzeptieren oder sich an das Leben, ohne die verstorbene Person anzupassen?
- Haben Sie sich in der Zeit nach dem Suizid eher auf den Verlust selbst konzentriert oder darauf, Ihr Leben wieder aufzubauen? Können Sie Beispiele nennen?

3. Bedeutung und Erfahrungen mit Postvention

- Fiel es Ihnen leicht oder schwer, Unterstützungsangebote in Ihrer Region zu finden?
- Gab es im ländlichen Raum genügend Angebote?

4. Auswirkungen auf das Leben und Bedeutung des Verlustes

- Wie hat die gesellschaftliche Wahrnehmung oder Reaktion auf Ihren Verlust Ihren Trauerprozess beeinflusst? Haben Sie sich wegen der Art des Verlustes verurteilt oder isoliert gefühlt?
- Inwiefern wird Suizid Ihrer Meinung nach in Ihrer Gemeinschaft oder von anderen noch stigmatisiert?

5. Wünsche und Empfehlungen

- Was würden Sie Fachkräften oder Institutionen empfehlen, die mit suizidbetroffenen Hinterbliebenen arbeiten?
- Was müsste sich Ihrer Meinung nach im gesellschaftlichen Umgang mit Suizid und Trauer verändern?

Interview Guide: Bereaved – translation into English

Continuing Life After a Suicide Loss: The Necessity and Challenges of Postvention from the Perspective of the Bereaved and Professionals **Interview Guide for Suicide-Bereaved Individuals**

Introduction

Before we begin, please take a moment to check in with yourself and notice how you are feeling today. If at any point during the conversation you feel uncomfortable or overwhelmed, we can pause or stop the interview at any time. Are you ready to continue?

1. Background Information

Age

Gender

Relationship to the deceased person

When did the suicide occur? (Month/Year)

Have you received professional support since then?

2. Experiences After the Suicide

What challenges did you face in accepting the reality of the loss or adapting to life without the deceased person?

In the period after the suicide, did you focus more on the loss itself or on rebuilding your life? Can you provide examples?

3. Meaning and Experiences with Postvention

Did you find it easy or difficult to locate support services in your region?

Were there sufficient services available in rural areas?

4. Impact on Life and Meaning of the Loss

How has society's perception or reaction to your loss influenced your grieving process?

Did you feel judged or isolated because of the nature of the loss?

To what extent do you think suicide is still stigmatized in your community or by others?

5. Wishes and Recommendations

What would you recommend to professionals or institutions working with people bereaved by suicide?

In your opinion, what should change in the way society deals with suicide and grief?

Interview Guide: Professionals – original version in German

Das Leben nach dem Suizidverlust fortsetzen: Die Notwendigkeit und Herausforderungen von Postvention aus Sicht der Hinterbliebenen und Fachkräfte Interviewleitfaden für Beraterinnen und Berater

Einleitung

Vielen Dank für Ihre Teilnahme. Ihre Expertise ist wertvoll, um das Verständnis für Postvention nach Suizid zu verbessern und weiterzuentwickeln.

1. Berufliches Profil

- Beruf / Tätigkeitsfeld
- Institution / Organisation
- Erfahrung in der Arbeit mit suizidnahen Hinterbliebenen
- In welchem Kontext bieten Sie Postvention an?

2. Perspektiven auf Postvention

- Wie definieren Sie persönlich „Postvention“?
- Welche Unterstützungsformen bieten Sie in der Praxis an?
- Welche Hauptprobleme oder Herausforderungen erleben suizidnah Hinterbliebene Ihrer Erfahrung nach?
- Wie integrieren Sie traumasensible Prinzipien in Ihre Arbeit mit suizidnahen Hinterbliebenen?
- Was beobachten Sie in Bezug auf gesellschaftliches Stigma im Zusammenhang mit Suizid, und wie wirkt sich dieses auf die Hinterbliebenen aus, mit denen Sie arbeiten?

3. Erfahrungen und Reflexionen

- Welche Reaktionen oder Bedürfnisse beobachten Sie am häufigsten bei Hinterbliebenen?
- Wie gehen Sie in Ihrer Arbeit mit möglichen Tabus, Schuld- oder Schamgefühlen um?
- Was empfinden Sie als hilfreich bzw. hinderlich in der Postventionspraxis?
- Haben Sie selbst sekundäre Traumatisierung oder Mitgefühlsmüdigkeit in Ihrer Arbeit erlebt? Wie gehen Sie mit diesen Herausforderungen um?

4. Strukturen und Verbesserungsbedarf

- Welche besonderen Herausforderungen oder Vorteile beobachten Sie bei der Bereitstellung von Postventionsangeboten in ländlichen Regionen wie Niederbayern im Vergleich zu städtischen Gebieten?
- Gibt es Ihnen bekannte oder von Ihnen mitgestaltete lokale Initiativen oder Kooperationen zur Postvention in Niederbayern?

Interview Guide: Professionals – translation into English

Continuing Life After a Suicide Loss: The Necessity and Challenges of Postvention from the Perspective of the Bereaved and Professionals **Interview Guide for Counselors**

Introduction

Thank you for your participation. Your expertise is valuable in improving and further developing the understanding of postvention after suicide.

1. Professional Profile

Profession / field of work

Institution / organization

Experience working with people bereaved by suicide

In what context do you provide postvention?

2. Perspectives on Postvention

How do you personally define “postvention”?

What forms of support do you provide in practice?

Based on your experience, what are the main problems or challenges faced by people bereaved by suicide?

How do you integrate trauma-informed principles into your work with suicide-bereaved individuals?

What do you observe regarding social stigma related to suicide, and how does it affect the bereaved people you work with?

3. Experiences and Reflections

What reactions or needs do you most frequently observe among the bereaved?

How do you address possible taboos, feelings of guilt, or shame in your work?

What do you find helpful or hindering in postvention practice?

Have you personally experienced secondary traumatization or compassion fatigue in your work? How do you deal with these challenges?

4. Structures and Areas for Improvement

What particular challenges or advantages do you observe in providing postvention services in rural regions such as Lower Bavaria compared to urban areas?

Are you aware of, or involved in, any local initiatives or collaborations related to postvention in Lower Bavaria?

Appendix C: Exemplary Empirical Statements

This appendix presents selected anonymized excerpts from empirical material to illustrate the narrative depth and thematic diversity of participant perspectives. The excerpts are intended to provide insight into the type of material on which the analysis is based.

The selected statements do not represent complete interviews but serve as illustrative examples of recurring themes and experiential narratives. All excerpts were carefully anonymized to ensure that individual participants cannot be identified.

Interview H05

Suizidverarbeitung

Notes created on September 14, 2025 at 3:18 PM by Minutes AI

Persönliche Angaben

- Alter: 64 Jahre, 11 Monate
- Geschlecht des Suizidopfers: männlich, Alter: 27
- Beziehung zum Suizidopfer: Vater der ältesten Tochter, Freund
- Alter des Sprechers zum Zeitpunkt des Suizids: 27
- Zeitpunkt des Suizids: Oktober '87
- Professionelle Unterstützung: Keine erhalten

Erfahrungen nach dem Suizid

- Trennung kurz vor dem Suizid (2-3 Monate vorher)
- Beschreibung des Verstorbenen: "leicht bis stark geisteskrank", Psychosen, Fremdgehen bei Problemen
- Umzug nach Niederbayern zur Mutter wegen Angst vor dem Partner und zur Kinderbetreuung während der Arbeit
- Polizeiliche Mitteilung über den Suizid; Name des Sprechers in der Hosentasche des Verstorbenen gefunden
- Keine Hilfe von der Polizei angeboten

Schuldgefühle und soziale Isolation

- Mutter des Verstorbenen beschuldigt Sprecherin am Suizid
- Starke Schuldgefühle und Angst vor sozialer Interaktion
- Ausbildung zur psychologischen Beraterin als Teil der Verarbeitung
- Schwieriges Verhältnis zur Tochter, da diese bei der Familie des Verstorbenen aufwuchs und eine ablehnende Haltung entwickelte

These notes were taken with Minutes AI (<https://myminutes.ai>) Umgang des Umfelds mit dem Suizid

- Keine Hilfsangebote
- Aussagen des Umfelds: "du hast das doch gewusst, der Alfred ist ein Spinner."
- Anziehungskraft des Verstorbenen lag in seiner Andersartigkeit: "Weil er anders war wie die anderen, weil ich das nicht wollte, was da sonst so war."

Herausforderungen

- Das Leben ohne die verstorbene Person war nicht das Problem.
- Schuldgefühle und Projektionsfläche
- Schuldgefühle gegenüber dem Kind und dem Vater des Kindes.
- Die Tochter konnte den Vater als Projektionsfläche nutzen und alles in ihn hineinprojizieren, was sie nicht hatte.
- Die Tochter war zweieinhalb Jahre alt.
- Die Verwandtschaft färbte die Wahrnehmung der Tochter negativ ein.

Verarbeitung des Suizids

- Konzentration auf die Tochter und Versuch, "da durchzugehen".
- Arbeit als befreiend empfunden.
- Schritt für Schritt weitergegangen, bis es leichter wurde.

Postvention

- Definition: Hinterbliebene sind erst ab dem Zeitpunkt des Suizids Hinterbliebene.
- Postvention als Beratung nach dem Ereignis.
- Der Begriff Postvention ist in der Wissenschaft verankert.
- Unterschiedliche Wahrnehmung des Begriffs Postvention im Vergleich zu Prävention bei Beratungsstellen.

These notes were taken with Minutes AI (<https://myminutes.ai>) • Postvention als Prävention: Aufarbeitung ermöglicht präventive Einstellung auf das weitere Leben.

Unterstützung und Auswirkungen

- Unterstützung durch Bekanntenkreis, Ausbildung, andere Tochter und Schwiegersohn.
- Keine spezifischen Unterstützungsangebote in Niederbayern vorhanden.
- Auswirkungen auf das Leben und Bedeutung des Verlusts.

Gesellschaftliche Wahrnehmung und Stigmatisierung des Verlusts

- Die Sprecherin fühlte sich verurteilt, besonders von anderen Müttern.
- Isolation und Stigmatisierung waren anfänglich sehr hoch.
- Es dauerte ca. 20 Jahre (von 45/47 bis 65), um den Verlust zu verarbeiten und offen darüber zu sprechen.

Verarbeitung des Verlusts

- "Wie hast geschafft durch reden doch wahnsinnig viel."
- Gespräch mit einer Bekannten, deren Mann Suizid begangen hat, half.
- Schuldgefühle sind ein zentrales Thema für Hinterbliebene. "Schuldgefühl ist schon ein Kapitel."

Stigmatisierung von Suizid und Behandlung

- Die Sprecherin kritisiert, dass Depressionen nicht ausreichend behandelt werden.
- Der Partner der Sprecherin war in einer Klinik, wurde aber entlassen, obwohl er Suizidabsichten äußerte.
- Die Sprecherin vermutet, dass ihr Partner nicht richtig behandelt wurde.

Empfehlungen für Fachkräfte

These notes were taken with Minutes AI (<https://myminutes.ai>) • Die Sprecherin wünscht sich mehr Angebote für Suizidbetroffene Hinterbliebene. "Dass sowas. Gibt als erstes einmal gibt es ja noch nicht wirklich."

- Zuhören ist entscheidend in psychologischen Beratungsgesprächen.
- Fortbildungen für Fachkräfte sind notwendig.

Erfahrung und Einfühlungsvermögen

- Die Sprecherin zweifelt an der Kompetenz von Personen ohne entsprechende Erfahrungen, z.B. in der Kindererziehung oder im Umgang mit Suizid.
- Sie betont, dass man die Realität erst dann wirklich versteht, wenn man sie selbst erlebt hat, z.B. als Elternteil oder als Hinterbliebener eines Suizids. "Du weißt nur, wie das Business wirklich anfühlt, wenn das Kind bei der Kasse zum Brüllen fährt."

Umgang mit Suizid und Trauer in der Gesellschaft

- Es brauche mehr Offenheit und Ehrlichkeit im Umgang mit Suizid. "Offenheit ist gleich Ehrlichkeit und mit Trauer."
- Trauer sollte nicht tabuisiert werden, und Menschen sollten lernen, darüber zu sprechen und die Gefühle anderer auszuhalten.

Verbesserung der Unterstützung für Hinterbliebene

- Beratungsstellen sollten zunächst einmal bekannter sein.
- Vertrauen ist entscheidend, aber es entsteht nicht durch schematische Vorgehensweisen. "Die arbeiten nach irgendeinem Schema. So und so funktioniert das und die gehen eigentlich nicht auf mich ein, sondern die haben ein Schema drauf. Dann würde für mich das Vertrauen würde ich sofort blocken."
- Empathie, Individualität und Ehrlichkeit sind wichtig.
- Beratungsstellen sollten Hinterbliebenen das Gefühl geben, angenommen zu werden.
- Religiöses Gerede sei nicht hilfreich.

Selbsthilfegruppen und Suizid

These notes were taken with Minutes AI (<https://myminutes.ai>) • Existieren Selbsthilfegruppen zum Thema Suizid?

- Argus Deutschland hat 52 Gruppen, in Niederbayern (Bayern) gibt es nur eine einzige.
- Problematik: In Selbsthilfegruppen gibt es oft "Schwätzer", die alles einnehmen.
- Schwierigkeit, Betroffene zu erreichen, z.B. nach einem Suizid in der Familie.

Umgang mit Betroffenen

- Telefonseelsorge als mögliche erste Anlaufstelle, um Betroffene weiterzuvermitteln.
- Viele Menschen haben Redebedarf, aber das Thema ist sehr sensibel.
- Betroffene müssen sich äußern, z.B. über Schuldgefühle und deren Ursachen.

Therapie und Zeit

- Problematik: Manche Menschen sind schwer zugänglich für Therapie, auch wenn sie Hilfe wollen.
- "Was wichtig ist, ist viel Zeit...die Zeit war eigentlich das Wichtigste und auch das zu reflektieren, warum das passiert ist, war die Zeit."
- Zeit für die eigene Entwicklung ist notwendig.

These notes were taken with Minutes AI (<https://myminutes.ai>)

Interview Professionals: H04

Das Leben nach dem Suizidverlust fortsetzen: Die Notwendigkeit und Herausforderungen von Postvention aus Sicht der Hinterbliebenen und Fachkräfte

Interviewleitfaden für Beraterinnen und Berater

Einleitung

Vielen Dank für Ihre Teilnahme. Ihre Expertise ist wertvoll, um das Verständnis für Postvention nach Suizid zu verbessern und weiterzuentwickeln.

1. Berufliches Profil

- Beruf / Tätigkeitsfeld

Dipl. Soz. Päd. (FH)

- Institution / Organisation

Caritas xxx Sozialpsychiatrischer Dienst

- Erfahrung in der Arbeit mit suizidnahen Hinterbliebenen

Ja

- In welchem Kontext bieten Sie Postvention an?

Gespräche

Gruppe Hinterbliebene nach Suizid; offen regelmäßig einmal im Monat

Traumagruppe – thematische Gruppe an 6 Terminen mit maximal 6 Teilnehmern – einmal im Jahr nach Anmeldung

2. Perspektiven auf Postvention

- Wie definieren Sie persönlich „Postvention“?

Unterstützung und Begleitung der Hinterbliebenen, Stabilisierung – dadurch Vermeiden bzw. Verringern einer eigenen psychischen Erkrankung, Prävention eines Suizides der betroffenen Hinterbliebenen selbst

- Welche Unterstützungsformen bieten Sie in der Praxis an?

Gespräche

tägliches Angebot in der Beratungsstelle eines Krisentermins über den Krisendienst, teils auch aufsuchend einmal jährlich Traumagruppe falls PTBS

- Welche Hauptprobleme oder Herausforderungen erleben suizidnah Hinterbliebene Ihrer Erfahrung nach?

ständige Triggererlebnisse im Alltag. Oftmals mit Rückzug verbunden Schuld und Scham – ich habe nicht gut genug aufgepasst, gehandelt

- Wie integrieren Sie traumasensible Prinzipien in Ihre Arbeit mit suizidnahen Hinterbliebenen?

Wie kann ich mit Flashbacks umgehen, Hyper-Hypoarousal – wie komme ich in meine Mitte, wie komme ich aus der Konstriktion, wie kann ich wieder Freude und Leichtigkeit in mein Leben lassen und Emotionen zulassen wichtig Psychoedukation, Beziehung, Interventionen erlernen

- Was beobachten Sie in Bezug auf gesellschaftliches Stigma im Zusammenhang mit Suizid, und wie wirkt sich dieses auf die Hinterbliebenen aus, mit denen Sie arbeiten? Unsicherheit der Gesellschaft im Umgang damit, Betroffener und Umgebung ziehen sich oft zurück aus Angst, dass dieses Thema angesprochen wird. Suizid wird dadurch von den betroffenen Hinterbliebenen als noch belastender erlebt, Rückschluss – bei uns stimmt was nicht ich muss mich schämen

3. Erfahrungen und Reflexionen

- Welche Reaktionen oder Bedürfnisse beobachten Sie am häufigsten bei Hinterbliebenen?

Scham, Schuld, neg. Zukunfts- und Selbstbild

- Wie gehen Sie in Ihrer Arbeit mit möglichen Tabus, Schuld- oder Schamgefühlen um? Klar ansprechen, als Symptom benennen, situativ damit arbeiten, mehrere Seiten beleuchten – Beziehung zum Verstorbenen hinterfragen – Rituale

- Was empfinden Sie als hilfreich bzw. hinderlich in der Postventionspraxis?

Es gibt Dinge die immer klar benannt werden – Scham, Schuld, neg. Zukunftsbild, hier kann man gut arbeiten.

Hinderlich sind oft die sich im Hintergrund schleichend entwickelnden negativen Einstellungen, die die Beziehung zu anderen Menschen, den eigenen Selbstwert und das Selbsterleben(dürfen) der Betroffenen beeinflussen

- Haben Sie selbst sekundäre Traumatisierung oder Mitgefühlsmüdigkeit in Ihrer Arbeit erlebt? Wie gehen Sie mit diesen Herausforderungen um?

Fachliche Distanz – was ich tun kann, ist genug und gut – ich kann das Geschehene nicht ungeschehen machen Gute Struktur in der Arbeit, Pausen einhalten, gute Selbstfürsorge und ausgleichende Freizeitbeschäftigung

Gutes durchmischen der unterschiedlichen Problemstellungen der Klienten in der Arbeit, bei der Terminierung darauf achten

4. Strukturen und Verbesserungsbedarf

- Welche besonderen Herausforderungen oder Vorteile beobachten Sie bei der Bereitstellung von Postventionsangeboten in ländlichen Regionen wie Niederbayern im Vergleich zu städtischen Gebieten?

Erreichbarkeit – oft längere Fahrtwege, Scham – hoffentlich kenne ich niemanden

- Gibt es Ihnen bekannte oder von Ihnen mitgestaltete lokale Initiativen oder Kooperationen zur Postvention in Niederbayern?

Nein

Appendix D: Ethical and Data Protection Procedures

D1 Recruitment and Participant Information

Participants were primarily recruited by the researcher. Bereaved family members were approached through personal networks and by other bereaved individuals, who informed potential participants about the study. In addition, one bereaved participant was referred through a counselling service.

Professional participants were recruited by contacting counselling services and support institutions directly. Institutions that expressed interest were provided with detailed information about the research project. In several cases, institutional representatives informed potential participants about the study and facilitated contact with professionals who were willing to participate.

Before each interview, participants received comprehensive verbal information regarding:

- the purpose and aims of the research,
- the voluntary nature of participation,
- the possibility to withdraw from the study at any time without negative consequences,
- and the confidential and anonymized handling of all collected data.

Participants were given the opportunity to ask questions prior to agreeing to participate.

D2 Consent Procedure

Due to the sensitive nature of the research topic and the qualitative interview format, consent was obtained verbally prior to the start of each interview. Participants explicitly confirmed their willingness to participate in the study and agreed that their anonymized statements could be used for academic research purposes.

To minimize the risk of emotional overload, particular care was taken to ensure that participation took place only after an appropriate temporal distance from the suicide event. Interviews were therefore conducted only when several months had passed since the loss, allowing participants sufficient time to stabilize before reflecting on their experiences within the research context.

This consent procedure followed ethical recommendations for qualitative research in sensitive contexts, where trust-based and flexible consent procedures are often considered appropriate and less intrusive for participants affected by traumatic experiences.

D3 Data Protection and Anonymization

All interviews were pseudonymized during transcription. Identifying information, including names, locations, and institutional affiliations, was removed or generalized to protect participants' identities.

Audio recordings and transcripts were stored securely and were accessible only to the researcher. The data were used exclusively for academic purposes and were handled in accordance with general principles of research data protection and confidentiality.

Special care was taken to ensure that individual participants could not be identified through contextual or narrative details.

Summary of the dissertation in Polish

Samobójstwo stanowi istotny problem zdrowia publicznego na całym świecie. Pomimo rosnącego zainteresowania badaniami nad zapobieganiem samobójstwom, doświadczenia osób, które utraciły bliskich w wyniku samobójstwa, oraz formy wsparcia dostępne dla tej grupy pozostają stosunkowo słabo zbadane. W wielu kontekstach żałoba po samobójstwie jest nadal postrzegana głównie jako indywidualna reakcja psychologiczna, a nie jako proces osadzony w szerszych uwarunkowaniach społecznych i strukturalnych. Jednocześnie postwencja – rozumiana jako wsparcie dla osób dotkniętych samobójczą śmiercią bliskiej osoby – jest często niewystarczająco zdefiniowana, rozproszona instytucjonalnie i słabo zintegrowana z istniejącymi systemami pomocy. Problemy te są szczególnie widoczne w regionach wiejskich, gdzie zasoby instytucjonalne są ograniczone, odpowiedzialności poszczególnych instytucji nie zawsze są jasno określone, a relacje społeczne są silnie ze sobą powiązane. W tym kontekście niniejsza rozprawa doktorska analizuje doświadczenia żałoby po samobójstwie oraz postwencję w wiejskim regionie Dolnej Bawarii w Niemczech.

Głównym celem badania jest zrozumienie, w jaki sposób żałoba po samobójstwie jest przeżywana, interpretowana i społecznie negocjowana oraz jak postwencja jest postrzegana i realizowana w codziennym życiu oraz w kontekstach instytucjonalnych. Badanie opiera się na założeniu, że żałoba po samobójstwie nie może być rozumiana wyłącznie jako indywidualny proces radzenia sobie ze stratą, a postwencja nie może być redukowana do pojedynczej interwencji. Przeciwnie, doświadczenie żałoby rozwija się w złożonym splocie doświadczeń biograficznych, relacji społecznych, norm kulturowych oraz struktur instytucjonalnych. W związku z tym badanie obejmuje zarówno perspektywy osób, które utraciły bliskich w wyniku samobójstwa, jak i perspektywy profesjonalistów zaangażowanych w działania wspierające po takim zdarzeniu.

Pod względem metodologicznym rozprawa opiera się na jakościowym i kontekstualnym podejściu badawczym. Dane empiryczne zostały zebrane za pomocą półstrukturalizowanych wywiadów oraz pisemnych relacji osób dotkniętych samobójczą śmiercią bliskiej osoby, a także profesjonalistów pracujących w różnych obszarach wsparcia, takich jak poradnictwo psychospołeczne, służby ratownicze, duszpasterstwo, instytucje medyczne oraz środowisko edukacyjne. Uczestnicy badania zostali dobrani celowo, aby uchwycić różnorodne doświadczenia i perspektywy charakterystyczne dla badanego kontekstu wiejskiego. Analiza danych została przeprowadzona przy użyciu

analizy tematycznej, łączącej podejście dedukcyjne i indukcyjne, co umożliwiło identyfikację powtarzających się wzorców, struktur znaczeń oraz społecznie uwarunkowanych dynamik obecnych w materiale empirycznym.

Wyniki badania wskazują, że żałoba po samobójstwie nie jest ograniczoną w czasie fazą, lecz długotrwałym i społecznie osadzonym procesem. Doświadczenie straty jest kształtowane nie tylko przez emocjonalne reakcje na śmierć bliskiej osoby, lecz także przez reakcje otoczenia społecznego, interpretacje kulturowe oraz warunki instytucjonalne, które wpływają na to, czy żałoba może być wyrażana, uznawana lub marginalizowana. Osoby dotknięte samobójczą śmiercią bliskiego często doświadczają niepewności, milczenia lub stygmatyzacji w swoim otoczeniu społecznym, co może prowadzić do tzw. wtórnej izolacji. Jednocześnie nieformalne sieci społeczne, takie jak rodzina, sąsiedzi, wspólnoty religijne czy lokalne stowarzyszenia, mogą stanowić ważne źródło wsparcia, choć dostęp do tych zasobów jest nierównomierny.

Jednym z kluczowych wniosków empirycznych jest fragmentaryczny charakter struktur postwencji. Wsparcie dla osób w żałobie rzadko jest doświadczane jako spójny system opieki. Zamiast tego postwencja często pojawia się pośrednio poprzez osobiste relacje, indywidualne zaangażowanie profesjonalistów lub nieformalne sieci wsparcia. W wielu przypadkach pomoc instytucjonalna koncentruje się na bezpośrednim okresie po samobójstwie, podczas gdy długoterminowe formy wsparcia są ograniczone. W rezultacie wiele osób pozostających w żałobie musi w dużej mierze samodzielnie radzić sobie z procesem żałoby po zakończeniu fazy kryzysowej.

Badanie pokazuje również, że kontekst wiejski Dolnej Bawarii w istotny sposób kształtuje doświadczenia żałoby oraz dostęp do wsparcia. Regiony wiejskie charakteryzują się gęstymi sieciami społecznymi, ograniczoną anonimowością oraz dużą widocznością relacji interpersonalnych. Warunki te mogą sprzyjać wsparciu społecznemu, ale jednocześnie mogą nasilać doświadczenia kontroli społecznej, stygmatyzacji oraz powściągliwości w komunikowaniu emocji. W konsekwencji wiejskość nie stanowi jedynie tła geograficznego, lecz funkcjonuje jako kontekst społeczny, który aktywnie kształtuje sposoby przeżywania żałoby, dostęp do pomocy oraz praktyki postwencji.

Rozprawa wnosi wkład do badań nad żałobą po samobójstwie i postwencją na kilku poziomach. Po pierwsze, poszerza rozumienie żałoby po samobójstwie, ukazując ją jako proces relacyjny, społecznie osadzony i długoterminowy, a nie wyłącznie jako indywidualną reakcję psychologiczną. Po drugie, wskazuje na strukturalną fragmentację

postwencji oraz podkreśla znaczenie ciągłości wsparcia, społecznego uznania oraz relacyjnej stabilności systemów pomocowych. Po trzecie, wprowadza kontekst wiejski jako istotną kategorię analityczną dla zrozumienia sposobów przeżywania żałoby oraz organizacji wsparcia.

Z perspektywy praktycznej wyniki badania sugerują, że skuteczna prewencja zależy w mniejszym stopniu od rozbudowy pojedynczych usług, a w większym od rozwoju skoordynowanych, kontekstowo wrażliwych i relacyjnie zakorzenionych struktur wsparcia. Wzmocnienie współpracy między instytucjami, uznanie roli nieformalnych sieci wsparcia oraz przeciwdziałanie stygmatyzacji mogą przyczynić się do poprawy długoterminowego wsparcia dla osób dotkniętych samobójczą śmiercią bliskiej osoby.

Niniejsza rozprawa pokazuje, że żałoba po samobójstwie oraz postwencja muszą być rozumiane w szerszych kontekstach społecznych, kulturowych i instytucjonalnych. Łącząc jakościową analizę empiryczną z refleksją teoretyczną, badanie przyczynia się do pogłębienia wiedzy na temat żałoby po samobójstwie oraz otwiera nowe perspektywy dla dalszych badań naukowych, praktyki profesjonalnej oraz społecznego podejścia do konsekwencji samobójstwa.

Summary of the dissertation in English

Suicide remains a major public health issue worldwide. Although there has been significant progress in suicide prevention, the experiences of those who have lost loved ones to suicide and the support available to them are still relatively underexplored. In many settings, grief after suicide is often viewed mainly as an individual psychological response rather than as a process rooted in social and structural factors. Additionally, postvention—understood as support for those bereaved by suicide—is frequently poorly defined, scattered across different institutions, and only loosely integrated into current care systems. These issues are especially evident in rural areas, where resources are limited, responsibilities are less clearly outlined, and social networks are tightly knit. In this context, the present dissertation investigates suicide bereavement and postvention in the rural region of Lower Bavaria in Germany.

The main goal of the study is to examine how grief after suicide is experienced, understood, and socially negotiated, and how postvention is viewed and implemented in everyday life and institutional settings. The research recognizes that suicide bereavement cannot be seen only as an individual coping process, nor can postvention be simplified to a single intervention. Instead, grief following suicide occurs within a complex network of personal histories, social relationships, cultural norms, and organizational structures. Therefore, the study explores both the perspectives of individuals who have lost someone to suicide and those of professionals involved in providing support after such tragedies.

Methodologically, the dissertation adopts a qualitative and context-sensitive research design. Empirical data were gathered through semi-structured interviews and written accounts with bereaved individuals and professionals from various institutional fields, including psychosocial counseling services, emergency services, pastoral care, medical institutions, and educational settings. Participants were selected through purposeful sampling to capture a wide range of experiences and perspectives within the rural research context. The data were analyzed using a thematic approach informed by qualitative research methods, combining deductive and inductive coding to identify recurring patterns, meaning structures, and socially embedded dynamics within the empirical material.

The findings show that suicide bereavement is not just a short-term phase but a long-lasting and socially embedded process. Grief after suicide is influenced not only by emotional reactions to loss but also by social responses, cultural interpretations, and

institutional factors that affect how grief is expressed, acknowledged, or silenced. People who are bereaved often face uncertainty, cautious silence, or stigmatization in their social environment, which can lead to secondary isolation. At the same time, informal social networks like family members, neighbors, religious communities, or local groups can offer important support, though these resources are not evenly accessible.

A key empirical insight is the fragmented nature of postvention support systems. Support for bereaved individuals is rarely experienced as a cohesive system of care. Instead, postvention often occurs indirectly through personal relationships, individual efforts by professionals, or informal networks. Institutional support generally focuses on the immediate aftermath of a suicide, while long-term support structures are limited. As a result, many bereaved individuals must manage their grief largely on their own once the initial crisis has passed.

The study further shows that the rural setting of Lower Bavaria significantly influences both the experience of grief and the availability of support. Rural areas are defined by close social networks, limited anonymity, and high interpersonal visibility. These conditions can offer helpful resources for support but may also heighten feelings of social control, stigma, and hesitation. As a result, rurality is not just a geographic location but a social environment that actively shapes how grief is expressed, how support is provided, and how postvention is carried out.

The dissertation advances research on suicide bereavement and postvention in multiple ways. First, it expands the understanding of suicide grief by framing it as a relational, socially embedded, and long-term process rather than just an individual psychological response. Second, it identifies structural fragmentation within postvention and highlights the importance of continuity, recognition, and relational trust in support systems. Third, it introduces a postvention interface misalignment model, which conceptualizes postvention gaps as the result of insufficient alignment between individual needs, institutional logics, and sociocultural conditions. Fourth, it presents the rural context as a crucial factor for understanding how grief and support are experienced and organized.

From a practical perspective, the findings suggest that effective postvention relies less on expanding isolated services and more on developing coordinated, context-aware, and relationally based support structures. Enhancing cooperation among institutions, recognizing the importance of informal support networks, and addressing social stigmatization may help improve long-term support for people bereaved by suicide.

Overall, this dissertation shows that suicide bereavement and postvention must be understood within broader social, cultural, and institutional contexts, and that their effectiveness depends on how these dimensions are structurally and relationally aligned.