ASSOCIATION OF SUICIDE BEREAVEMENT OF PARENTS AND SIBLINGS WITH OUTCOMES: THE ROLE OF SOCIAL AND PSYCHOLOGICAL FACTORS

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CERTFICATE

It is certified that PhD Dissertation titled **"ASSOCIATION OF SUICIDE BEREAVMENT OF PARENTS AND SIBLINGS WITH OUTCOMES: THE ROLE OF SOCIAL AND PSCYHOLGICIAL FACTORS"** prepared by Ms. Amna Noureen has been approved for the submission to National University of Modern Languages, Islamabad.

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Candidate of **Doctor of Philosophy** at the National University of Modern Languages do hereby declare that the thesis **"Association of Suicide Bereavement of Parents and Siblings with Outcomes: The Role of Social and Psychological Factors"** submitted by me in partial fulfillment of PhD degree, is my original work, and has not been submitted or published earlier. I also solemnly declare that it shall not, in future, be submitted by me for obtaining any other degree from this or any other university or institution.

Amna Noureen

Signature of Candidate

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DEDICATION

This thesis is dedicated to my parents, and my husband Dr. Haziq Mehmood for their unwavering support, guidance, love, motivation and prayers.

ABSTRACT

The aim of the research was to investigate the relation of suicide bereavement with various outcomes including anxiety, post-traumatic stress disorder, depression, shame, stigma and post traumatic growth and the role of environmental reward in these relationship. Group differences on bereavement and outcomes were explored based on circumstantial factors and demographic characteristics of the participants and the deceased including gender, age, family system, relationship status, religion, education level and occupation. The study follows mix method approach and cross-sectional research design. Two interrelated studies were conducted. Study-1 comprises the semi-structured interviews followed by adaptation and instruments validation in local context while considering the initial trends in the data. Subsequently, in study-II (i-e the main study) the hypotheses testing was conducted. Sample of bereaved parents and siblings were considered within Pakistan. Participants were eligible for inclusion in the study if they had experienced bereavement within six months to five years following the death of their child or sibling. The Urdu adapted version of Core Bereavement Item Scale (Brunett et al.,1997), Environmental Reward Observation Scale (Armento & Hopko,2007), Patient Health Questionnaire by Robert et al. (1999), Generalized Anxiety Disorder Scale by Spitzer et al. (2006), Impact of Event Scale by Horowitz et al. (1979), Societal Stigmatization Scale by Williams et al. (2009), State Shame Scale by Marschall et al. (1994), and Posttraumatic Growth Inventory-Short Form developed by Cann et al. (2010), followed by the demographic sheet, were used for data collection. Translation process was completed by using the procedure of Back translation technique. The findings from Study-1 provided compelling evidence regarding the validity and reliability of the translated instruments. Analysis of data from study-II revealed

significant negative association between suicide bereavement and post-traumatic growth, while there exists a significant positive association with Post traumatic stress disorder, shame, and stigma. However, non-significant associations were observed of anxiety and depression with bereavement. Environmental reward showed a significant positive correlation with posttraumatic growth. Considering environmental reward as moderator, the results indicated that environmental reward significantly moderated the relationship between suicide bereavement, shame, anxiety and depression. However, the environmental reward did not play a significant role in suicide bereavement effects on post-traumatic stress disorder, stigma, and post-traumatic growth. Findings revealed that the duration of suicide bereavement played a significant role. In the first year, post-traumatic stress disorder, shame, anxiety, and depression were higher, while post-traumatic growth and environmental reward increased with the duration of suicide bereavement. However, no significant difference was found for stigma. While examining the relationship status of parents and siblings, parents exhibited higher levels of intense bereavement, Post traumatic stress disorder, shame, anxiety, depression, and stigma. Whereas siblings showed higher levels of environmental reward and post-traumatic growth. Regarding gender differences, females experienced higher levels of depression and Post-traumatic stress disorder as compared to males. Group differences based on the gender of the deceased were also examined, revealing significant mean differences only for shame. Results indicated that the suicidal demise of a female (sister or daughter) led to significantly more shame. Group differences based on family system showed significant differences on post-traumatic stress disorder and depression. While, those living in joint family systems experienced greater depression and post-traumatic stress disorder as compared to those in nuclear families. The finding underscores the need for tailored outreach programs aimed at promoting mental health awareness and

destigmatizing help-seeking behaviors among bereaved individuals and their familie

Chapter I

INTRODUCTION

Globally, approximately eight million people die by suicide annually, which makes it of the top ten leading causes of death across all age groups (WHO,2023). Among those a significant number of individuals attempt suicide more commonly than dying by it. Suicide is considered as an impulsive coping mechanism for those facing daily life stressors. Each suicide is a tragedy that affect individuals, families, and communities making an enduring and profound impact on people left behind. One suicide impacts 135 people, including not only immediate family members but friends, colleagues and community also (Cerel & Brown, 2018).

Suicide of a loved one is a genuinely tragic event that leaves many unanswered questions, and conflicting emotions which are not easy to answer and control. Bereavement arising from suicide is a tragic journey riddled with grief, confusion, disorientation and extreme loneliness. It is vital to investigate the strategies for helping the suicide bereaved and also consider the different factors influencing a suicide bereaved individual (Pitmal et al., 2016).

Ranked as the fourth most common cause for death, suicide is a serious public health concern (WHO, 2023) with its risk being more prevalent in youth ranging from15 to 29 age group. It is important to note that 77% of global suicides occur in low and middle income countries (WHO, 2023). Youth suicide is a serious and complicated issue with a major impact on families, communities, cultures and most importantly on society. The loss of a child through suicide is indeed a massive tragedy for parents. Studies indicate that the sense of loss that follows a child's suicide brings a range of emotions including shock, disbelief, guilt, and chronic emotional suffering. Research addressing the emotional impact of suicide among

teenagers on parents demonstrate an intense sense of loss and emptiness in the aftermath of such a tragedy (Goldman, 2014).

The research on sibling bereavement often includes themes of severe and profound grief and personality disruption along with overtones of shock and uncertainty. Wagner et al.'s (2021) research has examined the connections between sorrow, despair, grief and guilt associated with surviving, and the emotions and feelings of siblings who suffer the loss of a sibling by suicide.

In Pakistan, majority of self-harm and suicide cases remain unreported due to the stigma and Islamic injunctions against suicide (Kiran et al., 2021). Suicide was a crime in Pakistan due to the limitation of legislature till October 2023.Therefore, the attainment of statistics seems challenging. In Pakistan, there is a dearth of official record of national suicide statistics. However, available data suggests that there are approximately 8.9 % suicide fatalities for every 100,000 persons in Pakistan (WHO, Kohari, 2022).

Islam, is Pakistan's official religion, forbids its following from taking their own lives. This injunction appears to have a significant impact on the way people approach their lives and other people's death. Although religious beliefs might provide comfort to some, they may also lead to existential crises or feelings and thoughts of guilt in others, which can contribute to anxiety, despair and depression. Religious leaders and charity organizations provide support and assistance to the aggrieved. However, Islamic teachings against suicide can also aggravate feelings of guilt and shame, which can hinder and delay the grieving process (Gearing & Alonzo, 2018).

In Pakistan, the stigma and the taboo surrounding mental illness and suicide can cause grieving individuals become isolated from society. They may decide to handle and deal with their anxiety and depression on their own if they fear being judged, and be

viewed negatively; they may also be prone to unfair treatment if they seek assistance and support. The availability of mental health assistance and services in Pakistan are limited for people in urban settings in general and in particular for those living the rural areas. Consequently, individuals, with prolonged grief, are bound to suffer and are unlikely to received assistance easily.

Suicide Bereavement

Bereavement is defined as a reaction to loss, and factors which lead to bereavement include traumatic life events, loss of a loved one, any previous psychiatric history, death by suicide and others. Bereavement causes an imbalance in physiology, psychology and emotions, including its cognitive, behavioral and spiritual manifestations.

Suicide bereavement may lead to psychological issues including anxiety and post-traumatic stress disorder (Parkes, 1998). Seven dimensions related to the concept of bereavement are defined as: images and thoughts relating to the lost person, feeling of presence related to the deceased, hallucinatory phenomenon, acute separation, experience of sadness, sense of loss and grief related behavior (Burnett et al., 1997). One of the most common but under researched area of bereavement is suicide bereavement (Hafford-Letchfield et al 2022).

Suicide bereavement is defined as the psychological state of loss after the suicidal demise of a loved one. A suicide-bereaved individual is a person whose loved one died by suicide, and as a consequence faces many psychological and social changes. Prevalence for bereavement is still unknown. According to a study, 90 respondents out 106 reported they had experienced bereavement, and 9.4% reported prolonged-grief disorder (Steil et al., 2019). Suicide bereavement is different from other forms of bereavement, as it also depends on the relation with the bereaved. Every individual grieves uniquely; however, those bereaved by

suicide experience significant distress, shame, guilt, sadness, rejection and fear leading to psychological issues after the loss (Ali, 2015)

Suicide bereavement has significant societal, cultural and psychological implications and impacts survivors' psychological, mental, physical and their overall health. Anxiety and hopelessness are common reactions and feelings following the demise of a loved one which include depression and anxiety and psychological after-effects. These issues can last several months despite reduction in grief and depression, often resulting from the severe shock of the loss (Molina et al., 2019).

Grief, Mourning and Trauma

Suicide bereavement leaves individuals in a great deal of pain, guilt, shame, and societal rejection, which results in emotional and psychological issues with bereavement being followed by grief. Grief is a universal phenomenon occurring after kind of loss or traumatic event. Grief is categorized as acute grief, complicated grief, inhibited grief, and delayed grief. In acute grief, bereaved individual may experience strong, upsetting emotions after the loss of a loved one. It can be an instant emotion after losing a loved one and may last for days, weeks and even months. Some common stages include shock, rage, guilt, regret, anxiety, fear, intrusive images, discontinuation from reality, feelings of loneliness, dissatisfaction, and depression (Young et al., 2012).

Prolonged grief is also known as complicated grief; it is experienced with extended period of bereavement. However, other factors are also involved: for instance, relationship of the deceased with family members, recurrent thoughts and images related to the suicide scene. It is important to note that the bereaved individual loses meaning in life, and this type of grief causes disturbance in life. Traumatic suicide images also cause panic which takes more time to heal as they cause social as well as occupational dysfunction (Elizz, 2019).

Suppressed grief often goes hand in hand with unexpressed indicators of sorrow. While it does not appear visibly, sadness is a way to release intense emotion. Consequently, when loss is expressed, the bereaved person frequently realizes that grief has taken a physical form. Inhibited grief can emerge physically if it is not acknowledged emotionally in various ways, including sickness, stomach issues, nausea, insomnia, muscle tightness or aches, headaches, and appetite issue. However, inhibited grief is more common in Asian culture as bereaved individuals do not seek any clinical help and isolate themselves, and repress their grief (Mairanz, 2019).

Delayed grief is the period in which there is no instant reaction to the loss; it can even take months and years to grieve about the incident. It is because grief does not follow a straight pathway with irregular patterns associated with flashbacks of the incident and distress recalling the suicide scene. Delayed grief is also referred as unresolved grief with an asymmetrical schedule (Rowe, 2022).

Grief leaves an individual in pain including shame, guilt and no motivation for the future. However, it can be managed if the person is prepared for the painful reminders. A bereaved individual should bereave in their unique way. Accepting emotions is a part of the bereavement process instead of repressing them; one should embrace emotions by adopting healthy coping strategies, by keeping in touch with the deceased person by adopting their role, by remembering them on special occasions. It gives a sense of connectedness with the deceased and, lessens the bereavement period and its intensity.

Mourning is another related concept which refers to the cultural patterns used for expressing grief. APA Dictionary of Psychology (APA, 2015) states that mourning implies the expression of feelings associated with grief and it occurs at the time of death and thereafter. Most of the feelings expressed in mourning resemble symptoms of depression, but they disappear with time and are not usually viewed as pathological.

Another related concept is psychological-trauma which is an invisible wound that bereaved individuals suffer. APA dictionary of psychology (2015) describes trauma as an intense experience characterized by feelings of helplessness, fear and blow to the existing adaptive schemas. Trauma can occur as a result of either artificial adversity such as rape and murder or a natural calamity such as an earthquake.

Bereavement is a traumatic experience for many if not for everyone because the death of a loved one is synonymous a traumatic event. The death of a significant other creates intense grief for bereaved parents and siblings. However, the intensity of bereavement experience differs from person to person, from situation to situation, and from culture to culture. Research in Pakistan has reported that forms of expressing grief and the intensity of grief vary across individuals (Suhail, Jamil, Oyebode, & Ajmal, 2011).

Factors Related to Bereavement

The death of a loved one by suicide enhances the likelihood of suicidal thoughts and self-harm among the family members. A significant number of family members are affected by a single suicide event consisting of parents, siblings, colleagues, and significant others. Numerous social factors are linked for impact on suicide bereaved. For instance, bond with the person who died, earlier trauma, stigma, cultural factors, and less integrated groups which increase suicide outcomes for the bereaved. Most adolescents who are bereaved by suicide show lack of peer attachment, low self-esteem and moral support, guilt, and a high level of rejection from society (Areba et al., 2021). These factors can lead to long-term grief.

In past literature, the term of ‘grief and bereavement’ was used if someone faced death or reaction to loss respectively. Bereavement and grief reaction are two different terms. Suicide bereavement leaves bereaved individuals in a great deal of pain, guilt, shame, and societal

rejection, which results in emotional and psychological outcomes which is followed by grief (Young et al.,2012). Grief is a universal phenomenon that occurs after any loss or traumatic event. It can be in the form of instant emotions after losing a loved one and may last for days, weeks and even months. Some common feeling states include: shock, rage, guilt, regret, anxiety, fear, intrusive images, discontinuation from reality, feelings of loneliness, dissatisfaction, and depression (Young, 2012).

Bereavement is specified as the loss of a significant one and its symptoms may include fatigue, sadness, numbness, shock and guilt. On the other hand, grief is referred to the emotional, cognitive, functional, and behavioral reactions to the loss.

Sometimes the victim is not aware of suicide bereavement or any other clinical psychological deviation like Generalized Anxiety Disorder (GAD) and Post-Traumatic Stress Disorder, depression, as it seems normal to a victim. Normalizing the victim's psychological deviation is often approved by culture and religious belief system. Subsequently, these emerging factors compel the victim to report and seek psychological help. The loss of children unexpectedly deeply impacts most parents. Family and relatives of deceased intend to normalize the death or they may not be aware of what suicide bereavement is. And if they become aware of it, they do not report it as it is against the ethics and norms; they might also lose their grace in religious settings (Cerel et al., 2008).

Grief is an emotional reaction carrying physical symptoms (Zisook, & Shear, 2009). The bereavement period impacts people's social, biological and psychological health, with implications for the underline causes of the suicide, it has been noticed that some people are aware of a person's intentions to have suicidal tendencies but remain quiet due to their relationship with that individual. The grieving period also fluctuates with the death type whether it is sudden death or suicide.

Gunshot, hanging, drug overdose, various forms of poisoning, and jumping off buildings, are some of the various means through which individuals take their own lives. It is quite challenging to distinguish between indirect and direct suicide attempts, as many suicides go unreported. Sometimes it is also difficult to ascertain whether a particular instance of suicide was planned or unplanned (Young et al., 2012).

As mentioned earlier, there is no uniformity in the intensity and outcomes of bereavement experiences across individuals, families, situations and cultures. The suicide demise of a young one is deeply painful and shocking for the parents, siblings and spouse. Conventionally, the initial days of bereavement appear to be more distressing and emotionally painful as compared to the days following a year of bereavement.

It has also been observed that bereaved individuals feel consoled and more in control of an adverse situation by practicing religious rituals and receiving social support. Factors that lead to the suicidal death, characteristics of bereaved individuals, time since death, and type of coping used, these all influence the intensity of bereavement and the probability of positive or negative outcomes of suicide bereavement.

The current research focuses on a sample consisting of bereaved parents and siblings. The main focus of this study is on the psychological and social states after suicide bereavement and their lived experiences. Questions domain included are sense making stage, challenges faced in the bereavement period, copying strategies and engagement in different activities after the suicide**.** This present study also aims to gain an insight into how end-of-life lived experiences affect parents' grief, and how their mental illness increases with time. Designing and getting approval for such studies can be challenging. Meanwhile, the lack of contemporary literature that draws inspiration from bereaved parent's experiences with the research process is limited.

Considering the participation of parents in research who experienced the loss of a child to suicide is itself a huge challenge, as one of the reasons is that the responsibility of a child's upbringing is the responsibility of the parents. The death of a child by suicide often raises doubts about the parenting style. Pakistani society which is somehow collectivist in nature, often attributes the blame on parents' upbringing, eventually putting parents in guilt, shame and rejection by near ones.

To investigate the feelings of these stressed parents, who are surrounded by societal values, and to explore their lived experiences, a qualitative investigation in the local context was deemed essential. The present study aims to fill the research gap by selecting a large sample size as earlier researches were conducted with a small sample size (Fhailí et al., 2016) and better participant selection. In a collectivistic culture like Pakistan, there is a dire need to explore suicide bereavement and grief expressions. The present study aims to fill that gap by incorporating qualitative and quantitative approach. Following the mix method approach, the study intends to explore the role of suicide bereavement among parents and siblings that will help in finding social and psychological outcomes.

The current research focuses on exploring the process of suicide bereavement within the behavioral-activation framework. The prime objective was to explore the moderating role of environmental rewards between suicide bereavement, common psychological issues of anxiety, depression and post-traumatic stress disorder, social outcomes of shame, stigma and post-traumatic growth. Another objective of the research was to explore the intensity of bereavement concerning the relationship with the deceased (intensity of bereavement for parents and siblings).

Suicide Bereavement and Psychological Outcomes

Individuals who are suicide bereaved, frequently suffer from depression, characterized by persistent sadness, a lack of interest or pleasure and enjoyment in activities, noticeable weight changes, insomnia, fatigue, overwhelming guilt and feeling of worthlessness, and recurring suicidal thoughts. That depression could lead to complicated grief, a prolonged and intense form of mourning that disturbs daily functioning. According to Pitman et al. (2014), bereaved may struggle to overcome their grief and sadness.

In addition to the feelings of sadness, despair and anxiety, the suicide bereaved individuals might show: excessive concern, worry, anxiousness, agitation, restlessness, irritability, difficulty concentrating, and insomnia. Among those who are suicide bereaved, panic episodes and generalized anxiety disorder are also prevalent. Bereaved may go through increased anxiety and hyper vigilance, fearing that they might contemplate suicide themselves or worrying continuously about the safety of other loved ones (Grafedeli et al., 2021).

Anxiety, hopelessness and despair may have an adverse and negative impact on one's mental health when a loved one commits and attempts suicide. Research shows that hopelessness, despair and anxiety negatively and adversely impact and affect suicide bereaved mental health (Pitman et al., 2014), which lowers their standard and quality of life. It is difficult to keep up and maintain relationships and connections in daily tasks, every day responsibilities, or operate well at work or school under these conditions and circumstances. Chronic anxieties and depression have been scientifically shown to have a harmful and deleterious effect on an individual's state of physical well-being, increasing and enhancing their susceptibility and vulnerability to conditions and illnesses such as: heart disease, diminished immunity, and gastrointestinal problems (Clarke & Currie, 2009).

Anxiety and feelings of sadness or loss to the family members in Pakistan are influenced and affected by cultural, socioeconomic, and religious factors and beliefs. These factors or elements influence and impact people's readiness to ask for and accept support, help and assistance, as well as, their capacity and ability to communicate and express their sadness and hopelessness. Family and community are very important and essential elements in Pakistan's collectivist society and culture. These cultural frameworks can be reshaped by a family member's suicide, which additionally causes serious psychological and emotional pain or suffering.

Suicide have a profound effect on the deceased family members' lives. Depression, anxiety, post-traumatic stress, guilt and isolation are major feelings that parents and siblings experience when they lose a loved one through suicide. The intensity of suicide risk is found to be often high in such individuals (Kourkouta et al., 2019).

On the one hand, people who face bereavement by death (other than suicide) hold beliefs of sense-making (giving meaning by mutual observations). On the other hand, individuals who face bereavement by the suicide of a loved one find it difficult to give meaning to life (Draper et al., 2013). However, in South Asia most of the people are unaware of the fact that they face social and psychological transition with the symptoms of anxiety, depression, post-traumatic stress disorder, stigma and lack of social support. Depending on these symptoms they never enter sense-making stage (connection with reality and future motivation) (Henry & Greenfield, 2009).

Parents who lost their child (sudden death caused by any ailment) may spend years avoiding any kind of discussion on this topic. It is obvious that they show anger and bitterness. They use suppression and blaming as a coping strategy to show social withdrawal and tend to avoid family gatherings frequently. Fathers endeavor to avoid negative feelings by being

engrossed in their work. For siblings, it is difficult to talk about their sibling's death even after years (Entilli, 2021).

Parents do not usually discuss the situation with their other bereaved children as they may become overprotective about them. However, some parents show negative feelings and neglect their remaining children. Bereaved siblings were curious to find the reason behind suicide and most of them show feelings of shock, pain and suicidal ideation. Most of the participants were found to be in denial stage at the initial phase and most of them reported shame, guilt and confusion. Later on, some of the bereaved siblings became conscious of the situation and tried spending more time with family by accepting the loss by showing personal growth. However, it is found that bereaved siblings often allow open communication as compared to their bereaved parents (Adams et al., 2019).

There was a strong perception of stigma, which was different according to cultural setting as mentioned in previous qualitative studies (Cvinar, 2005, Hanschmidt et al., 2016). The findings showed various aspects of suicide bereavement which is linked with stigma and could affect suicide behavior (Pitman et al., 2018). Two key arguments were identified: specific negative attitudes of others and social isolation. However, the arguments raised by the interviewees experiencing suicidal bereavement, and those affected by unexpected natural, unnatural and accidental death, were familiar. A significant number of participants reported social awkwardness due to stigma, but they perceived it due to self-stigma.

A recent qualitative study (using interpretative phenomenological analysis) conducted in Pakistan on grief reaction and suicide bereavement among parents, included grief reactions, shame, responsibility and religious beliefs regarding suicide (Ali & Rehna, 2022). Despite the availability of information on the suicide bereaved, there is a need to explore the potential factors provoking sibling suicide. The present part of the qualitative study focused on the

siblings' relationship bond with each other and the impact of their relationship interactions on their psychological health.

Suicide bereavement and other bereavement (following other forms of death) are different. But they share some common emotional outcomes for instance sadness and shock. Those who are bereaved by suicide will have some expected grief reaction as compared to other types of deaths. In earlier research it was found that those who were bereaved by suicide had higher levels of stigma, shame, rejection and responsibility, while results for other psychosocial factors like social support, poor mental health and guilt were inconsistent (Jordan, 2001).

The grieving period promotes vulnerable effects on stigma, shame, anxiety, depression and Post-traumatic stress disorder. It also depends on the underline causes of the suicide; some people already know that the person will commit suicide but remain quiet because of their relationship with that individual. The grieving period also fluctuates with the death type, whether it is sudden death or suicide. Gunshot, hanging, drug overdose, various forms of poisoning, and jumping, are some of the ways in which individuals commit suicide. Since it can be challenging to distinguish between indirect and direct suicide attempts, as well as, between some more direct means of suicide, many suicides go unreported. It is sometimes difficult to ascertain whether the suicide was planned or not (Young, 2012).

Suicide Bereavement and Depression

Depression can last from a couple of weeks to number of years as mentioned in DSM-V. It could cause significant impairment in life functioning. It could decrease motivation, lack of concentration, low self-esteem, fatigue and there could be extreme behavior such as a suicide. A heart attack could be one of the medical consequences of depression. When talking about the psychological impacts, the perplexed state of grief leads to the clinical emblems of depression at an acute level as the suicide bereaved confronts traumatic loss, he/she might prefer loneliness over mutual gatherings which provokes suicidal ideation. The society in this way provides grounds to the victim i.e. stigma and guilt or shame and intense feeling of anger or shallow coping capability. These are some of the common symptoms that enhance risk of depression in suicide bereaved such as substance abuse, insomnia and fatigue (Bellini et. al., 2018).

It is also noted that due to lack of support and a lack of accessing support programs, there is a prolonged period of depression, anxiety, suicide ideation, provoking thoughts and intrusive imaginations linked to the suicide act (Spillane, 2018). If they face social stigma and guilt from people around them, it prevents any clinic service. They experience high levels of depression and stop sharing their feelings with anyone. A promising study revealed that bereaved individuals (bereaved parents) were found to be more depressed as they were unable to identify or answer why someone would die, not making sense of factors behind committing suicide and still they were considered responsible for child suicide (Ali, 2015).

Findings of the longitudinal studies have depicted that compared to men, women are at higher risk of depression, and men have less vulnerability against traumatic events. It is because women have less exposure to news and have more feeling-expression capability which is why women have a higher risk of depression as compared to men (de Groot et al., 2013., Saarinen

et. al., 2000;). A sibling shares a close and connected relationship when they face the loss of their dear one. They experience a great deal of distress, insomnia, behavioral difficulties and depression. Siblings who live far from each other may show low-level symptoms of depression, but according to twin studies siblings may suffer from a great psychological loss, adjustment issues, and lower satisfaction and expectations from life (Rostila et al., 2012).

For suicide bereavement, there is a significant relationship between physical and psychological outcomes. In recent studies, psychological outcomes like anxiety, depression and post-traumatic stress disorder were found to be complex in those who were bereaved by suicide in comparison with other modes of death. Depression has a high rate and is found in bereaved family members, approximately (30.5%) of alleviated rates of depression were seen in these individuals. Suicide bereavement is linked with heightened levels of depression and suicidal attempts (Bolton et al., 2013). Those who are bereaved by suicide seek help and have feelings of guilt, sadness, anger, nightmares and depression (McMenamy et al., 2008; Pettersen et al., 2015). Depression was at elevated levels and with great intensity, having a positive relationship with suicide bereavement (Feigelman et al., 2009).

Behavioral activation has depicted that when environmental reward use is reduced, and there is an increased use of depressive behaviors, healthy behavior and quality of life are extinct (Stats et al, 1985). Theories have depicted that the persistence and development of depression is due to decreased environmental positive reinforces (Carvalho et al., 2011). Less use of environmental rewards led to clinical depression, dysphoria, and passivity (Lewinsohn, 1974). A smaller number of environmental reinforcers is proposed as the main mediator for severe depression and overt behavior (Lewinsohn, 1974). When there are fewer positive reinforcers in the environment, the antecedent (an event that caused depression) and the consequence i.e., depression will have a positive relationship (Marlena et al., 2012; Lewinsohn & Graf, 1973).

Studies have shown a connection between mood state and pleasant events, and individuals who report fewer positive events, less use of environmental reward, and less ability to get reinforcement ultimately lead to greater depression (Hopko et al., 2003; Lewinsohn & Graf, 1973; MacPhillamy & Lewinsohn 1973). However, the context in which depression is experienced, particularly in relation to suicide bereavement, remains unclear. This uncertainty underscores the strong rationale for conducting this study.

According to Pitam et al. (2020) behavioral activation is an effective therapy for involving individuals in those activities that are mindful and peaceful for them but it can also lead to environmental rewards. Environmental rewards may include social interactions and the pleasurable activities that play an important role for the reduction in the depression. However, these activities or the social interactions are the stressors for the individuals, as they can result in isolation, over thinking and can also insomnia which lead to the symptoms of depression (Pitam et al., 2020). Hence, behavioral activation is not always effective, considering the environment, quality of activity and social interactions are also very important.

One of the study depicts that poor emotional regulation in suicide bereaved people can also result in the increase in depressive symptoms. Emotion regulation is the ability to manage emotional experiences effectively. Those individuals who have poor emotional regulation, are not able to find pleasure in any situation and may find struggle to derive peace and satisfaction from environmental rewards even when these rewards are available. This results in the suicide bereaved people's involvement in the pleasurable activities which results in the increase of depressive symptoms (Hardt, 2023).

Past findings demonstrate showed that those suicide bereaved individuals who were involved in cognitive biases such as negatively judging an event or concentrating on negative aspects of a situation, may experience depressive symptoms. Individuals in the suicide

bereavement phase, have the chances to negatively evaluate the pleasurable events that can lead to the symptoms of depressions such as lack of interest or pleasure, isolation and over thinking. study also showed that the passive and repetitive focus on these negative situations (rumination), can result in the depressive symptoms in the suicide bereaved people which also stir emotions and mood regulation among them (Pitam et al., 2018).

Past literature covers the relationship of suicide bereavement and depression, but evidence regarding the environmental reinforces affecting the bereavement and psychological and social factors are not substantial. To understand the relationship between environmental rewards with depression while facing suicide bereavement, there is a need to evaluate the relationship between depression and suicide bereavement at first. Therefore, this study aims to investigate the relationship between suicide bereavement and depression.

The environmental rewards, specifically, involvement in positive activities has been researched for reducing depression (McPhee et al., 2020, Sturmey et al., 2009). But no prior research has seen the impact of suicide bereavement on contemporary relationship among environmental rewards and depression.

The present study predicted that “Environmental rewards will have a negative association with common mental disorders (depression), and environmental reward will have a moderating role in the relationship of suicide bereavement and psychological outcomes.” Suicide bereavement and anxiety, feelings of agony, despair, distress, irritability, temper loss or severe mood swings, restlessness and ever-present body aches or headaches are the emblems of anxiety common in suicide bereavement.

Bereavement is a natural grieving process; however, most individuals hide their feelings and as a result, face increased levels of stress, anxiety and depression. It is good to be with those who care for us, as they tend to provide a secure base, share their success and are

always motivate others to do new things. They are secure places where one can return to when under stress.

If a certain person is not available or not responding, it creates a situation which causes anxiety and it can be seen during acute grief. However, the acute anxiety promotes negative feelings, guilt, shame and suicidal ideation. In other words, it seems as a root as it germinates suicidal ideation, and that gets complex in future (Young et. al., 2012).

In one way or the other, anxiety, depression and post-traumatic stress disorder are interlinked and come under the fold of clinical features that involve suicide bereavement, respectively (Tidemalm et. al., 2011). Suicide bereavement may cause maximum level of anxiety and fear. Zisook (1990) noted anxiety symptoms are more prevalent than expected. It was noted that early bereavement may cause symptoms of anxiety which is more prevalent than is often appreciated." It was also noticed that earlier stages and age of the individual bereaving may bring feelings of insecurity, helplessness, and inadequacy which get compounded with stressors like social isolation and financial constraints.

Suicide Bereavement and Anxiety

Studies revealed that bereavement causes poor mental health with anxiety disorders. When a child is separated from a loved one then anxiety is the natural reaction. It is seen in adults and children and this occurrence of anxiety and complicated grief can make it difficult to have natural reactions to grief, and cause pain due to heightened anxiety (Shear et al., 2012). Traumatic events lead to a high level of risk of anxiety and traumatic grief. Anxiety symptoms can be seen between 3-6 months after the traumatic event occurs, and it may not become prolonged if treated with clinical help. The findings imply that long-term physical and psychological health issues and unhealthy coping mechanisms may not always be caused by

the stress of bereavement. Instead, it seems that psychological consequences like profound bereavement are important to consider when choosing which bereaved people to support who are vulnerable to long-term dysfunction (Holly et al., 1997).

Sometimes, when significant others are not available or we perceive that they are in danger, we often experience some degree of separation anxiety correspondingly, separation anxiety is usually a prominent feature of acute grief (Shear et al., 2012). Loss of a bereaved individual can cause or worsen major depressive disorder (MDD), and complicate grief, where it's difficult to experience a natural healing process (Rosenberg et al., 2021). The majority of people experience intense bereavement in connection with the loss of a loved one, and after taking part in bereavement support group for several years show no apparent change in sadness, anxiety, or depression.

The findings consequently highlight the issue of whether bereavement support groups can truly help the bereaved. It might be kept under consideration that the bereavement period for every individual is different, and every person expresses it uniquely' however, based on responses it might not be possible to get an insight into anxiety and depression without the support group intervention (Näppä et al., 2016).

Previous study suggests that suicide bereaved individual may overestimate threats in every situation even in those situations where environmental rewards are present. These overestimations from suicide bereaved individuals can result in the symptoms of anxiety and that environmental reward may not always be effective in coping the anxiety symptoms but in some aspects also increase them (Hanschmidt et al., 2016). Research suggests that suicide bereaved individuals can alter and change the rewards processing from environment which results in the diminishment of pleasurable feelings and can leads to anxiety (Shear & Skritskaya, 2012).

Earlier research shows that neurobiological pathways play an important role for the reduction and increase of anxiety in the presence of environmental reward. Amygdala works for processing of fear and responding to a threatening situation. If in the suicide bereaved individuals, amygdala is not processing fear effectively and also the threatening situations, the individuals may not find pleasure in any activity or reward from environment and perceived threatening situations even in the presence of environmental rewards, which may result in the increase of anxiety symptoms (Fox et al., 2015).

Prior study depicts that suicide bereaved individuals often engage in the avoidance behavior, as they may want to avoid people, social interaction and also avoid pleasurable activities. If the suicide bereaved people demonstrate avoidance behavior, which include behaviors that avoid factors from environmental rewards, and can lead to enhanced anxiety. They avoid them because of the negative perception of the event (Andriessen & Krysinska, 2020). Research also suggests that those individuals who lost their loved one to suicide may have low self-efficacy and lack of control over their environment. So if the suicide bereaved individuals have a lack of control over the circumstances, this can lead to low self-efficacy and may also result in anxiety among these people (Valois et al., 2015).

Earlier research shows that there are many cognitive theories that indicates that suicide bereaved people are prone to negative appraisals of the positive or neutral environmental rewards. These negative appraisals result in the diminished positive rewards from the environment which results in increased anxiety symptoms of suicide bereaved people (Barkus, 2021). A research indicates that those suicide bereaved people who have high level of physiological arousal can reduce the enjoyment of positive events from the environmental rewards. This physiological arousal makes them difficult to fully participate and engage in the pleasurable activities and environmental rewards which can results in increased anxiety symptoms among suicide bereaved people (Pizzie & Kraemer, 2021)

Past studies have shown that suicide bereaved people often find it challenging to regulate their emotions effectively. Therefore, this emotion dysregulation from suicide bereaved people may find it challenging to derive the pleasurable experience from environmental reward and to regulate the emotions effectively which results in the increase in anxiety symptoms (Yang et al., 2023). Research also suggests that social support plays an important role in coping with the trauma of suicide bereaved people. Those individuals who lost their loved one to suicide may have low social support or social interactions may not experience the full benefits of environmental rewards and may results in increase anxiety symptoms (Buur et al., 2023).

Past literature showed the effects of environmental enrichment rewards on anxiety related to drug addiction and substance intake (Rodríguez-Ortega & Cubero 2018). Another study was about behavioral activation and depressed and anxious university students (Gawrysiak et al., 2009). Past studies also investigated the relationship between anxiety and suicide and the role of stressors (Taylor et al., 2011). To the best knowledge of the researcher not even a single study has examined the negative relationship between behavioral activation rewards operating in the environment and anxiety. This study is the foremost in studying the environmental rewards effects on the levels of anxiety caused by suicide bereavement.

The study conceptualizes that if environmental rewards mitigate the relationship between anxiety and depression as shown in past literature, it would have an impact on the anxiety and depression caused by suicide bereavement. Another significant aspect which this study fulfilled is that it is based on the lived experiences of the parents and siblings who are struggling with anxiety, and will show whether environmental reinforcement have reduced their anxiety or not. Past research has investigated that anxiety and use of environmental rewards bring changes in anxiety symptoms and environmental reward is an important outcome

in behavioral activation (Stein et al., 2020). These studies have been conducted with the general population affected with anxiety whereas specific populations about suicide bereavement have not been studied yet and it is the gap found in most of the studies.

Suicide Bereavement and Post-traumatic stress disorder

Another research also indicates that post-traumatic stress disorder, anxiety, and despair are among the longtime psychological influences. Additionally, parents may experience complex grief, characterized by an extended mourning period that interferes with everyday functioning (Soole et al., 2015). According to Calati et al. (2019), social isolation can be brought on via the stigma associated with suicide. Parents may also keep away from social interaction out of embarrassment. The effectiveness and accessibility of help-systems vary. Suicide is a horrible and scary concept, bereaved individuals, frequently experience and suffer from post-traumatic stress disorder, worry, anxiousness and despair.

A serious and severe mental illness post-traumatic stress disorder, or post-traumatic stress disorder, usually results from experiencing and witnessing stressful circumstances and situations. The sudden and abrupt, and sometimes violent or brutal character of the loss in the context of suicide bereavement can lead to and result in the development of post-traumatic stress disorder. Suicide bereaved who suffer and undergo from post-traumatic stress disorder may experience and develop a variety of symptoms, such as hyper-arousal (irritability, trouble falling sleeping, and hyper vigilance), recalling and reliving the traumatic event (flashbacks, nightmares), avoiding and preventing reminders of the trauma, and negative mood and thought changes (feelings of guilt, anger, or detachment). Rehabilitating and healing from post-traumatic stress disorder can be more challenging and distressing for survivors when it coexists with other mental health conditions including, use and abuse of drugs, depression, or anxiety (Mitchell & Terhorst, 2017).

Suicides may be extremely and highly devastating because they are sudden and unexpected, violent deaths. Bereaved have painful and difficult images and strong recollections, that can worsen post-traumatic stress disorder. Studies show that those who saw a suicide attempt, or found the body had a higher risk of developing and suffering from post-traumatic stress disorder. Post-traumatic stress disorder symptoms can be made worse by intense and severe feelings of shame and self-blame, which are prevalent and frequent among suicide bereaved.

The bereaved might ask what they might have done to stop and prevent the death from happening again. Post-traumatic stress disorder affects and impacts one's mental and physical wellbeing and overall health. as it causes ongoing anxiety, stress, emotional numbness, and challenges with day-to-day functioning and daily tasks. Post-traumatic stress disorder seriously compromises mental health. Relationships at the workplace, and overall quality of life may all suffer. Long-term and chronic stress related to post traumatic stress disorder can also be harmful and detrimental to one's health, as it can weaken and lower the immunity, raise or increase the risk of heart disease, and result and lead to in gastrointestinal issues.

Complying with suicide in Pakistan, social, religious, and cultural factors and other variables all have an impact on post-traumatic stress disorder. In Pakistani culture, the family is the primary and main institution of support. But the guilt attached and associated to suicide may ruin and destroy family dynamics, causing or creating isolation, and aggravating or worsening post-traumatic stress disorder symptoms. Because of the social pressure to maintain and uphold family honor, trauma survivors may decide to keep their experiences and losses hidden and concealed. Pakistani society and culture are a collectivistic culture, which means that personal tragedies and traumas, like suicide, are often and frequently made public and subjected to criticism and shame. The trauma and post-traumatic stress disorder symptoms

of bereaved might experience deterioration as a result and consequences of such public exposure and contact.

In Islamic perspective, suicide is considered a serious sin. It can cause and lead survivors to experience and go through intense shame, severe guilt and spiritual suffering. This spiritual perspective and thinking may worsen the signs of post-traumatic stress disorder, as they add a layer of existential and moral crises to the mental trauma. For obtaining relief or comfort, some people with post-traumatic stress disorder turn to social guide networks, aid businesses, and religious practices and rituals. However, stigmatizing suicide among religious communities can also result and lead to rejection and isolation, worsening the bereavement process. The symptoms of post-traumatic stress disorder may intensify or worsen due to social isolation brought on by the stigma associated and linked with suicide in Pakistan. Bereaved can decide to process their trauma in solitude and isolation if they are afraid of being rejected, ignored and judged (Adil et al., 2023).

Direct or indirect exposure to prolonged and acute psychological event that is tragic and for an individual comes under the fold of posttraumatic stress disorder (APA, 2013). Those bereaved by suicide who witness the death or find the body, may experience the symptoms of post-traumatic stress disorder such as flashbacks or nightmares. Young et al., (2012) proposed that the probability of Post-traumatic stress disorder is higher in survivors of suicide bereavement as compared to the other types of death. He also put forward the notion that people who lost their loved ones are generally separated from societal activities and live passively. This can enhance suicidal ideation and psychological distress that gets prolonged and acute, hence, the need for developing post-traumatic stress disorder which need to be dealt with promptly. In such cases psychiatric and psychological services become necessary in order to avoid suicidal ideation or another harmful aftermath (Young et. al., 2012). If indulgence in positive activities in any way prove to be the environmental reward, psychological distress and post-traumatic

stress disorder would reduce. The idea of investigating the relationship between suicidal bereavement and psychological outcomes with environmental rewards intervention was to build evidence for the enhancement of psychological therapies imbedded in with the surrounding positive factors.

Murphy and Johnson (2002) concluded that parents whose children died by violent death risked the diagnostic criteria for post-traumatic stress disorder and mental disturbance five years after the event. It was evident that post-traumatic stress disorder is more prominent, and symptoms of post-traumatic stress disorder exist up to even after five years of the death. In comparison, three times as many mothers and twice as many fathers met the criteria for a diagnosis of post-traumatic stress disorder.

The psychological suffering experienced by the suicide-bereaved individuals occurs due to attempts at understanding the motives behind suicide. Bereaved individuals mostly exaggerate their relationship complexities with the deceased and blame themselves. Therefore, they suffer from psychological issues, mainly post-traumatic stress disorder and major depressive disorder (MDD). They not only suffer from mental illness but also suffer from emotional confusion - the confusion and ambiguity are major concerns for psychological suffering because bereaved individuals may live their entire lives attempting to find validity to these questions (Berardelli et al., 2020).

Longitudinal design-based research by Erlangsen, et al (2014) focused on bereavement after spousal suicide. They identified that beavered spouse faced mental, physical and social health issues. In mental disorders, it was found that anxiety, post-traumatic stress disorder, mood disorders, and drug use disorders were more common in bereaved spouses.

Individuals who have lost someone to suicide and if they choose to share their feelings, and also have social support, and a more positive approach towards self-regulation are more in a position to experience personal growth after the suicide tragedy (Levi-Belz 2015,2016). Those who demonstrate high resilience and growth have higher levels of PTG among suicide bereaved. (Moore, Cerel, & Jobes, 2015). However, positive activities and environmental rewards affect the relationship of suicide bereavement with the psychological outcome, specifically, loneliness with post-traumatic disorder and no prior investigation has been done regarding this area (Levi- Belz, 2017). Past literature showed a case study studying Behavioral activation effects with co-morbid post-traumatic stress disorder with depression (Patrick et al., 2004), however, the present study has undertaken the initiative to investigate this significant aspect by studying the effects of environmental-reward within the parameters of suicide bereavement specifically with post-traumatic stress disorder as an outcome. We believe if environmental rewards affect depression, then it would affect depression when co-morbid with post-traumatic stress disorder caused by suicide bereavement.

Critical analysis of the above research highlights the relationship between post-traumatic stress disorder and suicide bereavement, but does not find the moderating role of environmental rewards on their relationship. The present study was conducted to explore these rewards in qualitative interviews, and then to test the relationship between these rewards and outcomes quantitatively.

Post-traumatic growth

It refers to the adaptive outcome of any adverse experience including bereavement. Post traumatic growth is a construct of positive psychology. This term was proposed by Calhoun and Tedeschi (1996) and since then the term is prevalent in literature. It is considered Growth both as an outcome, and a process (Walter & Bates, 2012). As a process, growth helps in

escaping the negative effects of traumatic event through distortion of certain aspects of the event (Maercker & ZoeIIner, 2004). Reinforcing the concept, Park (1999) argued that the absence of negative association of growth with distress is the indicator that the individuals reporting growth distorted the adverse effects of trauma.

Zoelllner and Maercker (2006) viewed post traumatic growth as recovery from trauma and personal growth of the individual. It can be viewed as combination of adaptive transformations (Beachem et al, 2018) which is reflected in the presence of five distinct domains: a) view of having better relations with others, b). possibilities in life, c). enhanced personal growth, d). increased appreciation of life, and spiritual enhancement on post traumatic growth inventory.

According to Calhoun, Cann, Tedeschi and McMillian (2000), post traumatic growth is a significant positive change, which people report in the context of coping with the adversities, such as, bereavement. It is now a widely accepted notion that growth implies adaptive changes that occur as an outcome of dealing with adverse event (Tedeschi & Calhoun, 2004). However, according to Janoff-Bulman (2014) reconstruction of the shattered schemas is termed as growth. Besides individual level, growth can also be experienced at a collective and community level (Wlodarczyk, Basabe, Paez, Villagran & Reyes, 2017).

The dimensions of growth include: (a) view of having enhanced relations with other people (b) having opportunity and possibilities (c) enhanced personal strengths (d) increased gratitude for life (e) and spiritual betterment (Calhoun & Tedeschi 1996). These dimensions are reflected in improved confidence, empathy and esteem, closer relationships and easier communication with others, and more attention to the present moment along with increased spirituality (Arnedo & Caesellause- Grau, 2015).

Moreover, research has also indicated certain other characteristic of growth, reporting individuals, which include being judicious and more accommodating to extremities of life, being more mature and having higher self-efficacy, being more brave, having empathy, patience and tolerance, having more religious belief and spirituality, and having higher awareness about existence (Affleck, Tennen, & Rowe, 2012; Calhoun & Tedeschi, 1998b; Edmonds & Hooker, 1992; Schaefer & Moos, 2001; Yalom & Lieberman, 1991).

The literature has also indicated that extremity of negative events is critical for post traumatic growth (ZoeIIner & Maercker, 2006), which means less stressful events may not yield ground for growth. The reports of growth have been documented in aftermath of a variety of adverse events, which range from bereavement and war to natural disasters, and terminal disease such as cancer (Barakat, Adelfer, & Kazak, 2006; Colville & Cream, 2009; EngeIkemyers & Marwit, 2008). With reference to time of growth occurrence, there is divided opinion about the length of time it takes for growth to occur. Calhoun and Tedeschi have stated that moving forward is a lengthy process, whereas (Frazier et al., 2001) have observed that growth has been reported even after two weeks of bereavement.

Post traumatic growth and other similar concepts

There are various concepts which appear to be quite similar in meaning to the idea of Post traumatic growth. They include growth related to stress (Park et al.,1996), to adversarial experiences (Joseph & Linley, 2005), benefit finding (Affleck et al.,1996) and thriving (Carver, Schier, & Weintraub, 1989). Only post traumatic growth conceptually represents the positive change after trauma as an expected outcome, and not as a coping mechanism of extremely adverse events, and as a psychological experience that may last concurrently with distress.

Post traumatic growth is a phenomenon that goes beyond the coping mechanism whereas concepts of resilience, hardiness, optimism, and sense of coherence, imply characteristics of an individual that may help in dealing with adversities (Tedeschi & Calhoun, 2004). There is a fundamental difference between post traumatic growth and the concept of resilience. The former refers to perception and occurrence of adaptive changes that may not have been present before the adverse event whereas, the latter refers to the restoration of pre-trauma state (Cardenas-Castro, Martinez, & Abarca, 2016).

Post traumatic growth implies experience of every psychologically adaptive change that occurs while struggling with the life challenges (Joseph & linely, 2008; Tedeschi & Calhoun, 2004). In fact, we view every aspect of our life in the light of our core beliefs (Janoff-Bulman, 1992). The spirit of post traumatic growth is to recover from the damage to the core beliefs by the traumatic event (Janoff-Bulman, 2014) and the struggle to reconstruct these beliefs (Taku, Calhoun, Tedeschi, Gil-Rivasv, Kilmer, Cann, 2007; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2012). According to Khanna and Greyson, (2015) growth implies an improved psychological state that is beyond the pre-trauma state.

Post traumatic growth and Distress

Distress is a natural response to adverse experiences; the more the adversity, greater the distress. The research has indicated that extremely stressful events can lead to growth (e.g., Tedeschi & Calhoun, 1995, 2004). However, Occurrence of growth does not lead to a decrease in psychological distress (Calhoun, Tedeschi, Cann, & Hanks, 2010), instead severity of stress appears to be a pre-requisite for growth, since it is an outcome of struggling with extremely distressful events (Calhoun & Tedeschi, 2014). Post traumatic growth concept has been described by its profoundness as a positive mental health change which is experienced due to a struggle in challenging life situations (Tedeschi, & Calhoun, 2004).

It is in this context that understanding of the growth and distress relation appears important and valuable. It is one of the most debated topics in post-traumatic growth literature (Hall, Saltzman, Canetti, & Hobfoll, 2015). The Important questions, in this regard are: (a) growth means absence of distress, (b) Are these two constructs concurrent, or (c) Is there any relation between the two constructs. To answer these questions, three possible patterns of growth and distress relations have been documented in the literature.

Some studies have indicated negative association of growth with distress (e.g., Frazier et al., 2001). In this way, they are not different from each other (Dekel, Eindor, & Solomon, 2012). In contrast, other studies have reported positive association between the two phenomena. For example, Solomon and Dekel (2007) have reported that more distress leads to more growth. A meta-analytical review has also reported positive association of post traumatic growth with post-traumatic stress disorder (Hall et al, 2015). In a sample of young Iraqi war survivors living in Turkey, Kilie, Magruder, and Koryurek (2016) observed positive association of post-traumatic stress disorder symptoms with growth.

However, past studies have reported that growth is independent of distress as no significant association of growth with distress was observed (e.g., Joseph, Williams & Yule, 1993). Very few studies have supported the association. A study by Bayer-Topilsky, Itzhaky, Dekel, and Marmor (2013) reported non-significant association of growth with distress. Widows, Jacobsen, Boot jones, and Fields (2005) reported the co-existence of post traumatic growth and distress. In a study, mothers, who were bereaved by death of neonatal babies, reported some experience of growth aligned with the ongoing distress (Waugh, Kiemle & Slade, 2018).

In a sample of Australian ambulance personnel, Ragger, Heibeler- Ragger, Herzog, Kapfhammer, and Unterrainer, (2019) observed that growth and distress are independent of each other, and they coexist in the aftermath of critical incidents. The Organismic valuing process theory (Joseph & Linely, 2005) also postulates growth and distress as independent of each other.

A few studies have explored distress and growth relationship (Laufer & Solomon, 2010); review of the extensive literature shows that there are findings on the relation between growth and distress (Hungerbuhler, Vollrath, & Landolt, 2011). Different studies have reported different findings about this relation that include (a) positive relationship (Sawyer, Ayers, & Field, 2010), (c) Curvilinear relationship (d) no relationship at all. According to these findings it can be summarized that the relationship between growth and distress vary, and that growth is possible (a) in the absence of post-traumatic stress or (b) they can exist simultaneously (Folkman, 2008).

Suicide Bereavement and post traumatic growth

Possibility of growth in the context of bereavement and other adversities is largely documented in extant literature (e.g., EngeIkemeyers & Marwit,2008). The concept of growth while experiencing adversity has been in existence for long; however, attention of researchers and mental health practitioners has only recently shifted in this direction (Dekel, Mandl, & Solomon, 2011). With this change in focus, many studies have documented reporting of growth following bereavement and other adversities (e.g., Braun & Berg, 1994., Calhoun & Tedeschi, 1998b).

Bereavement which is traumatic event it can cause adverse mental health issues and cause suffering (Hungerbuehler et al., 2011); Those people who struggle with such distressing

event, there could be chances to have adaptive change in them. Joseph and Linley (2008) and Znoj (2005) have reported that individuals who were bereaved with suicide have they get stronger with passage of time and also become more resilient with any adversity they have faced. Carlsoon and Nilsson (2007) study on post traumatic growth and suicide bereavement have also reported that there is chances of growth after bereavement. Studies on neonate babies' death reflect that there is chances that mother recover and grow after the bereavement (e.g., Waugh, Kiemle, Slade, 2018). In bereaved members who have experienced negative events of disaster, war, cancer, and any other type of bereavement they have also reported growth. (EngeIkemeyers & Marwit, 2008, Joseph & Lineley, 2005).

When an individual faces struggle in life it can lead to positive changes which amounts to benefit (Affleck & Tennen, 1996), growth related to stress (Park, et al., 1996) and most commonly growth (PTG) (Tedeschi & Calhoun, 2004). It also includes having strong feelings, becoming close to friends and family, having greater appreciation for life, and having new possibilities, and positive change towards religion or spirituality. After bereavement, post traumatic growth is most likely to occur, when someone lose a loved one, it may increase feelings towards others, such as an achieving feeling of connectedness, and a new meaning to life. (Calhoun et al.,2010). Thus, after prenatal death, and death of family members and friends(non-violent), post traumatic growth has been observed (e.g., Bartl, et al., 2018).

The question remains if the post traumatic growth is adaptive or is it maladaptive response? Traditionally, adaptive cognitive recovery mechanism has been found to have beneficial outcome, whereas others have pointed out that post traumatic growth hamper recovery with self-deceptive/avoidant strategy (e.g., Boals & Schuler, 2018; Frazier et al., 2009). Zoellner and Maercker (2006) posited the "Janus-face" model of post traumatic growth, which holds that perceptions of post traumatic growth may be helpful in processing a major

stressful life-event, but there are some positive illusions which counterbalance emotional turmoil.

In earlier studies, the term post-traumatic growth is not only linked with emotion and problem focused mechanism, but also with avoidance and denial coping (Boals & Schuler, 2018). When traumatic aspect of loss is avoided it sometime hampers recovery and cause acute reactions (Boelen, van den Hout, & van den Bout, 2006).

Thus, it can be assumed that more post traumatic growth might result in maladaptive coping/behaviors that could further result in mental health problems. Earlier studies have shown that bereaved population have links with prolonged grief symptoms and post traumatic growth (e.g., Currier et al., 2012) and a connection of Post-traumatic stress disorder symptoms of post traumatic growth which is positive, but have non-significant relation. (e.g., Taku et al., 2008). The finding of meta-analysis depicts that there is an inverse relation between post traumatic growth and depression, however, it is not related to anxiety (Helgeson, et al., 2006).

Self-perception is one of the areas in which change would be noticed due to post-traumatic growth other than five other areas (Calhoun, & Tedeschi, 2008). Growth concept which is more vulnerable yet stronger can be measured through self-concept. When a sudden or violent death occurs in a family, they tend to believe they are also vulnerable to it, and life is unexpected, unpredictable and anything tragic can happen, but at the same time this experience helps them to become more confident and stronger**.** Another domain of post-traumatic growth is that relationship with others change in a positive way. One of the aspects of growth is that crises or loss can cause negative impact in life and a negative change in relationships. Positive change in relationships are also reported by bereaved people. This change happens mostly with close and significant family members and close friends. In post-

traumatic growth, there is a sense of connectedness towards other people which brings feeling of compassion in general and towards others, who suffer from similar loss.

Another category of post traumatic growth is new possibilities; it opens up hope or possibility to begin new relationships. It is certain that the one they have lost cannot come back, and they themselves will not behave the same way, but the space created due to loss makes space for other people to enter in their life. In post-traumatic growth individuals start appreciating life, and it is difficult for some people to accept this change, but they attempt to involve themselves in new habits, and live more diligently.

Other areas of post traumatic growth include existential approach, which shows its spiritual and religious aspects, depending on geographical and cultural aspects. Due to connection with deceased, individuals experience change, and a new understanding of themselves, and their existence as human beings. This aspect is reported in multiple studies on bereavement. In a study of group of bereaved parents, religious coping was identified as one of the top three indicators of post-traumatic growth (Znoj, 2006). For those caregivers bereaved due to HIV, spirituality was one important source of growth (Cadell, 2007).

In literature, negative outputs for bereavement are mainly highlighted and documented; however positive outputs have received very little attention (Eisma et al., 2019). Although there is a great deal of interest about post traumatic growth, limited consensus has been observed about positive life changes, as seen in cross-sectional design studies, with limited small samples (Engelhard et al., 2014). Most of the studies focused on qualitative interview to understand the local context. The five domains typically do not include all methods of grieving process, and once explored in context with parents and siblings some new factors will emerge.

Experiencing negative symptoms is common for trauma survivors which normally fade away with passage of time (Rothbaum et al.,1992). Some of the survivors develop resilience and post traumatic growth (Foa & Riggs, 1995; Solomon & Dekel, 2007). However, some of the trauma survivors develop post-traumatic stress disorder (Green, 1994). Theoretical literature and empirical studies showed evidence in support of both the negative and positive outcomes of bereavement experiences. As a matter of fact, most of the past studies have reported maladaptive outcomes of bereavement experiences such as prolonged grief, depression and post-traumatic stress disorder.

Since the emergence of positive psychology, exploring the possibility of positive outcomes has also been a focus of research. The trend of exploring growth in the aftermath of adverse events began in the 1990's (Naik & Khan, 2019). Maitlis (2019) has also asserted that growth has been the focus of research for more than two decades. According to Cadell, Rehghr and Hemsworth (2003), initially evidence of growth was recorded by Moos and Schaefer (1986). Many studies have documented this change in focus of bereavement and trauma research from negative to positive outcomes (e.g., Helgeson, Reynolds & Tomich, 2006; Laufer & Solomon, 2010). Numerous studies have now documented reports of positive and adaptive outcomes of bereavement, as well as. adverse experiences.

In literature, the positive and adaptive outcomes are discussed in different terms such as benefit-finding, post-traumatic growth hardiness, growth related to stress, positive changes. The term post traumatic growth is considered as a more appropriate term to refer to the adaptive outcomes of adverse events and it is more prevalent in research.

Suicide bereavement has immediate social consequences. Research indicates that bereaved often enjoy an abundance of aid from friends, circle of relatives, and the community

in the instant wake of the loss. But over the years, this aid typically wanes, leaving human beings to handle their grief commonly on their very own.

Research also indicates that losing a cherished one can critically intrude with daily functioning. Following the initial period of social adjustment, suicide bereavement can arise in social adjustment rather shortly. Past findings shows that with growing intensity of grief, social disengagement is standard. Bereaved might also have a smaller social circle, and probably reveal the feelings of loneliness and being isolated from people who do not completely understand their struggles. According to studies, suicide stigma can cause discrimination and judgment from society. Bereaved can also enjoy insensitive comments or a lack of comprehension, which can isolate them even more, and make their grieving extra difficult (Pitman et al., 2016). After a quick term of social modifications, suicide bereavement can purpose medium term social changes and modifications. According to the studies, conducting network activities, including aid organizations or suicide prevention advocacy, can offer consolation for bereaved. These hobbies can offer a feeling of cause and connection (Andriessen et al., 2016).

After a medium time period social adjustment, suicide bereavement causes long term social variation. Research shows that over the years, bereaved regularly reconstruct their social networks, developing new relationships and fortifying those that already exist. Reintegrating into society is vital for fitness and restoration. Research additionally shows that many bereaved use their sorrow as motivation for intellectual growth and suicide prevention (Feigelmen et al., 2018).

When suicide bereavement period is extended, it affects personal area of an individual and becomes extremely stressful. According to Feigelman and Jordan (2009), even though it is hard, prolonged bereavement can result in profound non-public development. The high-quality psychological changes that can make an individual over extremely difficult life occasions are

known as growth. People often uncover resilience and inner strengths they were formerly unaware of. Their extended fortitude will allow them to address limitations in the future with greater efficiency (Drapeu et al., 2016).

Studies reveal that following bereavement, relationships come to be more meaningful and richer. Additionally, bereaved possibly grow in empathy and compassion that could beautify their relationships. A man or woman often become appreciative of being alive after suffering the excessive loss of a cherished one. The bereaved ought to get a clear feel of motives, and discover ways to value things/relationships which can become very important to them (Andrissen et al., 2016). According to research, relationships become deeper and more meaningful after a loss. This can also entail a stronger bond with their faith, or a more expansive spirituality and a deep comprehension of problems of existence (Becker et al., 2007).

Suicide Bereavement and Social Outcomes

Alongside the psychological impact, suicide bereavement also has a social effect on the survivors. Research indicates the household of the deceased individual, due to the stigma associated with mental illness and suicide, may get socially isolated. This may make it even more difficult for them to invite help, and also be sincere about their stories (Gressier et al., 2017). Past findings indicates that families bereaved by suicide also go through severe mental illness. Past research indicates that families have to frequently cope with more than intense emotions in addition to grief over a suicide, including helplessness, frustration, and melancholy associated with mental illness (Hoertal et al., 2015). Therapy, volunteering for organizations, and engaging in intellectual health advocacy are all useful coping techniques that assist people find meaning in life. Some households, despite their deep loss, experience a painful growth. The resilience that has been built over years of coping with the mental illness is usually

responsible for this development, which could result in tolerance, empathy, and focus (Bazrafshan et al., 2014).

Bereavement refers to the loss of one with whom one has a strong connection and bonding (Stroebe et. al., 2008) and when someone experiences suicide bereavement, the strong bonds of relationships become ruptured by physical and psychological detachment. The suicide bereaved tends to become more vulnerable against the catastrophic physical and psychological episodes. This higher vulnerability provides grounds for the risk of anxiety, post-traumatic stress disorder and depression (Pitman et. al., 2014). Guilt is increased and there is a heightened sense of rumination and mourning which may lead to prolonged grief disorder (Shear et al., 2011). These psychological outcomes could be one of the reasons why people's health deteriorates with time and they develop chronic health issues.

Suicide bereavement not only has psychological, emotional or behavioral impacts, such as anxiety, grief, stress, or posttraumatic development, but it also causes and leads to stigma and shame. Individuals who have lost a loved one to suicide frequently experience or encounter shame and stigma. According to Evans and Abrahamson (2020), the social stigma exists around suicide can occasionally take the form and shape of unfair criticism, and opinions, rejection, disapproval and discrimination. These experiences and events can have a negative and adverse effect on the social and emotional health of individuals who have lost a loved one to suicide.

Suicide bereavement and Stigma

Suicide stigma often worsens people's suffering by making them feel even lonelier and ashamed. In addition to the severe emotional affects, many parents whose children pass away due to suicide, suffer from or experience serious and long-term psychological issues and problems, depression, anxiousness, and post-traumatic stress disorder. Understanding the

intricate relationship and connection between psychological, emotional, and social factors in parental loss and sorrow is vital in order to develop successful interventions, and support services that address the needs of bereaved parents (Pitman et al., 2014).

Suicide is frequently seen, interpreted and viewed by society as an act of immorality or weakness of character, which results in severe and serious judgments and evaluations against the deceased and their relatives. This stigma can take many different forms, such as verbal assault, physical harm, social rejection. Survivors frequently internalize these unfavorable and negative views from society in addition to the external stigma, which leads to self-stigma. This includes feelings of regret, guilt, shame, and lack of self-worth. Self-stigma, according to Pipel and Amsel (2011), can make mental health problems worse and severe and prevent people from getting treatment.

Perception about suicide is shaped by cultural norms and ideologies. It is considered as shameful act that bring dishonor to the family. These ideas affect how societies view survivors and keep stigma and shame alive (Logan et al., 2014). Islam forbids suicide as a wrong and condemns it as a sin. Family members or friends who have lost loved one to suicide suffer stigma and face criticism for society at large. Research Indicate that media also contribute to the stigma in society (Leauane et al.2021).

Suicide bereaved people at different stages of the process can experience depression, anxiety and post-traumatic stress disorder often debilitating and difficult to manage. Stigma and shame can worsen mental health problems and emerging evidence suggests that avoidant social stigma negatively influences mental health outcomes.

Stigma is not only an interpersonal experience, it is a relational process that can lead to social withdrawal and isolation. This problem is compounded after suicide loss because bereaved survivors have been all but cast out of their social circles; after a suicide loss, friends, family and neighbors will often withdraw at the very time that they most need support. As a

result, survivors often lack a network of people to which they can turn. Seeking help is impeded by stigma. Stigma can stop survivors reaching out for help. They might be unable to access assistance like mental health services, support groups and even assistance from friends and family because of the fear of disapproval and discrimination (San et al., 2019).

The stigma and guilt surrounding suicide bereavement are firmly embedded in Pakistan due to cultural, social and religious issues. In Pakistani culture, family honor is a very important factor. In this way, suicide of a family member is often viewed as shame and a cause of embarrassment of the whole family. Because of the society's focus on honor or face, the family of an individual who commits suicide may be stigmatized and become isolated from the whole community. Because Pakistani communities are close-knit, personal matters such as the suicide of a family member come to light quite fast. Families may therefore experience prejudice and social exclusion, which might lead to a generalized stigma in society (Shekhani et al., 2018)

Islam, as the predominant religion in Pakistan, strongly opposes suicide as an unforgettable and deadly sin. This religious perspective subjects the bereaved families to grievance from both spiritual aspects as well as the wider public, which may intensify their emotions of guilt and embarrassment. The society's failure to recognize suicide could aggravate the stigma, negative stereotypes and perceptions making it difficult for families to seek assistance or comfort from their religious community (Shakil, 2016).

Families who lost their loved ones to suicide feel social isolation and exclusion, as the society does not accept these families. It is important for their relatives to be with them at their time of suffering and to help them cope with grief.

The social exclusion that the bereaved experience might make them feel more mentally and emotionally troubled. The stigma that is related to mental disorders and suicide is an important obstacle and barrier to seeking treatment in Pakistan. The bereaved might be unable and reluctant to receive mental health assistance, support and care, support groups, or even

informal assistance or support from relatives and close friends due to the fear of stigma, rejection and punishment. They might experience and suffer more sorrow and discover that it is difficult and harder to cope with their loss when they receive no support (Creuze et al., 2022). Public awareness campaigns and educational programs have the chance and potential to change and influence the cultural attitudes and values about mental health and suicide by reducing stigma, and creating a more welcoming and kinder environment for families who have lost a loved one to suicide.

Stigma is the disapproval of any negative act, which is socially unacceptable and based on conservational, judgmental and illogical beliefs that provoke distress (Ali & Rehna, 2022). If death is sudden and due to suicide, it is shocking and stigmatizing for the family. Pitman et., (2016) in a study have focused on perceived stigma (perception and awareness of others' stigmatizing attitude) and noticed that a higher stigma score would be partially associated with suicide bereavement and negative outcomes like suicide attempts, depression and anxiety.

One of the main differences between normal bereavement and suicide bereavement is the stigma received or experienced from the society that leads to isolation and mutism. Bereavement through suicide affects individuals deeply and creates a complex psychological and societal impact where family has to deal series of questions from the society; and eventually deal with emotional issues associated with that stigma (Cvinar, 2005).

Stigma narrows the person's self and social identity at interpersonal and intrapersonal levels. The aftermath of stigma is dehumanization, marginalization, and separation from society which has an added negative impact on suicide bereavement (Chen & Courtwright, 2016). Negative narrations lead to a negative emotional outburst, increasing the level of bereavement, as it directly attacks an individual's personal connection with the rest of the

society permanently. On account of which bereaved may choose to live in loneliness (Chen & Courtwright, 2016).

If the siblings of the deceased face stigmatization, parents feel for them, as they do not want their child to be hurt, because the chances of suicide attempts are higher in a sibling due to humiliation and stigma. Therefore, either way, parents feel far more psychological distress and are stigmatized in society (McClelland et al., 2020).

In Pakistan, most of the cases of self-harm and suicide go unreported due to the stigma and Islamic laws against suicide. People who go through the bereavement period find themselves in an isolated sphere. More so, clinicians and health care professionals usually fail to provide needed treatment to people reporting acts of self-harm. Pakistan to some extent being a collectivistic in cultural attributes, the people of this country feel shame and guilt while reporting such cases in the name of 'izzat' (dignity/honor, and respect) and declaring self-harm as an accident. They are reluctant to visit mental health professionals for fear of being labeled as ‘crazy /mad'. (Kiran et al., 2021). Bereaved Muslims (cause of death other than suicide) remain emotionally challenged but most of them reported that death is an eternal fact and therefore accepted it. Religious beliefs played a vital role in coping, and acceptance of death. However, on the other hand, bereaved individuals (who lost someone through suicide) remain reluctant to accept the loss due to religious laws and stigma related to suicide. Therefore, they prevent all gatherings, and alter crucial information related to suicide-related incident so that it is acceptable in society (Suhail et al., 2011).

Most reported cases focused on women, while not a single study has found on men, as men always suppress their emotions and do not report feelings of sadness and depression due to the stigma, and their masculine traits (Ahmed et al., 2019).

Innumerable studies were designed to study suicide bereavement and stigma and their relationship (Feigelman et al., 2009). The more the perceived stigma, the more the psychological distress, suicidality, self-harm and depression. Despite the recognized negative impact of suicide stigma on the bereaved, studies on suicide bereavement and environmental rewards are scarce (Evans & Abrahamson, 2020). It is a significant fact that stigma leads to many other psychological and social outcomes related to suicide bereavement (Hanschmidt et al., 2016) and if we could check its association with environmental reward, it could benefit future research to plan behavioral activation techniques to counter social outcomes.

Suicide Bereavement and Shame

Feelings of worthlessness, a sense of desire to hide, lack of trust, and powerlessness are all associated with a feeling of shame and guilt. Moreover, feelings of regret, tension and remorse are also associated. In shame and guilt, major difference arises that guilt resulting in regret, remorse, and tension. When feeling shame, the ego is focused on self-evaluation, but in guilt it is more focused on others, that how an act impacts others. Projection of anger or its avoidance is motivated by shame whereas guilt motivates constructive engagement and reparative actions (Broucek, 1991; Tangney & Salovey, 1999). In the case of shame and guilt, heterogeneity is evident, but many researchers believe that negative evaluation of behavior results in guilt whereas once the global self is negatively evaluated it results in shame (Brown, 2006; Tangney, Stuewig, & Mashek, 2007). our sense of attachment and belonging is also affected by shame, but not by guilt, which is a source of pain (Broucek, 1991; Brown, 2006). Shame is connected to a broad range of interpersonal problems, showing its negative interpersonal problem-solving capacity, PTSD, suicide, depression and anxiety. (Behrendt & Ben-Ari, 2012).

According to Watt and Sharp (2002), culture imprints a deeper impact on the survivor's hood of suicide bereavement if it is supportive, the chances of resilience are higher; and if the term suicide bereavement is stigmatized in culture, then the chances of recovery from grief are lower or unreported. Cultural norms significantly influence the parent-child relationship, leading to increased suicide rates among young adults and adolescents. As with age, the bonding of parents with their children becomes weaker, and at times there is no significant relationship. Therefore, the guilt, shame, social isolation, social stigma, and bullying experienced by children in the wake of the suicide leads to the intensification of suicide bereavement due to societal norms (Watt & Sharp, 2002).

The suicide bereavement embraces powerful negatively charged emotions like disrespect, disappointment, despair, confusion, and anger. These social factors cause the survivor to have negative judgments about themselves, and hence lower self-esteem causing guilt and shame feelings which leads to suicidal ideation (Wilburn & Smith, 2005). Young, (2022) proposed that most of the time people feel guilt by losing loved ones and blame themselves for nothing.

People who had a high degree of bonding with the deceased are likely to be victims of shame as they have to confront the traumatic circumstances of the event, and to live in a society where suicide is considered as sin, and where criticism is severe. Shame is the feeling of humiliation and men feel more humiliation as compared to women, while women express the humiliation much more as compared to men. Parents and siblings both have the same feelings of shame overall (Grad et al., 1997).

Those who are bereaved by suicide usually blame themselves for not being aware of the suffering; they think they might have overlooked something, and have feelings to continue to live after death. They blame themselves and believe that if they had been more attentive,

chances are that suicide could have been avoided (Shear & Zisook, 2014). There is a higher level of guilt after a suicide as compared to other kinds of death survivors in the 18 months after the loss, and with time this difference decreases, as mentioned in the findings of a Systematic review in 2008. (Sveen & Walby, 2008).

Study by (Pitam et al., 2017) showed that shame in the suicide bereaved people is often deeply ingrained and rooted due to perceived moral and social implications of suicide which is resistant to change even in the presence of environmental rewards (Pitam et al., 2017). Research also indicates that cultural and social factors also contribute to shame in suicide bereaved people. If this happens, shame will among suicide bereaved people could not be reduced even in the presence of environmental rewards (Pomplili et al., 2013).

Research on shame indicates there are many structural barriers like lack of social support and community support for suicide bereaved people results in shame and even though due to the presence of environmental reward it cannot be reduced (Jordan, 2008). Research suggests that discrimination from the society leads to the shame among suicide bereaved people and this fear of judgement and rejection from the society results in shame among them which is less likely to reduce with environmental rewards (Sheehan & Corrigan, 2018).

Prior finding indicate that suicide bereaved people may have indulged in many maladaptive behaviors most commonly drug addiction and from this the societal factor may contribute to the shame among suicide bereaved people which is less possibly to reduce with the presence of environmental rewards (Pompilli et al., 2013). Research also indicates that long term shame among suicide bereaved people will less likely to be cure with the interventions like environmental rewards (Hastings etal., 2002). Research also indicates that personal growth and meaning making in life are the most important factors that should be in suicide bereaved

people but due to the stigmas and shame among them will never lead to be in the process of meaning making and personal growth which can also never be done in the presence of environmental rewards (Geerish et al., 2009).

Earlier study demonstrates that those people who lose their loved one to suicide suffer from complicated grief and shame and this complicated grief and shame is less likely to be reduced with environmental rewards (Young et al., 2015). Research also suggests that sometimes the suicide bereavement often triggers existential and spiritual concerns among suicide bereaved people which may require a proper spirituality-based therapy instead of environmental rewards (Becker et al., 2007). Research also indicates that the quality of relationship with the deceased often contributes to the intensity of shame. The ambivalent and conflict relationship with the deceased may lead to the more shame factor among suicide bereaved people which can less likely to be reduced with environmental rewards (Stroebe et al., 2005.

Study finding showed that those suicide bereaved people who have negative core beliefs of one self and others may also contribute to the factor of shame in them which cannot be reduced even in the presence of environmental rewards (Pitman et al., 2018). Research also suggests that those suicide bereaved people with a history of traumatic experiences have the factors of shame and this less likely to be reduced with environmental rewards (Barle et al., 2017). Research indicates that self-compassion is an important factor that can be taught to suicide bereaved people and that may be help to reduced shame in them but this self-compassion does not effectively address the environmental rewards (Pitman et al., 2016).

Shame needs to be studied from the perspective of a bereaved individual, who suffered the loss of a loved one. Documenting the specific feelings of shame experienced by parents and siblings could be significant for handling these social outcomes for treating psychological outcomes (Oulanova et al., 2014). Whereas, Pakistani literature has not yet been published on

shame and suicide bereavement, as it a very sensitive issue and cannot be discussed with affected parents and siblings, as they might not be ready to share thoughts or information in order to avoid societal shame or guilt or they might be burst out owing to emotional reminiscence.

Behavioral Activation and Suicide Bereavement

Lewinsohn and colleagues coined and developed the concept of Behavioral Activation also known as behavioral psychotherapy (Dimidjian et al., 2010; Kanter et al., 2010). From very start, the focus of Behavioral activation was behavioral principles, which focused on training. Behavioral Activation stated that depression in suicide bereavement occurs due to deprivation of positive reinforcement, and focused more on identifying and scheduling activities that provide pleasure, and increase contact with positive reinforcement.

Behavioral activation is a therapy which is formally structured and focuses on the increase in pleasurable activities and reduction of maladaptive ones, along with depression reducing activities. It is based on behavioral model of Lewinsohn (1973) which postulated that those who are depressed get less reinforcement in a positive direction than others as they don't engage in pleasant activities or enjoy activities more (Ekers et al., 2014, Lewinsohn, 1973).

It was assumed that when patients engage themselves in activities which are more pleasurable it will improve their mood. In Behavioral Activation, patients learn this art of connection with what they do and how they feel about it, and monitor activities and mood, by using activities which acts as positive reinforcement and resolve problems, which prevent them from doing (Dimidjian et al., 2011). The evidence indicates that Behavioral Activation is effective for depression in adults as compared to the depression in older and young adults (Mazzucchelli et al., 2007).

Recent studies have depicted that mood is associated with enhanced activity level (Santos et al., 2017) and it was noticed that those who were depressed, there was change in brain functioning and part of brain which is linked to approach related behavior and reward processes function higher as compared to non-depressed adults (Pizzagalli et al., 2005). The research on Behavioral Activation is important to understand its theory and different process which are involved in it (Dimidjian et al., 2011). It is depicted in findings of the scientific research looking into brain-reward systems. Armento and Hopko (2007) and Carvalho, Gawrysiak et al. (2011); have used the term "reward" rather than "reinforcement" (Manos et al., 2010). These two terms are very dissimilar. Indeed, reward refers to the trait that some environmental cues have of activating approach reactions (white, 1989).

Environmental rewards can be understood as the perception of the positive or negative impact of environmental experiences and activities. Reinforcement, on the other hand is the tendency of particular stimuli to increase learnt stimulus-response patterns.

Behavioral Activation is contemporary and effective in treating anxiety, post-traumatic stress disorder and depression. It involves environmental reinforcement (either positive or negative) and exposing bereaved individuals to previously avoided stimuli and activities until discomfort disappears, and people begin to live their lives with reduced withdrawal effects. It helps individuals to gather the memories of the loved one who is no longer with them. Individuals who have lost a loved one, and who do not actively seek out exposure activities eventually start sharing their feelings and show active engagement in activities which acts as reinforcement for them (Acierno et al., 2011).

The experiments which are based on altering reinforcement activities are easy to examine because they are quantifiable. However, the experiments in which behavior changes are to be examined are somewhat difficult to measure because the examiner is not able to

control some aspects (e.g., relationship and occupational status). In this situation, some other factors when measured can be cognitive and emotional. Nonetheless, when measuring environmental rewards, we can accept two parameters: the concentration or active engagement of an individual in response to that activity, and the amount of interest the individual is to show in the activity (Correia et al., 2002).

Past finding showed that most of the bereaved individuals stop all social activities because they cannot find meaning in them, and being unable to find future direction. When they take less part in social activities, they receive low reinforcement and lacks motivation to do any work. As a result, they show avoidant behavior, and isolate themselves from the environment as it is easy to do. The people who experience symptoms of severe depression and complicated grief usually have extreme point of views of any subject (for instance there is no meaning to do this job, I will keep myself distant from any work indicating these individuals usually use negative coping strategies. However, when trained practitioners apply therapies on bereaved individual, they help them to see the underlying benefits of behavior activation (being socially active), which in turns reduce the negative mental outcomes (Acierno et al., 2011).

Behavioral activation is different than techniques of emotional processing used for prolonged grief (Papa et al., 2013). It suggests that when a person withdraws from their environment, it results in avoidance, environmental disengagement and becoming ruminated over those needs which are unmet (Stroebe et al., 2007). There are studies which suggest that avoidance, rumination and disengagement are some trans-diagnostic factors which help to precipitate and help to maintain symptoms of major depression and post-traumatic stress disorder (Dimidjian et al., 2011).

Evidence for the effectiveness of behavioral activation in the presence of suicide bereavement as an antecedent is still unexplored. We know that behavioral activation works,

but to explain how it works in the need of depression and associated psychological and social outcomes of suicidal bereavement such as anxiety, post-traumatic stress disorder, stigma, shame, and post-traumatic growth, is still unexplored.

Under the sociocultural context, suicide bereavement occurs, and is affected by societal attitude, post-traumatic stress disorder helps to differentiate between person who has attempted suicide than those who have suicidal ideation (e.g., May & Klonsky, 2016). Findings of systematic review (Kristensen et al, 2012) showed that both violent and sudden loss are different and distinct from each other and is linked with slow recovery with an increased risk and prevalence of mental health issues such as depression and post-traumatic stress disorder, as compared to bereavement from natural deaths. Parents or siblings affected by post-trauma of the suicide bereavement could have a chance to attempt suicide by themselves.

According to Bolton et al., (2013), those individuals who are affected with suicide loss and are in bereavement phase they physical, mental condition is affected. They health affected, they report more issue with pain, their chances of getting any physical or mental illness is more which include heart disease, stroke, having high blood pressure, and chances of diabetes mellitus, chronic obstructive pulmonary diseases. This bad impact on health could also reduce the chances that they could take any kind of psychosocial support and any facility in health services. At the time of bereavement any kind of support whether its formal which they take from psychiatrist or any mental health professional or any kind of support which in informal like discussing with friend, with family member or colleague or any other person who is important in their life is important at that time. But they are not able to get any informal support from these relations on timely manner because of feeling of judgment and stigma, taboo and they suffer in silence which also increase the chances of going through mental health disorders, such as guilt, shame, anxiety, depression, post-traumatic stress disorder. To break vicious cycle

of suicide bereavement and psychological outcomes the environmental rewards are used. Environmental rewards are how you view the environmental experiences and all those activities which are available in environmental like considering these as positive or negative. All these environmental experiences could be in different life circumstances or relationship which include conversation with a friend and getting any kind of promotion, including any hobby in life or reading favorite book.

These environmental rewards are helpful to understand the role of common mental disorders and social outcomes, such as depression, anxiety, post-traumatic stress disorder as well as stigma, shame and post-traumatic growth. External rewards are linked with behavioral activation model, which is linked with interventions used in the treatment of common mental disorders. Behavioral activation therapy designed with the aim of increasing activation and engagement in meaningful and rewarding activities, monitoring the daily mood fluctuations, identifying the here and now goals and needs, as well as, problem solving mechanisms (Ekers et al, 2014). These experiences and activities can occur in several areas of life such as relationships (e.g., having a pleasant conversation with a friend) and work (e.g., getting promotion).

One way to improve mental health is through physical activity; and a number of studies have found that it can benefit and reduce factors such as depression (Elliot et al., 2014) and anxiety (MsMahon et al., 2017). Physical activity has been shown to reduce aggression (Shacher et al., 2016, improve life satisfaction, and reduce post-traumatic stress disorder (Sato et al., 2016). Adventurous physical activity (e.g., rock climbing) improves positive and negative affect, and self-efficacy, ultimately providing confidence whilst targeting self-blaming. (Clough et al.,2016). The Theoretical Model (Martell et al 2001) also depicts that a life event that caused bereavement could endorse mental issues. However, the extent to which

physical activity may be beneficial to such outcomes, in those who have been bereaved, is unexplored (Rosenbaum et al. 2015).

Minimal environmental and social reinforcement results in the extinction of "healthy" behaviors and consequently the dysphoria and passivity, that often characterize depression, develops. Most of the studies examining environmental-reward found a positive moderating effect (Janssen et al., 2020). These environmental rewards can mitigate the effects of depression, anxiety and post-traumatic stress disorder (Dimidjian et al., 2014, Sturmey et al., 2009).

Behavioral activation is highly effective with an individual who suffers from a wide range of depressive symptoms and severe post-traumatic stress disorder symptoms. If these environmental rewards could be helpful in outcome of suicide bereavement such as depression, anxiety, post traumatic disorder, stigma, shame and post-traumatic growth developed is still unexplored. To the scholar best knowledge, no earlier research is found on suicide bereavement and environmental rewards (Pepper et al., 2013). Past research were focused on examining perceived changes in coping motives and depression symptoms as accounting for the relation between perceived change in environmental reward and psychological distress with alcohol consumption during the COVID-19 pandemic (McPhee et al., 2020). Another study explored the effect of environmental rewards on the relation between goal-directed behavior and the symptoms of depressed mood or anhedonia (Aoki et al., 2021).

Past research suggest that the individual's variations and their sensitivity to the environmental rewards due to the neurobiological factors can impact depression. There are differences in the brain regions of processing the information and it varies from individual to individual and it is involved in motivation, decision making and reward. Past findings also suggest that the individuals vary from each other in seeking pleasure from the environmental rewards. Some

individuals can seek pleasure from the environmental rewards others many find it stressful and least pleasurable which results in isolation, negative thinking and somehow the symptoms of depression (Kakarala et al., 2020).

One of the study's finding indicates that exposure to the chronic stress or the stressful life events can change or alter the mechanisms of brain which is involved in reward processing. These changes and alternations may reduce and diminish the ability of an individual to experience motivation and pleasure from environmental rewards. The changes related to the stress in reward can results to reward devaluation where previously the rewarding activities or experiences lost the individual ability to evoke the positive feelings. This process can result in anhedonia, the core and major symptom of depression that is characterized by lack of interest and pleasure in activities (Kakarala et al., 2020).

The significance of exploring environmental reward in the context of suicide bereavement is to build evidence for the behavioral activation model being applicable for post-traumatic stress disorder, stigma, shame, and post-traumatic growth other than depression and anxiety (Stein et al., 2021). As many bereavement outcomes such as depression, anxiety, anger, lower self-esteem, substance use, self-harm and suicide ideation are also mental health concerns, without the experience of a suicidal bereavement, it is plausible to suggest that options to improve mental health may well improve these issues when manifested with bereavement outcomes.

The present study is a valuable input in exploring the support and activities needed by bereaved individuals for reconstructing their lives after the loss and the impact of environmental rewards on the psychological and social outcomes is being examined. Acierno et al. (2012) have noticed that when behavioral activation, which is an intervention based on 5 sessions, is combined with exposure, it reduces the grief, post-traumatic stress disorder, and

depression after pre to post assessment and treatment. In one of the few studies examining Brief behavioral activation treatment for Depression-Revised(BATD-R) Eisma et al. (2015) described that behavioral activation treatment for Depression-Revised was given as compared to 6-8-week internet-based exposure intervention and have increased level of grief rumination and post traumatic growth. After three months' follow-up, it was noticed that symptoms were reduced for depression and grief in comparison to those who have received exposure intervention symptoms (Eisma et al., 2015).

Hence, the present study may provide the appropriate domain for environmental rewards that could be helpful in practical fields of life in our culture environmental reinforcement and could be incorporated in any religious practice, recalling individuals with good memories and elevating them, doing everyday chores, finding meaning in life, actively participating in social gatherings, and not using negative coping strategies for lessening psychological pain.

Relationship of Circumstantial and Demographic Variables with Bereavement

Objective circumstantial factors are critical to understand with reference to loss (Gerrish et al, 2009). For example, Holland, Currier, and Neimeyer (2006) have reported that length of bereavement is not significantly linked with either growth, or sense making and abnormal grief. Grief reactions are more intense in bereavement caused by sudden death (Suhail et al, 2011) and the recovery process is comparatively slow in bereavement caused by violent death. As compared to siblings, bereaved parents are more vulnerable to complicated grief particularly in case of violent death (Keesee et al., 2008). Providing the bereaved with more information and visiting the site of death facilitates cognitive processing of the traumatic experience (Kristensen, Weisaeth & Heir, 2012).

As, bereavement in the context of severe mental illness has mental and social impact on the survivors, bereavement within the context of ordinary or normal mental conditions have mental and social effects on those who lose their near ones to suicide. According to the study by Milner at al. (2013), because of the sudden death of the loved to suicide, the survivours, find it very hard and difficult to regulate their emotions and to express their initial grief response and reaction. Research also indicated that when a suicide occurred suddenly, individuals frequently appeared stunted or shocked because they did not know the causes of suicide attempt. In this it is hard for them to express their initial grief response (Gurhan et al., 2019).

Bereavement in everyday mental circumstance has a social effect on the survivors. Research indicates that the reaction of the community can fluctuate substantially, and the assistance and counselling centers are not always ready to give treatment in sudden cases of suicides. Therefore, in such situations experts and professionals ought to be approached (Salmi et al., 2019). Finding suggest, bereaved face additional trauma in coping and have to deal with the way in which the suicide happened. Crisis intervention, trauma-focused therapy, and developing and creating a strong support system, and assistance for bereaved people are all effective coping strategies. Sher (2019) shows that building or growing resilience would possibly involve figuring out what precipitated the death, which include running collectively to suicide, planning or arranging memorial offerings that honor the life and legacy of the departed.

According to (Owen, 2021) unexpected, and now and again complex grief that suicide sufferers experience underneath ordinary situations differ with the anticipatory grieving experience in settings of severe mental illness. The suicide on the other hand if occurs all of the sudden can cause mental illness (Owen, 2021).

Families of people with severe mental illness can also suffer from extended grief, while families of individuals who commit suicide unexpectedly may experience severe, acute

episodes of grief and trauma. Study shows that families managing extreme mental illness, might also find extraordinarily hard to get social aid due to the stigmas of mental illness and suicide, that can result in severe judgment and isolation (Calati et al., 2019).

On the other hand, suicide that happens in ordinary circumstances or conditions might cause greater surprise and confusion within the network. However, it is frequently accompanied by way of stigma and misunderstanding about the reasons of suicide (Motillon et al., 2022) and there is need for interventions. While families handling sudden suicides may additionally benefit more from trauma-precise interventions, families dealing with severe mental illness may benefit extra from mental health-targeted guide (Calear et al., 2016).

Earlier studies have shown that those who are bereaved have greater level of rejection, responsibility, shame and stigma, but at the same time results are inconsistent like social support, poor mental health and guilt (Jordan, 2001). People who have experienced death by suicide, they may face severe grief reactions and some challenges like symptoms of intrusive thoughts, and memories, guilt, stigma, blame, shame and trauma. (Bellini et al., 2018; Pitman et al., 2014; Young et al., 2012). Internalized stigma or perceived one may reduce the chances to seek help and it may in turn can increase the chances of suicide (Carpiniello & Pinna, 2017).

Suicide bereaved families report worst quality of life and experiences of effect on mental health functioning (Song et al., 2012, Valdimarsdottir et al, 2003). Numerous psychosocial challenges impede adjustment in the wake of a significant interpersonal loss. These challenges may include interpersonal pressure from others to “move on” before the bereaved individual is ready (Holtslander et al., 2010). Functional challenges may include the assumption of new responsibilities that had been performed by the deceased (Anderson et al., 1995). Psychological challenges such as the loss of identity conferred by the relationship with the deceased can prove another barrier to the bereavement adjustment. Cognitive challenges

such as negative beliefs about the self, others, and one's own grief are associated with worse mental health in bereaved individuals (Boelen et al., 2003,2006).

Past study demonstrate that powerful coping techniques are important in both situations in the severe mental illness and in normal mental conditions. Common strategies consist of participation in peer support organizations, and advocacy or memorial sports. Due to the intricacy of the grief, multiple techniques that cope with the sensible as well as emotional components of loss are important.

In bereavement studies, some limitations were noted like biased sampling such as convenience one which include seminar, members from bereavement group and students and sample size was small. In other studies, there were sample who have experienced suicide and compared to other type of death were differed on factors like length of time, time since death and method of suicide.

According to Chesney et al. (2014) long-term mental illness cases can increase a form of resilience that supports healing after loss. Research on bereavement reports in non-Western contexts, which includes Pakistan and different Lower and middle income countries, global places, is conspicuously missing. In these cultures, it is very important to conduct research about the effect of religious, social and cultural components on suicide bereaved people. This involves comparing the effects of network projects, assist agencies, and therapy. By utilizing both qualitative and quantitative research methods, we may get a deeper understanding of grieving. Quantitative statistics can identify factors of occurrence and hazard, while qualitative investigations can provide deep insights into human research and coping processes. To enhance culturally sensitive therapy, quantitative research about the trauma's value is mixed with qualitative records about cultural behavior and ideals. The two research approaches, can assist

in the production of assist structures which might be extra environmentally sustainable and culturally appropriate.

Suicide-associated bereavement is usually painful. However, the situations surrounding the suicide can greatly influence how the bereavement is experienced. One important distinction is made between suicides that occurs in the context of severe mental illness (SMI) and those that happen in normal situation, meaning where there is no indication of the severe mental illness. Bereavement within the context of severe mental illness has psychological and social impact on the survivors.

Research shows that Anticipatory grieving is a major factor for the families of people who have serious intellectual problems. (Foster, 2013). Anticipated grief can bring about complicated bereavement, which can result in the prolonged mourning process. According to the research by Schmutte at al. (2021), the mixture of the guilt and relief that incorporates bereavement along with severe mental illness is a unique feature. Another study indicated that suicide is frequently unavoidable and evident for those with severe mental illness (Fazel et al., 2019).

Moreover, considering mental illness and suicide are undesirable and traumatized in Pakistani culture and society, it can be extremely difficult for both men and women to obtain the care they require. Based on a research study conducted by Munawar et al. (2022), cultural and social beliefs and assumptions and a lack of mental health literacy are some of the reasons for refusal of assistance from professionals. Even though women are more inclined than males to seek out social services from their networks, cultural norms that require for them to continue in their roles as caretakers and emotional support systems may still face obstacles. But moreover, women are considered as weak and vulnerable as compared to men. On the hand, men may find it easier to internalize their emotions and are less prone to ask for assistance and treatment (Ceral & Sandford, 2018).

Research on gender differences of parents who are in suicide bereavement or are grieving, has also been extremely focused. Research suggests that the way of grieving can also vary in parents between a mother and a father (Pitman et al., 2014). Suicide bereaved mothers can freely express their emotions and can cry, whereas fathers may seek social support and may not be able to express their emotions more freely and therefore they feel separated, isolated and disoriented. These emotional variations across genders in ways of coping and grieving styles underline the need and worth of assistance services given by professionals which can respond to the unique requirements of suicide bereaved parents.

Finding suggest, parents use quite a few coping techniques, which include going to remedy, practicing faith or spirituality, and taking solace in recollections of the departed. Some mothers and fathers undergo demanding growth, locating new purpose in change in lifestyles and growing in empathy and resilience despite the severe grief (Stone et al., 2017).

A grief or melancholy are felt in suicide bereaved individuals experienced differently by men and women in Pakistan because of gender stereotypes. Noureen and Haque (2024) claim that whereas men may repress and hide their feelings and emotions in order to adhere and stick to traditional and conventional ideas of patience. Women are more likely to seek out assistance from others, and express or communicate their feelings openly and freely.

The study seek the specific challenges experienced by the parents and siblings that hinder their process of improvement and contributed in developing psychological and social outcomes. The attempt of looking into the challenges was made to make sense of their pain and outcomes faced by the bereavement.

Suicide Bereavement and Gender

Some studies have found no meaningful gender and age-related differences on post traumatic growth (e.g., Taku, Kilmer, Cann, Tedeschi & Calhoun, 2012). However, other

studies have observed that females report greater post traumatic growth (Swickert & Hittner, 2009; Weiss, 2002). A study conducted by Vishnesvsky, Calhoun, cann and Tedeschi, and Demakis (2010) has also observed reports of greater post traumatic growth in females. In a sample of Pakistani population, Suhail et al, (2011) found that females reported greater psychological distress and were more shocked by the death of their life partner as compared to males. Studies in Western culture also show that death of a male spouse is more distressing for their counterparts (Kaunonen, Paivi, Paunonen, & Erjanti, 2000). Death of spouse is considered to be more distressing because of the limited future options (Parkes, 1997).

Each person has a different way of experiencing and showing emotions after when his/her loved one commits suicide. Societal influences, cultural or individual factors they all have the impact on the emotion expressions of an individual in time of grief (Loyo, 2013). Gender difference has a major impact on the emotional expression or the experience of grief. It is very important to consider these gender differences in Pakistan where the role of the gender is strictly embedded. In Pakistan, it is noticed that there are different coping mechanisms adopted by men and women after a trauma when they are in the time of grief (Khan et al., 2013).

In Pakistani society, traditional gender roles are of great importance where women and men are expected to share or communicate their emotions and to deal with the situations accordingly. In Pakistani society, women may feel comfortable and safer in expressing the emotions in public, and they are also expected to provide care for others during the time of grief whereas males are considered socially strong, unresponsive, impassive or emotionless. These social norms, standards or cultural expectations have a very big and major impact on the emotional expressions based on the gender variations during the time of grief (Shekhani et al., 2018).

In most of the cultures, including Pakistan, a woman is responsible to maintain emotional stability and integrity of family. Due to the role that they are responsible and have to keep the families together and be the caregiver, women are more prone and susceptible to the trauma that can have impact on them like death of loved one to suicide or any domestic abuse. Finding suggest, women are more likely to express and communicate their emotions, share things freely and get assistance from the family or friends (Fischer & LaFrance, 2015).

Some women, however, remain unable to attain assistance due to stigma associated with mental health in the society. In contrast, men may experience social pressure to remain resilient, strong and composed in the face of difficulty and adversity.

Men may feel compelled and under pressure to conceal their feelings and maintain an authoritative figure as the head of the family such as in Pakistan: where mental and emotional stability, and firmness are commonly associated with masculinity. Studies show that because they do not want to appear fragile, weak or helpless, men in Pakistan may be hesitant and reluctant to seek professional, psychological and emotional help when they are in grief or traumatized. Internalizing one's emotions and feelings, however, increases the chances of risk of mental health issues such as substance misuse or depression (Mahsud & Ali, 2018).

The grief felt or experienced by parents and families, when a child attempts suicide is distinct for different genders. An exploratory study on depression or grieving process of parents who lost a child to suicide discovered that grief after suicide is complicated, and shifts in trying to make sense of the suicide, and of giving it a purpose and significance. It is found that mothers often undergo a prolonged grief period than fathers (Noureen & Haque, 2024). So, it is very important to understand how the expression of grief affects is different for each gender.

It is difficult to handle suicide loss and bereavement due to the interaction and relationship between gender stereotypes and cultural norms and standards. For instance, a qualitative exploratory study on bereavement practices in Pakistan observed that men are

expected to stay on with their interpersonal and professional roles and job despite their grief, while women usually take on the primary role of managing household responsibilities and grieving publicly (Suhail et al., 2011). It displays various methods of coping men and woman use in dealing with the loss and portrays the different expectations society has from men and women.

Gender differences in terms of coping strategies are also an apparent psychological factor. Females can and do express their emotions in high intensity, while males feel the emotions in high intensity. Therefore, suicide bereavement has varied impact on male and female in terms of gender differences (Valentino et al., 2018). In most of the research, women prevailed over men, and men mostly withdrew from the research. In Asian culture, specifically in local context, men usually do not discuss the death of their loved ones with others. Based on psychological and sociological factors, men can be considered hidden survivors with under-reported problems. Men do not show their feelings because of society's expectations to show their masculine nature and resolve. They experience an increase in negative emotions, but are socialized to suppress their emotions, and do not prefer counseling, as compared to women (Cheung, 2020).

The literature also documents observations that circumstantial factors and characteristics of bereaved individuals also influence the possibility and intensity of any given outcome of bereavement experience. Nature of death, time since death, gender and age of bereaved/deceased, relationship status of bereaved with deceased, ethnicity and family system, education level and occupation are some of the important factors that are considered in the context of possible bereavement outcomes.

Individuals including parents, spouses, and siblings, who may experience bereavement will have unique and different way of expressing it. However, parents and siblings deal with

bereavement by denying it, and do not express their emotions. It was discovered that suicide bereaved individual faces higher levels of social rejection, humiliation, and blame in society, and later develop symptoms of depression, anxiety related disorders and post-traumatic stress. The impressions of these traumatic events could be useful to explore in perspective of cultural differences, but studies regarding suicide bereavement are less researched in south Asian culture because most of people are unaware that they are going through a bereavement period. However, Adolescent suicide may have a profound impact on the bereaved relatives. (David et al., 1996).

Suicide Bereavement and its Relationship with the Deceased

Suicide bereavement affects the mental health and social functioning of the individuals; however, relationship with the deceased and timeframe since the suicide matters a great deal in the bereavement period. It alleviates suicide risk among parents, causes occupational dysfunction, and an increased risk for mental disorders. Genetics related studies shows that depression can be transferred to the next generation and to siblings, and mostly found to have increased rejection, shame and social isolation with suicidal ideation. To break this vicious cycle of suicidal attempts, shame and regret, this study was planned in a way to explore the concept of bereavement from the perspective of close relationships, such as parents and siblings, by examining their view point, and the emotions associated with bereavement.

Duration of Bereavement

Studies have shown that the duration of bereavement is one of the important predicators indicating that with increase of time, manner of grief changed, and it depends largely on nature of the loss. As more time passes such as 3-5 years, the grief of suicide bereaved decreases. A study with suicide relatives were conducted and same finding were found (Saarinen et al., 2000). After 3 years of loss, it was noticed that psychological distress was highest in acute

phase. As more time passed, it was noticed that it had mitigating effect on those psychological symptoms, which were pathological in nature; but there were some individual differences in the effect of bereavement. Examining factors complicating these reactions appears crucial.

A study explored the child age at time of bereavement, parental bereavement was associated with a significantly increased suicide risk when bereavement occurred from birth and throughout adulthood, but not when bereavement occurred in late adulthood (age 45 to 64). The odds ratio was highest when parents experienced bereavement during childhood and adolescence (before age 18) (Burrell, Mehlum and Qin, 2017).

In another study results showed that in the first years after loss, repeated suicide attempts and prior negative relationships with the decedent were associated with greater grief difficulties. However, as more time passed, all circumstances related to death were overshadowed by the importance of the time span since loss. This data also suggested that between 3 and 5 years usually marks the turning point, when acute grief difficulties accompanying a suicide loss begin to subside (Feigelman, Jordan, 2009). Findings suggest that the time point of time rated as the worst stage after a death is the first week for about one-quarter of suicide bereaved individuals, but many family members struggle with the loss for the first year (Spillane, Sikar, 2018).

Time period in bereavement matters a great deal along with intensity of grief found in early stage of bereavement period. In addition to other factors (for instance personality of individual and relationship with the deceased, depression and post traumatic symptoms can be seen within three months after the event occurred, as this phase is critical and intensity of pain is severe. In this current study, inclusion criteria were participants who lost their loved one within the last 5 years, so that intensity of bereavement can be studied, and clear results can be drawn.

The profound, difficult, and intense grief has a sizable and lasting effect on an individual's mental and social status. Numerous elements or variables, inclusive of the relationship to the departed, the instances or activities surrounding the loss, and personal and private coping ways can affect the duration, depth, and influences of grief and grieving. Suicide grieving happens in several phases and stages.

First, it occurs throughout the first six-month period of its appearance. In the moments following a loss, people frequently experience shock and denial condition. This initial and the first phase or stage of suicide bereavement is characterized and marked by numbness, weakness, disbelief, and feelings of helplessness. Studies indicate that since bereaved individual are unable and reluctant to grasp the real nature of the loss, individuals may feel disoriented, perplexed and confused at this period. Once the first shock subsides a profound sorrow or sadness appear. Among the symptoms involve deep sorrow, grief, crying spills, insomnia, and an ongoing sensation of desire for the person who died. The intrusive thoughts and visualization of the deceased that bereaved may experience can be particularly painful and distressing (Azorina et al., 2019).

Following the preliminary segment, suicide bereavement's first segment takes place in six months. In this stage, bereaved start to face the truth of their loss by confronting it. An improved emotional response, which includes episodes of sadness, tension, and rage, characterizes this period. It was found, if the emotional response isn't sufficiently addressed at some point within this time, complicated grief may expand. During this time, social disengagement is traditional because people feel misinterpreted by means of others. Suicide stigma can make people experience isolated, which makes them reluctant to invite for social assistance (Ross et al., 2018).

During the middle time period following first 3 months of suicide bereavement it may last from 1-3 years. This period of grieving, one usually goes through a difficult sage to face

the loss. Even so, bereaved may nonetheless undergo periods of extreme grief as they begin to adjust to this new reality. They may attempt to make feel of the loss at some point of time, frequently alternating between phases of distress. As indicated in longitudinal studies, some bereaved show signs of complicated grief or post-traumatic stress disorder(Chen & Laitila, 2023).

After this middle time period , the longtime phase of suicide bereavement which appear is of 3 to 5 years. Many individuals eventually begin to reintegrate back into society, coming across approaches to honour their loved ones' memory even as concurrently accomplishing meaningful activities. The signs and indicators of acute grief reduce with passage of time, although a few triggers may additionally still cause tough emotional reactions. Prolonged bereavement can bring about pent up stressful growth, a manner people change for the better because of their struggles with loss. Better relationships, a heightened appreciation for existence, and a revitalized sense of cause are a few examples of these modifications (Entili et al., 2021).

Suicide Bereavement in Parents

Parents with deceased teenage children frequently suffer emotional distress because of the feelings of guilt and shame that accompany suicide. Each day, they struggle to cope with the passing away of their kid, alternating between managing the severe grief and seeking to put together why the suicide occurred (Milner et al., 2013). It could be particularly challenging for parents to cope with bereavement in the wider context of society.

Adverse health outcomes are associated with suicide bereavement, albeit dependent on the closeness of the relationship to the deceased (Mitchell et al., 2009). Parents who lost a child have higher rates of committing suicide especially the mothers who have lost their young child, as they show the symptoms of disinhibited grief. Females are most likely to express their

emotions and receive sympathy from family and friends. Fathers are most likely to repress their emotions and continue to work; they do not show any increased risk of depression due to their masculine nature and they repress their emotions due to stigma received from the society.

High level of hospital admissions (for mental illness) found in bereaved parents; however, parents who lost their child in car accident were found to be more depressed (Pitman et. al., 2014). Bereaved parents were found to have increased rates of distress, anxiety and high level of depression, on the other hand bereaved parents who lost their children in accidents (deaths other than suicide) were found to have same symptoms. Researches often consider these group similar. However, due to their dissimilar nature, different groups produce inconsistent findings. The studies reported that suicide bereaved have found to be same level of depression and outcomes like parents bereaved by other causes of death (Bolton et al., 2013). Feigelman et al. (2008) examined 540 parents and their children died either by suicide or in other traumatic death circumstances, or died by a natural death. The results revealed that parents who were bereaved by suicide had greater difficulties in coping with their grief reactions and suffered more frequently from mental disorders such as prolonged grief, and Post traumatic stress disorder than the other bereaved parent groups.

Relationship bond with deceased is not a well-researched area. The present study attempts to know the relationship bond for seeking better understanding of the challenges faced by the people. The cohorts' studies of suicide bereaved individuals were frequently mixed with various bereaved subgroups, including parents, spouses and siblings, each of whom may have experienced bereavement differently and have unique way of expressing it. However, suicide bereaved were found to have increased level of rejection from society, shame and blaming than other groups (who bereaved from other forms of death) (Sveen & Walby, 2008).

Among bereaved parents mostly were found to be single parents' mothers and they were willing to participate in the research. on the other hand, fathers' withdrawal rate from research were higher. Suicide bereaved parents were found to have low income as compared to parents bereaved from other forms of deaths. In a developing and lower-middle income country like Pakistan, where financial issues are abundant, can be one of the reasons why people commit suicide and why the people left behind, closed ones, suffer even more financial issues, due to taboos and stigmas attached to suicide. Alcohol abuse was most identified in parents who lost their child to suicide. Symptoms of depression, anxiety, and mental illness diagnosis were even found after two years of suicide of the child (Bolton et al., 2013).

A study by Burrell, Mehlum, and Qin (2017) highlighted the role of social support. It was found that those children who have no or very minimal social support and also of single parent, and there is continuous change in their parent marital status, they are more vulnerable to have suicide ideation or attempt suicide as compared to the one who have high social support and not changing residence time to time. If social support would be improved between parent and child and if with providing intervention program it could have good impact during bereavement support group or intervention related to it. (Tein et al., 2006).

In qualitative study by Hartling et al., (2004), there were 22 Australian parents who reported the death of their son or daughter due to suicide and data were collected in time period of 2003 to late 2004. The them which was drawn from data were, it is hard for parents to talk about their child death and circumstances which lead towards death and how it leads them towards bereavement. Parents were avoiding contact with others and tell others not to talk about it and also themselves were reluctant to talk about it. The stories of parents revealed that how difficult it was for parents in terms of social, cultural, spiritual context and how difficult it was for them to accept it in surrounding stigma and taboo and were suffering with grief. This

silencing the parents can impact them into building shame resulting in isolation, thus increasing the chances of depression (Hartling et al., 2004). This could be one of the challenge faced by parents.

Other than that, incorrectly labeling individuals with a mental disorder could marginalize the individuals further going through the negative connotations associated with a mental illness such as stigma or shame (Shear et al., 2011) and if that labeling is accompanied by the history of suicide bereavement, it can cause hazardous effects on the people. This caused a dire need to understand the difficulties, social and psychological challenges of bereaved parents.

Suicide Bereavement among Siblings

Bereaved families psychological and social lives are extensively impacted due of bereavement, particularly when it takes place after a suicide. Findings depicts that parents and siblings of the deceased one are very negatively impacted. According to Adams et al. (2019), a depressing event like a sibling suicide may result in long-term fitness issues, extreme emotional and intellectual suffering, and social isolation. Study finding revealed that, within the moments after a child commits suicide, parents frequently experience a great deal of shock and disbelief. Usually, this first reaction is marked by means of severe disappointment, rage, guilt, and confusion (Buus et al., 2014).

Suicide bereavement related to siblings is another important factor that needs to be considered. Siblings assist one another throughout difficult times in Pakistani households and families. A study by Rostala et al., (2013), siblings of those who commit suicide, can experience the feelings of sorrow, anger and confusion. When a sibling passes away, sisters are more likely to convey their concerns truthfully and ask for help than brothers. Brothers, on the

other hand, generally conceal their emotions and decide to take on responsibility and provide security in the family.

Following sibling suicide arise the tremendous and considerable emotional trauma, difficulties, and problem with identity. (Rostala et al.,2013). Another study indicated that siblings have very important role throughout the grieving and depression period (Adam eta., 2019). Suicide in teenagers has permanent and overtime psychological problems and consequences, especially among the sibling and the parents. The long-term mental health problems include chronic, prolonged and extended grieving disorder, depressive disorders, post-traumatic stress disorder (PTSD) and anxiety happen often in parents. Long-term behavioral, psychological and emotional issues, such as continuous and persistent despair, nervousness, and trouble creating and maintaining relationships, can also have an influence on siblings. These long-term impacts and consequences underscore how essential it is to deliver and provide complete, regular and on-going mental health treatment that is specially adjusted and adapted to the requirements of bereaved families (Bartik et al., 2013).

Findings indicates that, siblings regularly feel an extraordinary experience of loss and identity disruption. Feelings of abandonment, survivor's guilt, and existential doubt can arise after a sibling passes away (Royden, 2021). Findings indicate that siblings might also experience long term affect after bereavement like post-traumatic stress disorder, anxiety, and depression, similar to parents. The friendship between siblings is unique, and possibly can have an effect on the bereaved experience of safety (Petterson et al., 2015).

According to Sands (2016), the loss of a sibling can notably change the dynamics of the circle of relatives, frequently including to the emotional and care giving obligations of the bereaved siblings. It was found that siblings may additionally locate it tough to connect with their peers and sense that their friends are not able to apprehend them. This seclusion can make loneliness and grief worse (Tucker & Weisen, 2015). Study indicated that, siblings can benefit

from peer support groups and therapy since they offer a platform for them to discuss their assessments or evaluations and receive affirmation (O'Reilly et al., 2020). Other researches indicate that some siblings have a stressful increase in life enjoyment and interpersonal ties while handling their loss (Sands, 2016).

Studies with a quantitative approach, have found out the frequency and hazard elements of complex grief in siblings and in parents. These research draw attentions to risk elements like prior intellectual fitness issues, a loss of social support, and the sort of dying (Winter et al., 2013). Qualitative studies offer a window into the actual-lifestyles reports of siblings and parents who have experienced loss. These researches inspect subjects like meaning-making, coping mechanisms, and the impact of societal attitudes concerning suicide through interviews and thematic analysis. The importance of cultural and contextual elements in influencing bereavement experiences is frequently emphasized in qualitative research. These researches show the approaches in which social norms, non-secular beliefs, and cultural ideals affect the grieving procedure (Grimmond et al., 2019).

Children and young people have a different understanding of death of their adults, and they may not fully understand the situation or their feelings related to it (Palmer et al, 2016). Siblings who bereaved by suicide were found to have higher rates of suicidal ideation and rejection from the society and they were unable to get attention and help from the society. Study finding indicates that siblings bereaved by suicide have same level of depression as compated to siblings who were bereaved by other forms of deaths. According to (Bolton et al., 2013), siblings who lost their twin to suicide have higher suicide attempt risk than siblings who lost their twin due to other causes of death (Bolton et al., 2013).

Loss of a loved one increases risk of suicide for the family members including parents, siblings, and colleagues. Suicide bereavement also contributes to a higher risk of fatal and non-

fatal suicide attempt (Hamdan et al., 2020; Hill et al., 2020; Pitman et al., 2014; Pitman et al., 2016). Subsequently, study finding showed, a correlation was found among individuals who has lost their siblings with increased suicide risk even after 18 years. It is due to the traumatic events (suicide of sibling) in their life or due to genetic cause. Bereaved siblings went through a lot of mental detrimental effects, personal readjustment, and attachment issues (Rostila et al., 2013).

It is identified that dealing with loss due to suicide of a loved one is more complicated and painful as compared to natural deaths, or accidental deaths. Individual who are closed to the deceased went through a period of complicated bereavement (Jordan, 2001). Among siblings' detachment from their brothers and sisters can increase the suicide risk. Experiencing a traumatic bereavement such as death by suicide as a child or a young person can increase suicidal ideation and attempts when compared to those who experienced bereavement due to a natural death (Hua et al., 2019).

Studies showed that bereaved individual have to face negative comments from the society due to their deceased siblings and as a result it causes anger issues (Barrett, & Scott 1990). Not only that, they could face a rejection from their peer group or the surroundings. Seeing parents disturbed and depressed due to siblings' attempt or death by suicide can also make them feel to attempt the suicide, therefore leading to more damages to the family as a whole. A qualitative study exploring the experiences of siblings for helping the left behind loved ones and overcoming suicidal attempts by others in response to their depression.

Gender of siblings can also be a factor for the difference of the intensity to experience suicide bereavement. Female siblings experiencing bereavement by their sibling's suicide can experience more depression as compared to the male siblings. When compared to men, women were found to have a slightly higher risk of suicide, following the suicidal death of a sibling.

This is because women give social interactions higher priority than men, especially when it comes to the parents and the family. Therefore, the loss of a sibling may have more profound emotional effects on women, which may contribute to a higher risk of suicide. This causes severe depression and anxiety related disorders among them. It shows that grieving following sibling loss has a greater impact on women's health than it does on men's health. During their lives, they are exposed to a lot of different types of environmental stressors including, breakups, violence, sexual abuse, and substance abuse (Rostila et al., 2013). The intensity of relationship with the deceased would give an outcome for the severity of bereavement, which leads to different social and psychological outcomes.

A study suggested a greater chance of suicidal thoughts or ideation in adolescent siblings whose any other sibling either brother or sister have committed suicide. (Wagner & Cohen 1992). In order to see that how other sibling suicide impact them there are 3 models which explain it that how it work i.e., sibling concordance. Firstly, it could be inherited or there could be role of genetic. If there is family history, if earlier someone in family have committed suicide, it increases the chances of suicide in other siblings (Shaffer, 1974; Shaffi, et al., 1985). Another model suggests if there is any sibling in a family who have attempted suicide before, the other sibling try to imitate that and it could cause possible trigger and other child could also get effected. Third reason could be the in the family. If there is lack of parental affection and showing controlling behavior towards children and more authoritarian (Asarnow, 1992) and harsh, rejecting parenting practices (Deykin, et al., 1985) are associated with higher rates of suicidal behavior in youth.

A study reported that adolescent siblings of teenaged suicide victims were at a sevenfold increased risk for developing a major depression within 6 months subsequent to their siblings' death, compared to a group of control subjects unexposed to suicide (Brent, et al.,

1993). Analysis of data from Danish registries shows that exposure to the suicide death of an adult child significantly increases a parent's risk of suicide and a direct comparison of suicide-bereaved mothers with mothers bereaved by non-suicide causes shows that risk of suicide is significantly higher for mothers bereaved by suicide (Pitman et al., 2014).

Theoretical Perspective

Grief is the component of bereavement which is linked to social and psychological outcomes. A bereaved individual who grief and suffers, passes from a period of readjustment, sorrows, disengagement from the society and attachment issues. Bowlbay (1969) elaborated the attachment theory; Infants possess an "attachment system" by innate system to adjust the relationship between infants and their caregivers. It depicts cause-and-effect relationship between attachment patterns and responses to bereavement. If a person is attached to deceased, grief must be complicated and prolonged. On the other hand, if the relationship is not strong grief is acute and prolonged.

Later on Parkes (1972) proposed four stages of grief which come under psychosocial model of bereavement. These four stages are shock and numbness, yearning and searching, disorientation and disorganization, lastly reorganization and resolution. These stages deal with the defense mechanisms that each person's subconscious mind develops to assist them with a loss within the context of their particular experience and perspective. The loss starts to feel real when they accept it.

Physical and functional impairments could worsen time to time, and bereaved might have trouble taking care of them or dealing with everyday challenges. According to Parkes, even though no one ever fully recovers from the loss of a death, one does manage to get through the process. The need for contemporary ideas is observed since orthodox beliefs are being

questioned and revised (Parkes,1972; Bowlby,1969). Two of the many modern theories that have been developed in response to the nature of bereavement and relationships with the deceased are the dual process model and behavioral activation.

Dual process model is a comprehensive and integrated approach, which explains that each individual bereaved in a different and unique way, and normalizing grieving is the part of the process. Stoebe and Schut proposed the idea of dual process model in 1995 and later on changes were made accordingly. This model states that rejection and avoiding grief is a part of bereavement process. It rejects the orthodox theories of attachment and stages of grief and gives an integrated approach to better understand grief process and how to cope with different stressors (Schut, 1999).

This theory differentiates stressors and categorizes it, indicating these stressors depend on individual itself and culture. The two types of stressors are, loss orientation and restoration orientation. Loss-orientation is the focus on handling one or more aspects of the actual loss experienced with regards to the deceased. This includes longing for the deceased, reminding events that are linked to that individual, variety of emotional reactions from enjoyable to painful, from happiness that the departed is no longer suffering to despair that one is left alone, looking at old images, and wondering how he or she would react. The second type is restoration orientation, which deals with the coping of secondary stressors like loneliness, and isolation. This involves seeking new experiences and learning new skills which the deceased used to perform, for instance handling financial services, employment, other duties and roles linked to that individual, Role is also changed from parent to parent of deceased and from siblings to sibling of deceased (Schut, Henk, 1999).

After these bereavement stages come oscillation which is the successful dealing with the stressors. It is the motion in backward and forward direction which includes denying,

avoiding and confronting the loss. Technique which psychologist uses normalizes the grief, acceptance of the loss and providing support with unconditional positive regard (Schut, 1999).

The other contemporary approach is behavioral activation. After the death of a loved one (through suicide) individuals who are close to it enters the phase of suicide bereavement. They isolate from the environment and stop doing their everyday activities. They do not find meaning in doing anything as they lose the sense of meaning making, future motivation and directions.

Behavior activation is a new concept here; it is defined as the engagement of bereaved people in environmental activities, which works as reinforce for them. However, it is somehow difficult to find out the positive reinforcement which increases their behavior activation. Study on behavior activation concludes that pathological grief is reduced when the individual maintains his grief symptoms, after connecting to the society by breaking passive reflection. Behavior activation focuses more on identifying meaning to the world, self-identification, goals making and ways to stay connected to the society (Stroebe et al., 2007).

Individual who has lost a loved one can reduce their daily life stressors by applying any copying mechanism which would not create any negative association with the past memories. Being in contact with the reality and present life individuals find ways to make sense of what is happening because in grief period most of the individuals' perspectives changes which causes adjustment problems (Papa et al., 2013).

Suicide bereavement fits well within the framework of Behavioral Activation and Dual Process Model because these is new emerging theories which provide new ways and coping strategies regarding the need for the bereaved individual. However, studies addressing the

process to explain the process of bereavement and its association with social and psychological outcome in our Pakistani culture have been never studied in the context of suicide bereavement.

Behavioral Activation proposes that less exposure of the individual to positive reinforcements in the environment after the stressful event leads to the mental disorders such as depression (Ferster, 1973; Jacobson, Martell, & Dimidjian, 2001; Lewinsohn, 1974; Lewinsohn & Graf, 1973). However, studies addressing the mechanism to explain the process of bereavement and its association with mental disorders has never been studied in the context of suicide bereavement. Few studies have been conducted to investigate the efficacy of behavioral strategies to treat bereavement (Acierno et al., 2012).

Jason and colleague (Holland & Diliberto, 2012) pointed out that theoretical explanation of behavioral strategies clearly points out that these strategies can be suitable for bereaved individuals, however, no advancement and follow the theoretical relevancy of behavioral strategies to bereavement, however, no studies were carried out to uncover the process of the bereavement in the context of behavioral strategies.

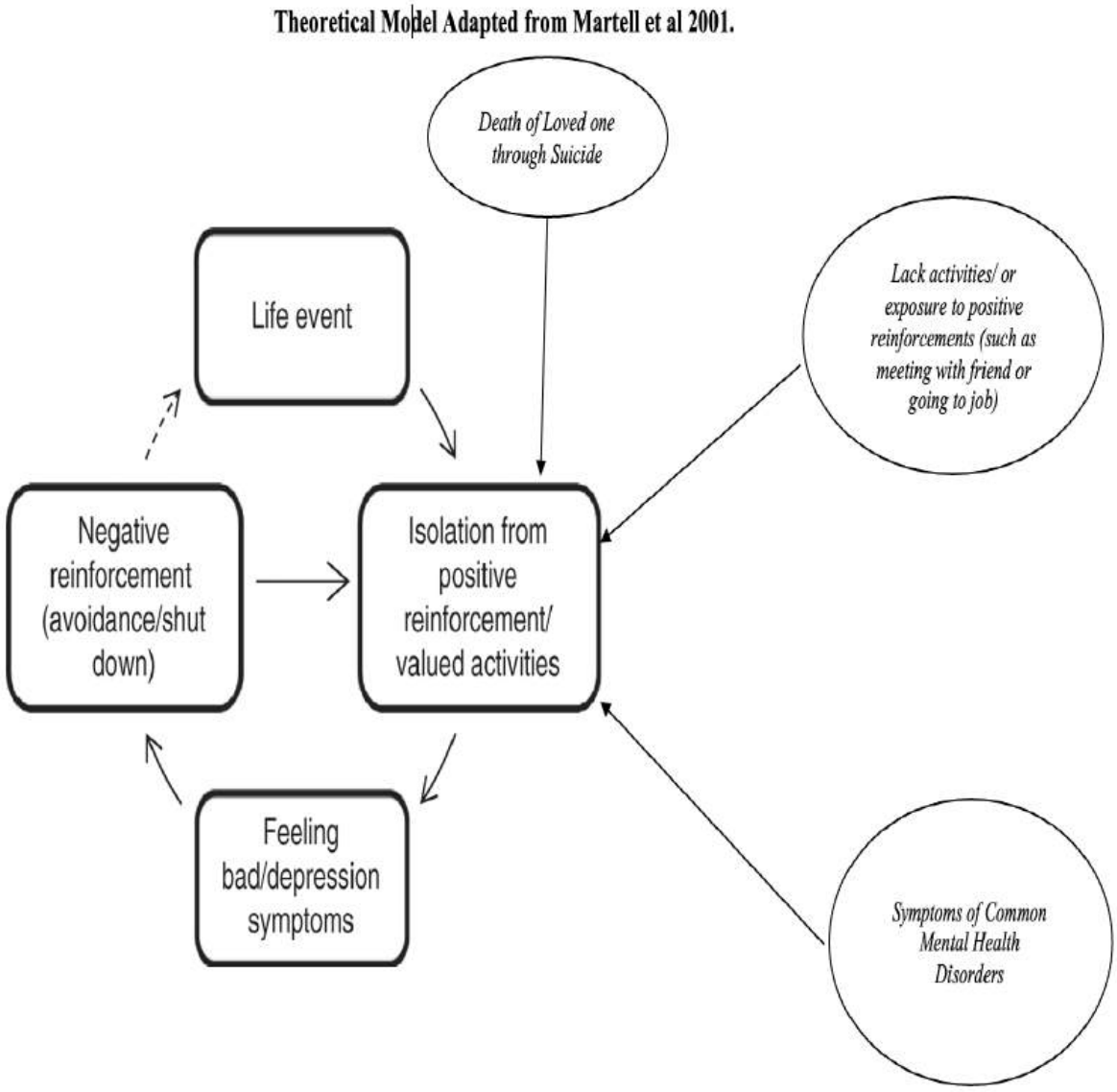
Based on the neurobiological literature examining brain reward systems, Armento and Hopko (2007) and Carvalho, Gawrysiak et al. (2011) used the term “reward” rather than “reinforcement” (Manos et al., 2010). These two terms are quite different Indeed. Some environmental stimuli elicit approach responses, and it is referred as reward whereas in White (1989) Reinforcement there are certain stimuli which strengthen stimulus response tendencies (white, 1989).

When environmental experience was conceptualized as positive or negative that is environmental rewards. In different areas of life like relationship (e.g., having a pleasant conversation with a friend) and work (e.g., receiving a promotion). If we see for construct

dimension, main objective is to measure RCPR magnitude with extended period of time, and also to include items which will measure 3 dimensions of RCPR (Lewinsohn, 1974): (a) events which are potentially reinforcing, to measure it; (b) In the environment availability of reinforcement and (c) To elicit reinforcement the instrumental behavior (or skill) of an individual. The function of the instrument was to be a brief screening tool. It is important to note that particular event rewarding value depend on personal value and it can vary across individuals. For instance, for any recreational activity, Miss B may prefer to visit a shop while Miss A may enjoy taking walks and observing nature, ((Armento & Hopko, 2007).

These environment rewards are helpful to understand the role of common mental disorders, perceived social support, suicidal ideation, and posttraumatic growth. As external rewards are linked with behavioral activation model, which is linked with interventions used in the treatment of common mental disorders.

Figure 1. Theoretical Model Adapted



Rationale

Suicide is a prominent anathema in the present world. Statistics reflect that one person dies with suicide in every forty seconds. The rate of committing suicide is high among young adults age 15-29 and is the second leading cause of death, while 79% of suicide occurs in low-income countries (WHO, 2019). Despite being taboo, suicide is still considered as a gateway to escape daily life stressors. In order to avoid combat with daily life crises an individual commit suicide. Certainly, the family of deceased is left in the shadows of depression, shame, and stigma.

The family of a deceased person who has died by suicide goes through a viscous cycle of pain and challenges. It is estimated that with one suicide in family 135 family members including friends, colleagues and larger community get affected Cerel and Brown (2018). The trauma of losing a loved one to suicide, comes with significant psychological and sociocultural challenges among survivors (Kramer et al, 2015). A number of risk factors are linked to the development, persistence, and severity of these psychological issues. Past literature witnesses that depression, anxiety and Post traumatic stress disorder are psychological issues due to suicide bereavement. These factors include exposure to trauma, and adverse life events (Carvalho et al., 2011).

Besides, confronting the psychological challenges, bereaved families are subjected to unending agonizing of stigma (cvinar,2005). Parents and siblings are more likely to confront stigma as compared to the other relatives (McClelland et al., 2020). To avoid the stigma, the bereaved family members tend to avoid social gatherings and withdraw from society. Due to limited social interaction, they become isolated from society. Due to low social support, the members are often subjected to feelings of sadness, loneliness and depressive symptoms.

In order to address the issues faced by the bereaved family member's, behavioral activation can be used to mitigate depressive symptoms. Behavioral activation is an empirically validated treatment for depression. If these environmental rewards are helpful in treating depression, and anxiety then it can be explored in the context of suicide bereavement along with other bereavement variables such as post-traumatic growth, post-traumatic stress disorder as well as social outcomes such as stigma and shame. (Pepper et al., 2013).

Previous research depicted the relationship of environmental reward with psychological distress, depression and coping mechanism but not in context of suicide bereavement. For instance, a study explored the perceived changes in coping mechanism and depression symptoms as accounting for the relation between perceived change in environmental reward and psychological distress with alcohol consumption during the COVID-19 pandemic and found that changes in coping mechanisms and depression symptoms mediated the relationship between perceived changes in environmental rewards and psychological distress, with increased alcohol consumption being a significant outcome during the COVID-19 pandemic (McPhee et al., 2020). Another study explored the effect of environmental rewards on relation between goal-directed behavior and the symptoms of depressed mood or anhedonia (Aoki et al., 2021). No prior research determined the exact relationship of environmental reward with suicide bereavement and with social and psychological outcomes. Therefore, the present study is a valuable input in exploring the support and activities needed by bereaved individuals for reconstructing their lives. This study also explores the impact of environmental rewards on the psychological and social outcomes.

Numerous factors hindered further research within area of suicide bereavement, especially indigenous research in Pakistan. For example, researchers have to overcome many challenging ethical, and moral difficulties in exploring issues in suicide bereavement. There is

struggle in seeking ethics approval from research ethics committees who usually regard suicide bereaved as vulnerable (Grad, 2005). It is an open justification why a significant number of previous studies were quantitative in nature.

Literature suggests that the past studies did not include bereaved individuals in the acute phase of their loss less than 6 months (Eisma et al., 2018) or 12 months' time point after loss (Ross et al., 2018). In present study the sample of both genders and individuals with grief period of 6 months to 5 years are included. Research on bereavement experiences in Pakistan, and in other low and middle-income Asian countries is critically lacking. The majority of studies at this point have focused on populations in the West, which do not accurately depict cultural and social dynamics found in these regions.

Previous empirical research suggests that in order to understand the inherent features of sociocultural and specific grieving processes, there is need to do more qualitative research with families bereaved by suicide. (Hjelmeland et al, 2010). Qualitative studies help to explore the experiences of families bereaved by suicide, focusing primarily to understand emotional changes experienced, cultural context and meaning making process. This included exploration of suicide bereaved families, exploring the type of relation they had with the deceased, and to understand the physical and emotional consequences of bereavement on the family and their social life.

Qualitative study aims to investigate the experiences of the parents and siblings of losing a loved one by suicide in order to get their perspectives and histories of the relevant sample. These perspectives helped us to explore the challenges they faced while confronting difficult times, thus getting deeper understanding of the psychological and social outcomes while suffering bereavement. This approach was adopted to get insight into the environmental rewards' impact if any on the parent's and sibling's bereavement and to study if they affect

psychological health or social interactions. This part of the research was to assess how environmental motivational rewards can offer important cues to prevent negative outcomes such as anxiety, post-traumatic stress disorder, depression, shame, stigma and enhance posttraumatic growth in family members.

There are myriad researches on bereavement and suicide bereavement in the West where different researchers have examined the various dimensions of suicide bereavement. Still, suicide bereavement is an under researched in non-western context, specifically, in local context of Pakistan with unique sociocultural values.

Quantitative research on suicide bereavement typically examines the methodologies and impacts of suicide, particularly on those left behind. However, studies specifically addressing the bereavement experienced by parents and offspring have been lacking so far. This research aims to address this gap, potentially providing valuable insights into this overlooked area. Based on this concept it was planned to use mixed-methods approach to benefit from advantages of both quantitative and qualitative methodological approaches, while being able to provide a more comprehensive consideration of the experiences of parents and siblings, asking about the psychological and social issues they faced, and environmental positive reinforcement while encountering bereavement.

The study aims to explore the process of the suicide bereavement within the behavioral activation framework. One of the main idea was to explore the moderating role of environmental rewards between suicide bereavement, common psychological disorders (such as depression, anxiety, PTSD) and social outcomes (shame, stigmatization, post-traumatic growth). With that in mind, the present study also explored the intensity of bereavement with respect to the relationship with the deceased (intensity of bereavement for parents and for siblings). Behavioral activation is mainly used for the purpose in increasing activation, and

indulge bereaved in rewarding activities, engaging the patient in a meaningful way. It was initially developed for depression; so, the study hypothesis has been conceptualized with the assumption that Behavioral activation may have applications beyond depression (Dimidjian et al., 2011), specifically PTSD, anxiety, and social outcomes i.e., stigma, shame and post-traumatic growth all accompanied and caused by suicide bereavement.

To the scholar's knowledge research on different types of anxiety and depressive symptoms among Pakistani suicide bereaved is notably and remarkably absent. This research gap emphasizes and highlights the necessity and the need to examine and explore particular and specific challenges bereaved individuals face and consider cultural variations and differences regarding suicide bereavement. Research is also lacking regarding the unique element of shame and stigma in Pakistani suicide bereaved families. Hence, more research is required to determine the impact of shame and stigma due to suicide bereavement on bereaved individuals. Research regarding psychological and social effects on Pakistani suicide bereaved individuals is also lacking and will be taken in account in this study,

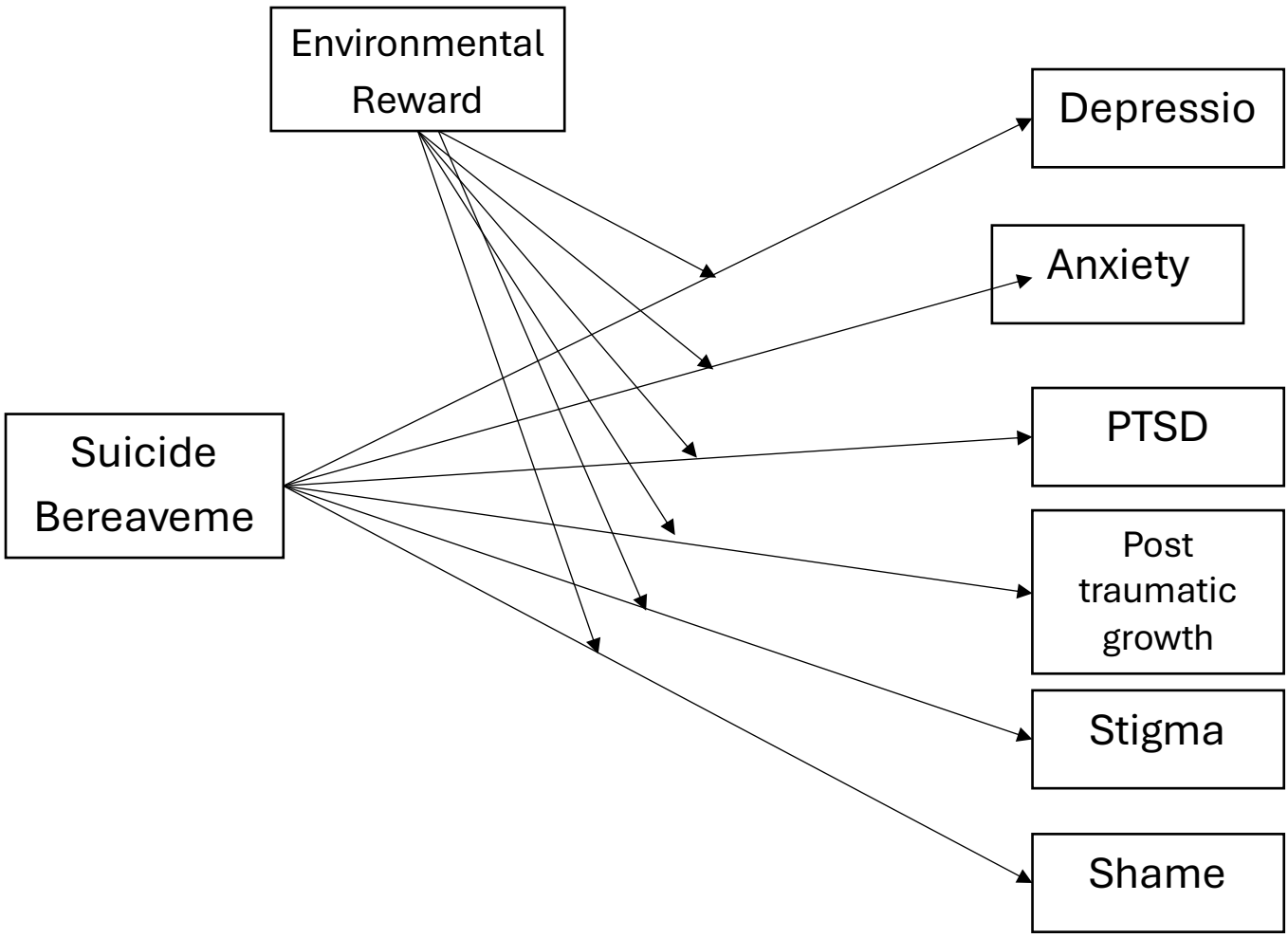
Culturally relevant mental health therapies and interventions adapted and tailored to the special needs and requirements of Pakistani bereaved people are important and necessary. The efficacy of incorporating cultural, religious, and spiritual components into the treatment process should be looked through this study. More study and research are needed to further understand differences in grieving and coping experiences between men and women suffering suicide bereavement. It also includes an examination of how frequently or prevalent gender conventions influence and impact bereaved families. Research should also focus on creating and assessing stigma reduction efforts which seek to change and alter public views concerning mental illness and suicide in order to enhance or improve the supportive environment in which grieving people live.

More research that looks at bereavement in diverse cultural contexts, such as Pakistani lifestyle, are necessary as a major portion of such research has been done in western cultural context. Knowledge of cultural traits can assist to develop plans that work better and deeper knowledge of the progression of grief and its long-term mental and social consequences are also an outcome of this study.

Proposed Conceptual Framework for the Present Study

The following diagram depicts the conceptual framework of the present study which shows that it is an interaction effect mainly focusing on interaction between Bereavement and outcome variables through Environmental reward.

Figure 2. Conceptual Framework



Chapter-II

METHOD

Objectives:

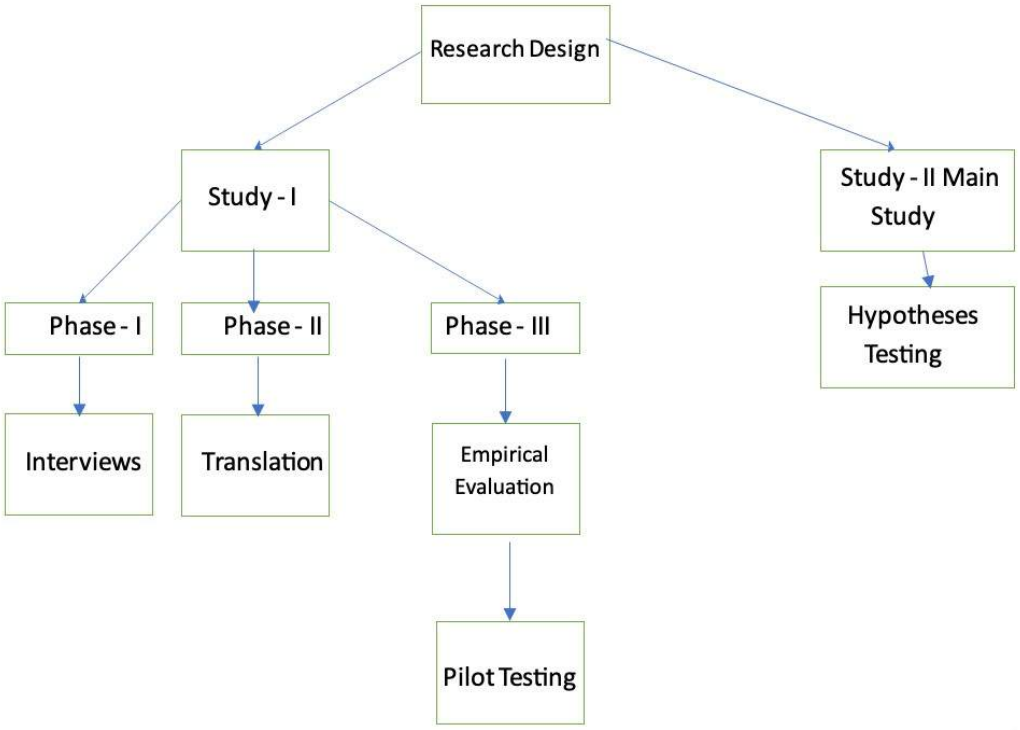
1. To explore the experiences of suicide bereaved family members.
2. What psychological and social outcomes are associated with individuals who have experienced bereavement due to suicide.
3. In bereavement period, what are the challenges faced by suicide bereaved individuals.
4. Translate and validate the instruments in Urdu language, the national language and lingua franca.
5. To examine the relationship between suicide bereavement and psychological outcomes.
6. To examine the relationship between suicide bereavement and social outcomes.
7. To study the moderating role of environmental rewards between bereavement and psychological outcomes.
8. To study the moderating role of environmental reward between suicide bereavement and social outcomes.
9. To investigate the group differences on outcome variables between parents and siblings.
10. To investigate the impact of the duration of bereavement on outcome variables on parents and siblings.

Research Design

Cross-sectional research design followed by mixed method approach were used. The following research design incorporates both qualitative and quantitative approaches. The

research was divided into two studies. Study-1 consists of 3 phases. In First phase, used the qualitative approach and adopted a semi-structured face to face interview. Phase-II involved translation and adaptation of scale and validating the instruments in the local context by using rigorous forward and back ward translation design and Phase-III was pilot testing of instrumentation in local context. Study-II (main study) was carried out to address the formulated hypotheses.

Figure-3 below shows the details of the research design.



STUDY-1

This section of the research encompasses the objectives, methods, results, and discussion of Study-1.

Objectives and Research Questions

The objective of study 1 was to explore the experiences of bereaved family members and examining demographic differences within various sociocultural context and circumstances. The findings from this exploration were used for translation and adaptation process in Phase-II. Specifically, the insights gathered from the interviews provided a comprehensive understanding of the unique needs, perspectives, and cultural nuances of the participants. This understanding was instrumental in ensuring that the instruments used were culturally relevant and sensitive. By incorporating the detailed gathered from the lived experiences shared by bereaved family members, scholar was able to tailor the language, content, and structure of the instruments to better align with the sociocultural contexts of the target population. This process involved not only linguistic translation but also the adaptation of concepts and measures to ensure they were meaningful and appropriate for the diverse demographic groups represented in the study.

Subsequently, in Phase-III was pilot testing of instruments. This phase was essential to validate the effectiveness and reliability of the instruments in capturing the intended data across different sociocultural settings. The iterative process of translation, adaptation, and pilot testing ensured that the final instruments were both scientifically robust and culturally attuned to the experiences of bereaved family members.

Interview and topic guide were based on following research questions to address:

1. What are the experiences of the individual who have lost someone close to suicide?

2. What are the particular lived experiences of Parents and Sibling Bereaved by Suicide of a child or sibling, respectively?

3. What psychological outcomes are associated with individuals who have experienced bereavement due to suicide?

4. What social outcomes are linked to people bereaved by suicide?

5. What challenges do individuals bereaved by suicide face during the bereavement period?

6. Do environmental rewards impact the psychological health or social interactions of bereaved parents and siblings?

Phase-I

Interviews

The bereaved parents and siblings were approached and interviewed one to one with a semi-structured interview followed by a topic guide of questions related to the lived experiences, challenges, psychological and social outcomes of bereavement and environmental rewards' role in their growth.

Sample

15 participants (parents and siblings) consisted of four fathers, three mothers, five brothers, and three sisters from eleven different families were selected and were included in the study. Purposive and snowball sampling was used. Data were collected from across Pakistan; primarily from various cities in Punjab. To understand the intensity of relations in multifaceted nature of experiences within families, both parents and siblings from each family were included.

Data were collected from emergency departments and record of Medical Legal Officer (MLO) document of Benazir Bhutto hospital, Rawalpindi. In order to be included in the study, potential participants were contacted and invited to be part of the study. Study was conducted from February 2023 to May 2023, and duration of interviews lasted for three months' period. All participants were able to understand Urdu.

Inclusion criterion

1. Suicide bereaved parents and siblings were included, who have experienced the loss and grief of a child or a sibling respectively

2. Parents and siblings who lost their loved one within six months to five years following the death of their child or sibling.

3. The age of deceased should not be more than 30 years.

4. There should be equal representation of data from both categories sample, parents and siblings, and gender.

5. Participants who were familiar with the Urdu language.

Exclusion criterion

1. Had a medical condition or substance misuse, dementia, abuse of alcohol or drug, schizophrenia, bipolar disorder, or any other disorder that could prevent participation.

2. Unable to engage, or respond to the interview questions.

3. Bereavement other than suicide were excluded.

Setting

Data of 15 Bereaved family members including Parents (Mother, father) and siblings (Sister and brother) were held at Psychiatry Department of Benazir Bhutto Hospital Rawalpindi, Pakistan. Face to face 13 interviews and on call 2 interviews of mother were conducted. The interview settings were mutually agreed upon by the interviewers and interviewees. Participants who requested reimbursement were compensated for their time and travel expenses.

Data Collection

Fifteen in-depth semi structured interviews were conducted in Urdu language by a scholar with prior experience in qualitative interviews. The scholar had participated in a Randomized

Controlled Trial of problem-solving intervention for adults with history of self-harm. Inform consent was taken from participants and semi structured topic guide to facilitate interviews was developed. Each interview commenced with the question, "How did your family experience suicide bereavement?" reminders or reformulations were given if discussions deviated from the research focus. Interviews were audiotaped with participant consent and later transcribed verbatim. Pseudonyms were assigned to ensure confidentiality. Topic guide was developed using following steps.

Structure of topic guide

It comprised on qualitative and quantitative components. In qualitative component, the parents' experiences, their mental health issues and social challenges they faced, and environmental rewarding activities they have employed were explored through open ended question.

Quantitative

At the start of each interview various social demographic factors such as gender, age, education level, family system, marital status, relation to the deceased, occupational level, city, mother tongue, religiosity and time period of suicide bereavement were collected. Data were also collected about the deceased and multiple factors such as age, gender, marital status at the time of suicide, method of suicide, structure of family, history of psychiatric illness and information about prior and post psychiatric consultations.

Topic Guide

Expert Panel Discussion

A group of experts consisting of three clinical psychologists and two psychiatrists who had prior experience in self-harm and suicide, were engaged in a 3-hour discussion to identify and

prioritize areas for the topic guide. The main focus was to use easy and understandable language for participants (parents and siblings).

Draft Development

First draft of the topic guide was developed by a senior psychiatrist and two clinical psychologists. After a comprehensive literature or search and insights gained from the expert panel discussion.

Evaluation

To check the language appropriateness and to make sure that all relevant areas were included, the draft was evaluated by a senior psychiatrist. Input was also collected from qualitative research experts and an English version was shared with them, to evaluate the question style to enhance in-depth data acquisition. To explore further information, and to probe further questions, and to encourage further details, open ended questions was used. All the transcripts and verbatim accounts were completed. Interviews were recorded with permission, translated into English, and then analyzed. Only on one occasion participants were interviewed and it lasted for an hour. After the interview, participants were asked if any psychological support is required, and counseling were offered and if any further services were required they were referred to mental health professionals. All the interviews were conducted till the time of saturation.

Quality control and Assurance

The Scholar is trained in qualitative data collection and its analysis. The scholar has also attended the Global mental health research capacity and capacity training on qualitative research and analysis in United Arab Emirates (UAE) which comprise of how to develop topic guide, how to conduct interviews and its role play sessions and didactic presentations involved

didactic presentations, development of topic guide, role play sessions to conduct interviews on sensitive issues such as self-harm, and hands on exercises using thematic analysis.

Data collection procedure and Ethics

The scholar provided Information leaflets to 15 participants. Consent was obtained from eligible participants for further contact, along with the provision of two contact numbers. They were informed that participation is voluntary. It was made clear to the participants and their family that participation in the study was voluntary and they can withdraw from study anytime and they need not to give us reason and there will be no detriment to them. Interview were also recorded. The average length of interview was 1 hour, but maximum time was till 1 hour 30 minutes. Frequent rest were given to them during the interview.

Recorded interviews and verbatim were transcribed. Participants were asked if they could describe about their experiences and views about life after loss. To use questions as prompt, semi-structured interview was used and also, they were allowed to adapt to participants account. The purpose of the interview, as explained to the participants, was to discuss their feelings about how their lives may have changed or remained the same after their loss.

To mitigate potential risk, they were given option of debriefing and continuous support by a therapist after the bereavement if they feel they need and it was necessary as mitigation strategy. Transcripts were anonymized and identification numbers were assigned to all the participants. A distress policy was put in place and counselling and support were offered to the participants in case they felt distressed during or after the interview. Ethical approval was received from National university of Modern language to conduct the survey.

Risk Protocol

There was a protocol in place to refer such participants for psychiatric evaluation and treatment and risk assessment policy was also put in place to assess any risk for participants. No participants were found to be at risk during the clinical interviews.

Thematic Analysis

Transcripts of semi-structured interviews were coded initially and labeled. These transcripts were reviewed multiple times to ensure the essence of participants' response. Pseudo names were assigned to all participants in order to ensure privacy and confidentiality. All the data and transcripts were anonymized and before conducting the interview consent was taken which serve as the primary data for analysis. All the topics were covered comprehensively, and data were collected until the saturation point. To identify the categories, themes and sub themes within the interview thematic analysis was conducted.

In this study qualitative approach focusing on the lived experiences were used and five step process for thematic analysis were used which were used as guiding framework. (Braun, V. and Clarke, V. (2006). To maintain validity of the analysis, measures were taken about continuous discussion regarding coding.

To maintain standard of qualitative reporting, the study followed the guidelines of consolidated criteria for Reporting Qualitative research (COREQ) checklist. This approach brings transparently and uniformity in findings and increase the credibility and trustworthiness of the study.

Results

In qualitative research, scholar have included parents and siblings whose deceased family members were aged 18 to 30 years and to find about their experiences. In this study we

have interviewed a diverse group including 4 fathers, 3 mothers, 5 brothers, and 3 sisters, totaling 15 individuals. Educational background varied from those who don't have any formal education and those who have achieved higher education like graduation or even a doctorate degree.

The method for suicide used were lethal and were equally diverse, like rat poison, wheat pills, drug overdose, or hanging. It was particularly important to note that most of the deceased were young men who had died either through wheat pills or use of rat poisoning. Participants were coping with loss for about two years, which shows the nature of the grief and its impact on their lives.

Demographic characteristics

	Family participants	**Gender**	**Age**	**Marital status**	**Mother Language**	**Education**	**Occupation**	**Relation with the deceased**	**Family System**	**consultation with Mental Health Professional**	**consultation with Faither Healer**	**Deceased Age**	**Deceased Gender**	**Marital illness**	**Method of suicide**	**Duration of Bereavement (Years)**	**Prior Mental illness**
P1	1	Male	52	Married	Punjabi	Middle	Mechanic	Father	Nuclear	NO	NO	18	Female	Single	Rat pills	1 Year	No
P2	1	Male	22	Single	Punjabi	11 grade	Student	Brother	Nuclear	NO	NO	18	Female	Single	Rat pills	1 year	No
P3	2	Male	32	Married	Urdu	BDS	Dentist	Brother	Nuclear	No	No	28	Male	Separated	Wheat pills	1 year	NO
P4	3	Male	32	Married	Siraki	Nil	Shop work	Brother	Nuclear	NO	NO	30	Male	Married	Rat pills	1 year	No
P5	4	Male	30	Married	Punjabi	Matric	Metal working	Brother	Joint	YES and before yes too	YES	27	Male	Divorced	Drug overdose	3 year	Yes
P6	5	Male	52	Married	Punjabi	Nil	Construction company	Father	Joint	No	No	26	Male	Single	Wheat pills	6 months	No
P7	6	Female	23	Single	Punjabi	Graduation	Nothing	Sister	Joint	No	No	30	Male	Married	Wheat pills	6 months	No
P8	4	Male	53	Married	Punjabi	Matric	Metal working	Father	Joint	Yes before	No	30	Male	Married	Rat pills	1 year	No

										son he no for both						
P9	6	Female	35	divorces	Punjabi	Matric	jobless	Sister	Joint	No	No	30	Male	Married	Wheat pills	6 months	No
P10	7	Female	53	widowed	Punjabi	Nil	Maid	Mother	Nuclear	No	No	27	Male	Divorced	Hanging	1 year	Yes
P11	8	Male	20	Single	Punjabi	8th	shop keeper	Brother	Nuclear	No	No	22	Male	Seperated	Wheat pills	3 years	No
P12	7	Female	22	Single	Punjabi	5th	Maid	Sister	Nuclear	No	No	27	Malel	Divorced	Hanging	2 years	Yes
P13	9	Female	55	Married	Punjabi	MA	Retired teacher	Mother	Nuclear	Ho	No	17	Female	Single	Wehat pills	3 years	No
P14	10	Female	50	Married	Kashmiri	Nil	jobless	Mother	Nuclear	No	No	25	Male	Single	Wheat pills	1 Year	No
P15	11	Male	63	Married	Punjabi	Nil	Dahari	Father	Nuclear	No	No	23	Male	Divorced	Rat pills	2 years	np

Demographic characteristics provides an overview of the characteristics of both the participants and deceased family members and provide insights into the demographics and circumstances surrounding these tragic losses.

Overview of Themes Across Parents and Siblings

Theme: Emotional Distress and Social Disconnection

Subtheme: Emotional Turmoil. Participants experienced emotional distress after the loss of loved one. It includes the symptoms of sadness, hopelessness and grief.

"After suicide of my son, it was difficult to control my cry, and there was continuous sadness and my whole world fill apart'.

Subtheme: Emotional and Functional Impairment. Emotional and functional impairment were also reported by suicide bereaved families and which affect the family daily activities and to maintain normal functioning. Functioning impairment have affected the attention, productivity and attention

"I used to focus on thoughts of my sister suicide, and were not able to focus on anything, and it was difficult to get out of bed even'.

Subtheme: Persistent Trauma and Intrusive Thoughts. Participants experienced traumatic thoughts about suicide of their loved one and these thoughts occurred unexpectedly, and caused emotional pain and distress.

"Even after so many months of my daughter's suicide, I have nightmares to how to find her. It's like I am reliving the trauma.

Subtheme: Feelings of Helplessness and Social Isolation. Feeling of helplessness and isolation, were expressed by bereaved individuals which came from shame and stigma. Withdrawing from social interaction and to be disconnected from others.

"After my sister suicide, People start avoiding me and I didn't know from where to get support, it was like nobody was understanding what I am going through.'

Subtheme: Preceding Warning Signs and Communication. Participants focused on communication pattern and warning signs which lead to suicide. Few have reported that there was change in behavior or mood and other expressed distress.

'After looking back, I have realization that there were few signs which my brother was struggling, but I couldn't make how to talk to him about it. Then I wished that I should have approached him earlier before it was too late.

Theme: Navigating Posttraumatic Growth and Personal Transformation

Subtheme: Finding Meaning and Purpose. About post traumatic growth participants have discussed that how it bought new meaning and purpose in their life after suicide of loved one. What a personal transformation and clarity about priorities and life goals were achieved.

"I find peace in my faith after my daughter's suicide. After her loss I found new meaning in life and was closer to Allah. I noticed that I had greater purpose and my life is more in alignment with my faith and values.

"I it is unbelievable for me that I will find strength in such a tragic event, but I become closer to Allah. I become more connected to Allah and got more resilience'.

"I have noticed that I have more inner strength which was never existed in me. This adversity brought a resilience in me which I was not aware that was there earlier in me.'

Theme: Coping Strategies and Resilience

Subtheme: Spiritual and Religious Coping. I turned to spiritual and religious belief become stronger which bought more comfort and strength in coping with the loss. I engaged more in religious practices, seek more comfort in prayers, and got meaning in faith-based teachings which helped me in coping

"To recite Quran and praying it bring more peace in me after my son death. I understood that it was God's will, and my faith become stronger during this tough time.

"After my daughter death, I start attending more religious event and guidance and it became my main source of support. I find that God is with us even in our tough time.'

Subtheme: Social Support and Friendship. To cope with grief social support and friendship played significant role. To participate in support groups, to connect with my friends and family, and to share experience with others who have gone through similar losses was a major support for me.

'After my brother suicide, my friends have been my lifeline. They don't judge me and offer unconditional support which was invaluable in my healing journey.'

Subtheme: Avoidance and Reluctance to Confront Grief. Although social support was important, but some participants also acknowledge that they have avoided or delayed confronting their grief. To confront grief and showing reluctance in it was due to feeling of shame, guilt, and fear.

'It's so painful to talk to my family about my son's suicide. I am fearful that I will breakdown in front of them and will burden them with sadness.'

Subtheme: Hope for Healing and Recovery. Although there were a lot of challenges because of suicide of family member, but participants have expressed hopeful approach towards recovery and healing. To believe about possibility of finding purpose in loss, having personal growth, to move forward with their lives were important coping strategies.

"I will have healing and peace. My daughter's suicide changed my perspective of life, but I think I can grow from this experience and find a way to honor.

Theme: Environmental Rewards for Coping

Subtheme: Environmental Reinforcement. Participants expressed that to deal with grief they have used Environmental reward and engaged themselves in Behavioral activation. It includes like spending time with nature, follow some hobbies, to meet friends and family, and engage in activities which bring pleasure, joy and comfort and give relieve for pain and grief.

"After my son's suicide, I started spending time in gardening. When I was outdoor and nurtured myself, it helped to be connected to positive even in the middle of grief.

"After my sister's suicide I started taking more interest in cooking. I found peace in in making meals for my family to distract myself.

Subtheme: Maintaining Routine and Structure. Significant of maintain routine and to have some structure in life as a way to cope with stress and grief were discussed by participants. They have highlighted that they find comfort and to get stability in familiar activity like following daily rituals, adhere to schedule, and to engage in familiar routine provide them sense to be normal in grief.

"After my daughter's suicide, to maintain daily routine and to be grounded I have learned about it. Although everything was chaotic, but to have structure in my life give me sense of control and stability.

"I have made sure that after my brother's suicide I should maintain my usual routine, which helped me to be grounded and helped me to be distracted from my stressful time and emotions and to know that what should I expect each day.'

Theme: Overcoming stigma, and barriers to seek professional help

Subtheme: Social Stigma and Judgment. Participants have highlighted how stigma and judgment of people have bring feeling of shame and isolation. They have described that how negative attitude and misconception from other have affected their ability to get support and to deal with grief.

"When my sister commit suicide, those people who didn't understand my pain they have judged me. They have made bad comments and avoided us, and we become more isolated'.

"Due to suicide bereavement, we have faced stigma and it was difficult to talk about our loss. Society has judged us, and we couldn't reach out for help.

"After my son's suicide I have not consulted any therapist as I was fearful that they would judge me. I had no plan to be seen as crazy or weak to get help.

Subtheme: Concern for the Well-being of Survivors. Participants emphasized that there should be support for the wellbeing of other survivors including family and friends. It is important to support others and provide them assistant.

"It made me fearful that my parents are coping with loss of my brother. We tried to support each other but it's hard to know they are also hurt and going through grief process.'

Subtheme: Social Isolation and Loss of Support. Participants mentioned they have faced social isolation and loss of support after suicide of loved one. Friends and family have disconnected from themes and they felt isolated.

"After my son's suicide, our relatives have stopped coming and friends did same. They have shown like we didn't exist and it increase my grief."

Subtheme: Shifting Responsibilities and Support Dynamics. Participants discussed that how after suicide roles were shifted and responsibilities within families. It was hard to take new roles to deal with own grief and also to support family.

"After my daughter suicide, I start taking more responsibilities for my children and for my wife. While dealing with own grief, I was also Juggling everything.'

Theme: Understanding Mental Health Struggles in the Context of Socioeconomic Challenges

Subtheme: Treatment and Self-Medication. Participants expressed concern regarding socioeconomic challenges they have faced regarding mental health treatment and self-medication. That there were difficulties to get professional due to stigma and financial difficulties.

"After my son's suicide, I was not in position to have financial support to get therapy, so I started self-medication. I knew it was not healthy but I was not having any other option.

Subtheme: Socioeconomic Stressors and Familial Strain. There were huge impact of family strain and socioeconomic stressors on my mental health. There were financial difficulties, Job loss, that caused psychological distress and contribute to vulnerability.

"After the death and suicide of my daughter, there were a lot of financial difficulties and which put strain in our family relationship. It felt at that time that everything was falling apart.'

Theme: Promoting social support for mental health awareness

Subtheme: Advocacy and Awareness Initiatives. Participants have highlighted the significance of awareness initiatives and advocacy for mental health awareness and suicide prevention. They have advocated the importance for need of education about mental health issues, and importance of policy change to get access to mental health services.

"About suicide prevention in our communities, we require more awareness campaign. To make aware people that its ok if they seek help when its required.'

Subtheme: Cultivating Empathy and Compassion. Participants expressed concern about empathy and compassion for people who have lose someone due to suicide. That society should be more understanding and supportive for those who struggle with mental health issues and to create environment which bring empathy for others.

"It's important for people show empathy and compassion towards others. We should not be judgmental and offer support to those who struggle with suicide bereavement.'

Theme: Understanding the Complexities of Suicide Bereavement

Subtheme: Psychological and Behavioral Characteristics of the Deceased. Participants have talked about characteristics which have complicated and contributed to

suicide. They discussed that there were variety of traits, like suicide ideation, mood swings, emotional distress which has impacted on their interaction and also on relationship.

"There were mood swings and aggression and my son was fighting with it before her suicide. It was sad to see him struggling and I wish I had known how to help my child.'

Subtheme: Strained Interpersonal Relationships. Before suicide strained interpersonal relationships were reported by the deceased. They have talked about conflicts, communication breakdown which have contributed to the feeling of guilt, regret.

"I had strained relation with my sister and we didn't talk for months and now I feel why I haven't reached her sooner.'

Phase-II Translation and adaptation of the Instruments

Prior to the phase-II, the data collected by interviews from participants reflected significant outcomes. The semi-structured interview gives an insight to the factors in suicide bereavement. The saturated themes and subthemes highlighted the identification of various psychological and socio-economic factors. These includes anxiety, depression, PTSD and post traumatic growth as psychological factors, meanwhile stigma and shame as social factors. Apart from these variables, the researcher identified the role of environmental reward among the participants of bereaved families. Considering the outcome, there comes a need of empirical evaluation of these variables, in order, to understand the pattern of relationship among variables.

Phase-II quantitative approach used various tools in appropriate settings to translate and validate the instruments within local context. The selected tools were in English language; however, the participants were Urdu understanding. Further, the demographic characteristics revealed the saturation of participants from low socio-economic class within the sample. There were participants who had not received formal education. Subsequently, the understanding of culturally sensitive term will be compromised. In order to eliminate the language barrier and culturally sensitive issues, translation and adaptation was required.

Objectives

The objective of the phase II in study-1 was to translate and validate the selected instruments in Urdu, the national language of Pakistan for use in the local context. These validated instruments would then be utilized in the main study (Study-II), to examine the pattern of relationships between the study variables.

Adaptation of scales

The interviews and experiences both revealed many factors that made the study enabled to adapt scales according to cultural aspects in Urdu language. The adapted scales were environmental reward observation scale (EROS), societal Stigmatization scale, State shame scale.

The most popular design, Beck translation (Hambelton, 2005), was used in the present study. Translation from source language (English) into target language (Urdu) was carried out independently by 6 academic experts including 2 Assistant professor of psychology from UMT university, one consultant psychiatrist of Psychiatry department Benazir Bhutto Hospital, 2 clinical psychologists with degree of MS clinical psychology and practicing psychologist in Benazir Bhutto hospital and one in NGO. These Urdu translations were synthesized into single draft by another 4 experts including 3 Assistant Professors and 1 psychologist after thorough consideration of each item of scale and their instructions in the context of word selection, sentence structure and understandability of language.

The draft of the scales finalized by the panel was given to another six bilingual experts for translating it back into the English language. These six backs translators were one Psychology professor and Dean, 1 CSS officer, 1 English newspaper editor and one psychiatrist. And one Assistant Professor of psychology from different institutes including Baluchistan University, UMT University school of professional psychology, and Dayspring newspaper editor. then 3 expert professionals in psychology examined and compared the back translated version with the original English version scaled in terms of their equivalence.

In summary, the translation process was completed through back translation design in which six translators adapt a test from the source language to the target language. Crafting six

drafts, a team of four experts aided the formulation of one draft. The experts focused on word selection, comprehensibility and sentence formation of the translated version. The first translated version of scale is referred as version 1.

In second step a team of six experts formulated backward translation of version 1 from target language (Urdu) to the source language (English). Another three experts weighed the equivalence of tool by comparing the backward translated and original version. In order to ensure the cultural sensitivity of sample, the stages and requirement of scale translation were adhered to the optimal level.

In addition to the translation, some changes were also made to the instruments as discussed and suggested by the expert committee. These changes were about the instruction for the all scales, for rating of post traumatic growth inventory short form scale which is six-point scale *(1) I experienced this change to a very small degree as a result of my crisis, (2) I experienced this change to a small degree as a result of my crisis.* But in my study, it was on 5-point scale from very great degree and rating of (1) to very small degree and rating of (2). small degree and very small scored both in one category due to expert discussion in committee approach that there is no difference and participants will get confused and also during pilot study where the participant couldn't find any difference in it and merged in one category**.** rating of small, very small to do it in one as its difficult for any participant to rate. Values assigned to response options; certain words/items used in the scales. Instructions and its duration mentioned in instruction were developed in committee stage in accordance with the present study variables and sample. for Post traumatic growth inventory, it was 0-5 in original English but change to 0-4 in Urdu keeping in mind that small and very small should be keep in same.

In core bereavement items scale it was also noted that the symbol (X) for the identity of the deceased was not very much appropriate term with the local population as it is an English language alphabet. However, after discussion in committee meeting it was agreed upon to retain the symbol (X) because using some noun could possibly coincide the actual name of some deceased.

Through this procedure Urdu version of the scales was prepared. The version was pre tested on a sample of 10 bereaved parents and siblings to assess its suitability and comprehension of the target population and to uncover the problems that go unidentified by the translators. After the pre testing, the translated version of the scales was empirically evaluated in pilot testing to address their psychometric properties in a sample of 150 bereaved parents and spouse.

Phase –III Pilot Testing

The objectives of the pilot study were to tackle instrumentation issues, evaluate the psychometric properties of the translated Urdu version scales, and explore the direction and strength of relationships among the study variables and to do instrumentation in local context.

Sample

Data for the pilot study were collected with self-reported instruments from 150 bereaved parents and siblings. Demographic details of each participant include their gender, age, Marital status, relationship status, family system, religion, and consultation before and after suicide with mental health professionals and faith healers. Sample included 63(42%) Females, 87 (58%) Male, and in parents 69 (46%) Father, 45(30%) Mothers, siblings 10 (6.7%) Sisters, Brothers 26(17.3%). Age range were 14 to 76 years. The participant's Marital status was 29(19.3%) singles,120 (80%) Married, and 1 (0.7%) divorced, 88(58.7%) belonged to

nuclear family system and 62(41.3%) from joint family system. 148(98.7%0 were Islam and 2(1.3%) were Hindu. Most of the participants 140(93%) did not consult to any psychiatrist after deceased suicide and 124(82.7%) not consulted with faith healer. 83(55.3%) participants showed the extremely positive relationship with deceased before death, somewhat positive were 57(38%), somewhat negative were 6(45), extremely negative 4(2.7%).

The participants were taken from five provinces of Pakistan Punjab, Sindh, Quetta, Baluchistan, Federal and Gilgit and including all ethnic communities in the Pakistan. Inclusion criteria were based on (a) survivors of suicide bereavement of 2 distinct categories parents and siblings were included who have experienced the loss and grief of a young offspring or a sibling respectively due to suicide, (b)Length of bereavement within Maximum 5 years and minimum 6 months. (c) The age of deceased should not be more than 30 years. (d)Participants who were familiar with the Urdu language.

Instruments

The following Instruments were used in translated version for pilot testing.

Core Bereavement Item

This instrument was originally developed by Burnettet et al., (1997) and Aziz (2012) have adapted and translated the version and was used in the present study. The scale has 17 items with the frequency of grief experiences to measure of core bereavement phenomena. There is no reverse item on the scale. Response options to each statement are rated on four point Likert type with range from *'Never* (0), *A little bit of time* (1), *Quite bit of time* (2), to '*continuously*' (3). Scale score range is from 0-51 and in order to obtain overall total score 17 items were added in with potential score. For the original scale was .84 to.90. The core bereavement item deviates when with relevant group and its internal reliability is (α = .91)

which is high and it reduces with passage of time (Burnett et al., 1997; Middletonet al., 1998). The alpha reliability coefficient for the present sample was .91.

Posttraumatic Growth Inventory-short form

This scale was originally developed by Cann,Tedeschi, Calhoun, Taku, Vishenessky, Triplett & Danhaurer (2010)) and translated by Aziz (2012). This scale determine how a person went through stage of post bereavement growth and how they improve themselves. items of scale are 10. It has no reverse item. Responses are made on the following five-point scale: (0) *I did not experience this change as a result of my crisis, (5) I experienced this change to a very great degree as a result of my crisis* with potential score range of 0-50. The maximum score of Post traumatic growth inventory short form is 50, higher score on this scale would indicate the higher post traumatic growth and for original scale alpha reliability was .66 for whole scale. (Siraj, 2020). Reliability coefficient and Cronbach alpha coefficient for present study was .73.

The Impact of Event Scale

Horowitz et al., (1979) originally developed Impact of event scale (IES) which is 15 questions short set and it determine the impact that a person experience post any traumatic event. Reason to use short version rather than using 22 items was that short and less items were convenient for sample and also psychometric properties were good. It's a 4-point likert scale with no Reverse item and Possible score range is from 0-75 and high score would show higher post-traumatic stress symptoms. To get the total score, each column score is calculated and then it is added to get the total score on impact event. Rating is '*not at all*" is valued at 0, "rarely" rated as 1, "sometimes" rated as 3 and "often" is rated as 5. Score is interpreted as 0 – 8 No Meaningful Impact, 9 – 25 Impact Event—you may be affected, 26 – 43 Powerful

Impact Event—you are certainly affected, 44 – 75 Severe Impact Event—this is capable of altering your ability to function. Scores above 27 reflect that individual would either meet partial criteria for post-traumatic stress disorder or the chances near to 75% of having post-traumatic stress disorder or at least there is presence of few symptoms. 35 and above represent cutoff for a probable diagnosis of post-traumatic stress disorder. Alpha reliability for original scale was .82 and of present study is .96.

State Shame Scale

Marschall, Saftner & Tangney (1994) originally developed state shame and guilt scale and defined it as scale which self-rated in the moment feeling related to shame with regard to the death of their deceased loved one. Five items for shame subscales are rated on a 5-point scale Likert scale.

shame part of the scale was used in the study as the objective of the present research focused on shame not guilt. Score range from 1 (*not feeling this way at all*) to 5 (*feeling this way strongly*). scores are obtained by summing the relevant items. Subscale scores range from 5–25, with higher scores indicating higher shame. Remember to rate each statement based on how you are feeling right at this moment. Scoring of Each scale consists of 5 items: Shame - Items 1, 3, 5, 7, 9. All items are scored in a positive direction. Total Shame (25 max).

One study, showed that it has good psychometric properties and confirmed through Confirmatory factor analyses. while The EFA results in a one-factor model of the GSES scale, both models have a good fit to the data, and the scale also showed high internal consistency (Cronbach's alpha = 0.89). The alpha value for present study was .82.

Environmental Reward Observation Scale

The Environmental Reward Observation Scale (EROS) which is 10 item scale was originally developed by Armento and Hopko (2007) who have identified that it identifies subjective experience of reinforcement by using proxy measure of Response Contingent Positive Reinforcement. To measure behavior during the past several months (e.g., "In general, I am very satisfied with the way I spend my time", "The activities I engage in usually have positive consequences") with scoring of 1 = Strongly disagree 2 = Disagree 3 = Agree 4 =Strongly agree. one-factor structure of EROS depicts good internal consistency and test-retest reliability since Cronbach alpha was 0.85 (Tavakol & Dennick, 2011) it showed good convergent validity with depression and with behavioral activation system, also showed moderate to strong correlations, (Armento & Hopko, 2007). Alpha reliability of present study is .67.

Societal Stigmatization Scale

Societal stigmatization originally developed by Feigelman et al; (2009) and stigma scale consist of two subscales: (a) a family and social strain and (b) a family and social harm/help subscale, both 11 items.

In family and social strain subscale, ask about that after the loss of child, if there is change or their relationship get affected with any 7 different family members (spouse, ex-spouse, parents, in-laws, children, siblings, and other relatives) or 4 social groups (coworkers, closest friends, less close friends, and neighbors). The scale is 4 point and respondent could answer with any of the following: not applicable, remained the same, became closer- stronger, or became weaker-strained relations. Score on subscale of strain was calculated by adding the number of relationship when it gets strained and score range from 0-11.

However, there was similarity between both subscales, family and strain subscale were logically similar to family and social harm help subscale. Instructions for societal stigma is that you ask participant or respondent that after first year when the child or sibling was lost how different family and relationship have acted or behaved. Respondents answered on a 5-point scale, from 1 (very harmful) to 5 (very helpful). It is scored any 1 and 2 responses as harmful ones. For harm subscales, scores were the sum of the number of relationship groups that demonstrated harm, so they could range from 0 to 11. In the present study cumulative score were used as advised and suggested by Author of the scale (appendix C). cumulative score was computed by add the two sub scale results together to get the overall rating of suicide stigma. In original scale these two subscales were moderately correlated (r =.55). The strain subscale (Alpha= .72), harm subscale (alpha=.73) and overall stigma scale (alpha= .76) were internally consistent. Alpha reliability of scale for present study is .78.

Patient Health Questionnaire

Robert, et al., (1999) originally developed the PHQ in the mid-1990s. It measures symptoms of depression and also used as diagnostic tool and have nine items and were updated in 2001. This scale measure if there is any severity or presence of depressive disorder. This scale takes less than three minutes to complete. In this, simply add up the individual item's scores. All the nine items are similar of DSM-5 symptom of depression. In patient health questionnaire, questions are about to measure respondents pleasure or interest level (anhedonia), feeling sad or down, insomnia or sleeping related other difficulty like difficulty falling or staying asleep, feeling lethargic, fatigued or minimal energy, problem related to eating (poor appetite or eating too much), doubt about self (feeling like a failure), inability to

focus or to maintain concentration, suicide ideation, psychomotor problems (speaking/moving slowly or fidgety/restless).

Responses is on 4 points: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3. Interpretation of total Score show depression severity 1-4 Minimal depression, 5-9 Mild depression 10-14, Moderate depression 15-19, Moderately severe depression ,20-27 Severe depression. In patient health questionnaire a tenth question assess and ask that symptoms they have mentioned how much it has affected on daily life functioning like his personal, professional, academic life. Although the response to 10^{th} question is not included in the final score, but mental health practitioner can use the response on this item to assess level of impairment. Add together column scores to get a total score. With regard to reliability for original scale, that was .89. The reliability was .85 for current study instrument.

Generalized Anxiety Disorder

Generalized Anxiety Disorders Scale (GAD-7) was originally developed by Spitzer et al., 2006, which is 7 items and was developed for screening of generalized anxiety disorder in primary care settings. For GAD-7 anxiety severity is calculated by assigning scores of 0, 1, 2, and 3 to the response categories. The assessment is indicated by the total score, which is made up by adding together the scores for the scale of all seven items with responses getting 0 to 3 points: Not at all (0 points), Several days (1 point), More than half the days (2 points), Nearly every day (3 points). Score ranges from 0 to 21. 0–4: minimal anxiety 5–9: mild anxiety 10–14: moderate anxiety 15–21: severe anxiety. An additional question at the end asks for a global rating of the severity of the patient's anxiety over the past 2 weeks. It has excellent internal consistency (Cronbach α = .92) as well as a good test-retest reliability (interclass correlation = .83) (Amit Sapra, 2020). Present study alpha reliability is .62.

Procedure

Participants were approached by using purposive and snowball sampling technique from all five provinces of Pakistan. Data was collected from June 2023 to August 2023**.** Considering the notion of study each member of the bereaved family was taken as an individual participant. However, the respective members of bereaved family were labelled as one unit, in order to understand that how an individual and a family unit undergo suicide bereavement. For instance, if a family consist of 5 participants including 2 parents and 3 siblings they were taken as individuals. Collectively, the data from this family was labelled as Family 1, and so on. Considering the availability of participants, they were facilitated at their residence or workplace or on call for obtaining data from them. Apart from paper pen surveys, google forms were used.

Prior to the actual study, a detailed consent form was taken from participants. Those who agreed to terms and condition were cordially invited to fill the scales. The participants were informed that their data would only be used for the present research purpose. They have a complete right of withdrawal in case of experiencing uneasiness regarding the statement of scales. However, debriefing session were provided wherever required.

Results of the pilot testing

The data were analyzed by using SPSS version 22. To address the psychometric properties of the translated versions, item-total correlations, reliability analysis and inter scale correlations were conducted.

Table 1.

Descriptive Statistics and Alpha Reliability Coefficients of Pilot Study (N = 150)

Variables	*Items*	*M*	*SD*	*A*	Score Range		Skewness	Kurtosis
					Actual	Potential		
Suicide Bereavement	17	41.55	6.74	.91	21-51	0-51	-1.08	.93
PTG	10	17.11	4.38	.73	6-33	0-40	0.37	.31
PTSD	15	47.49	20.7	.96	11-75	0-75	-0.10	-1.44
Shame	5	13.57	2.72	.82	5-24	5-25	0.10	2.03
EROS	10	24.79	2.56	.68	10-31	10-40	-1.60	8.08
Stigma	22	37.62	6.30	.78	23-48	0-66	-.86	-.47
Depression	9	12.09	3.78	.85	5-30	0-30	0.76	2.62
Anxiety	7	10.25	2.26	.64	4-21	0-21	1.10	5.60

Note. PTG = Posttraumatic Growth; PTSD=posttraumatic stress disorder; EROS = Environment Reward Observation Scale

Table 1 shows the mean, standard deviation, range of actual and potential scores, and alpha reliability coefficients of the study measures. The skew values indicate the degree of symmetry in the data, and in the present study, they were found to be within an acceptable range (i.e. ± 1).

Table 2

Item-total correlations and corrected Item-total correlations for core Bereavement Items (N =150)

Item No	*M*	*SD*	Item-total correlation	Corrected Item-total correlation
1	2.61	.542	.57**	.51
2	2.73	.501	.65**	.61
3	2.63	.550	.50**	.44
4	2.22	.503	.55**	.49
5	2.43	.617	.74**	.70
6	2.45	.765	.77**	.72
7	2.50	.621	.73**	.68
8	2.31	.655	.69**	.63
9	2.58	.648	.82**	.78
10	2.53	.631	.81**	.78
11	2.43	.649	.71**	.66
12	2.20	.568	.58**	.52
13	2.23	.628	.65**	.59
14	2.38	.730	.70**	.64
15	2.61	.601	.74**	.69
16	2.57	.595	.30**	.22
17	2.15	.712	.32**	.22

** $p < .01$.

` Table 2 shows the mean, standard deviation, item-total correlations, and corrected item-total correlations for each item. It demonstrates the consistency of each individual item with the total score. Similarly, the corrected item-total correlations indicate the correlation of individual items with the total score, excluding measurement errors (i.e.,

standardized values). In the present study, each core bereavement item correlated positively, with values ranging from .22 to .82.

Table 3

Item-total correlations and corrected item-total correlations for Impact Event Scale (N = 150)

Item No.	*M*	*SD*	Item-total Correlation	Corrected Item-total Correlation
1	3.01	1.79	.84**	.81
2	3.21	1.80	.84**	.82
3	3.09	1.77	.89**	.87
4	3.36	1.68	.78**	.75
5	3.28	1.70	.91**	.90
6	3.11	1.75	.90**	.89
7	3.23	1.76	.89**	.87
8	3.25	1.75	.88**	.86
9	3.45	1.72	.83**	.81
10	3.59	1.61	.80**	.77
11	3.52	1.61	.82**	.79
12	2.82	1.81	.75**	.71
13	3.01	1.65	.59**	.53
14	2.87	1.71	.64**	.59
15	2.67	1.71	.66**	.61

**$p < .01$.

Table 3 shows the mean, standard deviation, item-total correlations, and corrected item-total correlations for each item. It shows the consistency of each individual item with the total score. In the present study, each impact event item correlated positively, with values ranging from .53 to .91.

Table 4

Item-total correlations and corrected item-total correlations for the State Shame Scale (N =150)

Items	*M*	*SD*	Item-total Correlation	Corrected Item-total Correlation
1	2.16	0.82	.70**	.65
2	2.55	0.86	.78**	.71
3	2.44	0.76	.73**	.66
4	2.66	0.83	.82**	.66
5	2.72	0.96	.81**	.72

**$p < .01$.

Table 4 shows the proportion of correlation of each item with the total score of State Shame Scale. All individual items are positively correlated (ranging from .65 to .82) and significantly ($p < .01$) with the sum of total items.

Table 5

Item-total Correlations and corrected item-total correlations for the Environmental Reward Observation Scale (N =150)

Item No	*M*	*SD*	Item-total Correlation	Corrected Item-total Correlation
1	2.02	.37	.42**	.30
2	2.87	.38	.51**	.39
3	2.18	.43	.44**	.30
4	2.85	.42	.38**	.23
5	2.35	.50	.59**	.45
6	2.55	.53	.55**	.39
7	2.58	.54	.57**	.41
8	2.49	.71	.58**	.36
9	2.52	.58	.58**	.41
10	2.41	.53	.41**	.22

**$p < .01$

Table 5 highlights the correlation of each item with the total score of Environmental Reward Observation Scale. All the ten items are significantly positively correlated (ranging from .22 to .59) with the total test scores.

Table 6

Item-total correlations and corrected item-total correlations for Post Traumatic Growth Inventory Short Form (N =150)

Item No	*M*	*SD*	Item-total Correlation	Corrected Item-total Correlation
1	1.79	0.88	.35**	.16
2	1.71	0.81	.60**	.46
3	1.70	0.90	.56**	.39
4	1.79	0.82	.44**	.27
5	1.91	0.57	.54**	.43
6	1.89	0.71	.68**	.57
7	1.63	0.74	.63**	.51
8	1.47	0.86	.52**	.35
9	1.57	0.92	.49**	.31
10	1.65	0.83	.69**	.57

**p <.01.

Table 6 highlights the correlation of each item with the total score of posttraumatic growth inventory. All the ten items are significantly positively correlated (ranging from .35 to .69) with the total test scores.

Table 7

Item-total correlations and corrected item-total correlations for societal stigmatization Scale (N = 150)

Items	*M*	*SD*	Item-total Correlation	Corrected Item-total Correlation
1	0.98	0.76	.78**	.61
2	0.11	0.49	.44**	.27
3	2.36	0.55	.57**	.4
4	0.75	0.55	.51**	.33
5	0.88	0.59	.74**	.6
6	1.05	0.37	.34**	.21
7	1.01	0.18	.26**	.2
8	1.09	0.28	.47**	.38
9	1.10	0.28	.48**	.39
10	1.09	0.29	.47**	.38
11	1.01	0.08	.27**	.24
12	2.30	1.24	.76**	.6
13	1.89	1.39	.51**	.23
14	2.66	0.88	.43**	.26
15	2.11	1.35	.85**	.73
16	2.37	1.26	.78**	.64
17	2.97	0.41	.26**	.2
18	2.98	0.31	.32**	.25
19	2.99	0.18	.28**	.24
20	3.00	0.2	.26**	.22
21	2.99	0.18	.28**	.24
22	2.95	0.3	.32**	.25

**$p < .01$.

Table 7 shows descriptive statistics and the item-total correlation for 22-items of societal stigmatization scale. All items are internally consistent and significantly positively correlated (ranging from .22 to .85) with the total test scores.

Table 8

Item-total correlations and corrected item-total correlation for Patient Health Questionnaire (N = 150)

Items	*M*	*SD*	Item-total Correlation	Corrected item-total correlation
1	1.45	.69	.79**	.70
2	1.45	.57	.68**	.58
3	1.26	.82	.84**	.75
4	1.16	.78	.76**	.65
5	1.45	.59	.59**	.47
6	1.53	.56	.43**	.30
7	1.29	.53	.67**	.58
8	1.35	.52	.71**	.63
9	1.15	.41	.61**	.53

**$p < .01$.

Table 8 depicts the descriptive statistics and item-total correlation of each item with the total score of the scale. All items are internally consistent and significantly positively correlated with the total test score. The values of coefficient range from .43 to .79.

Table 9

Item-total correlations and corrected item-total correlation for Generalized Anxiety disorder (N = 150)

Items	*M*	*SD*	Item-total Correlation	Corrected item-total correlation
1	1.55	.53	.62**	.45
2	1.55	.71	.62**	.37
3	1.25	.55	.69**	.52
4	1.39	.57	.60**	.40
5	1.43	.57	.44**	.20
6	1.55	.55	.46**	.24
7	1.47	.57	.54**	.33

**$p < .01$.

Table 9 shows a significant positive relationship of all items of generalized anxiety disorder with its total scale score. The values of coefficient range from .39 to .70.

Table 10

Correlation between the variables in Pilot testing (N = 150)

	Variables	1	2	3	4	5	6	7	8
1	Suicide Bereavement	–	-.32**	.43**	.43**	.30**	.29**	.22**	.24**
2	PTG		–	-.29**	-.14	-.11	-.25**	-.03	.08
3	PTSD			–	.17*	-.01	.33**	.33**	.25**
4	Shame				–	.26**	.45**	.05	.19*
5	EROS					–	.24**	-.32**	-.09
6	Stigma						–	-.13	-.06
7	Depression							–	.55**
8	Anxiety								–

Note. PTG= Posttraumatic Growth; PTSD= Posttraumatic Stress Disorder; EROS= Environmental Reward Observation Scale, *$p < .05$, **$p < .01$

Table 10 shows the Pearson correlation among the study variables. Results indicated a significant negative correlation between bereavement and posttraumatic growth. Bereavement was also significantly positively correlated with PTSD, depression, anxiety, stigma and shame. Environmental reward was significantly positively correlated with stigma, shame and negatively correlated with depression.

Discussion (Study -1)

The objective of Study-1 which was conducted in three phases was to explore the experiences of suicide bereaved family members and to integrate the information gathered from semi structured interviews in instrumentation process and to address the psychometric properties.

Interview findings showed that the theme of emotional distress and social disconnection emerged prominently in the narratives of both parents and siblings experiencing suicide bereavement. The subthemes encompassed various aspects of emotional turmoil, impairment, trauma, and isolation. These findings are consistent with previous research highlighting the profound psychological impact of suicide bereavement (Maple et al., 2019; Smith & Jones, 2023). Interestingly, amidst the profound grief experienced by participants, however, a significant number of participants witnessed experiencing posttraumatic growth and personal transformation. The concluded findings aligned with studies suggesting that individuals can find meaning and purpose in the aftermath of traumatic events, leading to positive psychological changes (Garcia & Rodriguez, 2022; Tedeschi & Calhoun, 2004).

Participants described a variety of coping strategies and resilience mechanisms employed to navigate their grief. Spiritual and religious coping, social support, and hope for healing were identified as crucial factors in coping process. These findings resonate with the literature highlighting the importance of social support and adaptive coping strategies in facilitating bereavement adjustment (Wang & Chang, 2021; Patel & Shah, 2023). Another noteworthy finding was the utilization of environmental rewards such as maintaining routine and structure in life as coping mechanisms. Results suggested that individuals may find solace and comfort in their surroundings, contributing to their overall coping and adjustment. Such

findings are consistent with research emphasizing the role of environmental factors in facilitating psychological well-being (Chen & Lee, 2024; Pressman & Cohen, 2005).

Despite having the consciousness of seeking professional help in coping with bereavement, participants reported various barriers, including social stigma and concerns about judgment. These findings underscore the need for targeted interventions aimed to reduce stigma and mental health awareness within the community (Patel et al., 2018; Patel & Shah, 2023).

The intersection of mental health struggles with socioeconomic challenges was evident in participants' narratives. Familial strain and treatment barriers emerged as significant factors impacting bereavement adjustment. These factors highlight the importance of addressing socioeconomic inequalities and providing accessible mental health services to vulnerable populations (Khan & Haq, 2021; Patel et al., 2018).

Participants expressed a need for increased social support and advocacy initiatives to raise awareness on mental health issues. Cultivating empathy and compassion emerged as essential components of effective support systems. These findings underscore the importance of community-based interventions aimed at fostering supportive environments and reducing stigma (Hussain & Ali, 2022; Corrigan & Watson, 2007).

Finally, participants' narratives shed light on the complex nature of suicide bereavement, including the psychological and interpersonal dynamics. Strained relationships and behavioral characteristics of the deceased emerged as salient factors impacting the bereavement process. These findings align with existing literature highlighting the multifaceted nature of suicide bereavement and the need for targeted interventions to support survivors (Wang & Li, 2021; Maple et al., 2019).

In phase-II, some important considerations executed in adaption process were followed. Instructions for each individual scale were developed in the committee stage in accordance with the present research variables and sample. It is important to note that values for response options on the original scales of core bereavement items ranged from 1-4 and values were adapted from 0-3 and for Post traumatic growth inventory were 0-5 and values were adapted for 0-4. The amendments were made in consultation with the expert committee members to avoid confusion in understanding the interpretation of the questionnaire scores.

In core bereavement items scale it was also noted that the symbol (X) for the identity of the deceased was not very much appropriate term with the local population as it is an English language alphabet. However, after discussion in committee meeting it was agreed upon to retain the symbol (X) because using some noun could possibly coincide the actual name of some deceased.

Phase-III was devoted to empirically evaluate the translated scales and exploring the pattern of relation of the variables. In order to measure the psychometric properties of translated version, pilot testing was initiated. The study aimed to measure the validity and reliability of scale as it is administered on the target population. To examine the effectiveness of individual items within each scale, item total correlation and corrected item total correlations were conducted.

The alpha reliabilities value for scores on all the scales were above the accepted range. Overall, the findings are supportive that the scores on Urdu adapted version are valid and reliable measure to be used in the main study.

CHAPTER III

STUDY-II (MAIN STUDY)

Study I formulated a model for testing that inevitably requires scientific exploration. The recent study presented the underlying factors intervening the event of suicide bereavement such as psychological, social and environmental rewards. Group differences on study variables were explored based on circumstantial factors (Method of suicide and time since death), and demographic characteristics of the participants and deceased including gender, age, Marital status, relationship status, family system, education level and occupational level, mother tongue, city, consultation with mental health professional, and any mental illness.

Objectives

1. To address the construct validity of test scores of instruments through confirmatory factor analysis.
2. To investigate the relationship of suicide bereavement with psychological and social outcomes.
3. To examine the moderating role of environmental rewards between suicide bereavement and psychological outcomes.
4. To examine the moderating role of environmental reward between suicide bereavement and social outcomes.
5. To explore the group differences on psychological and social outcomes between parents and siblings.
6. To explore mean differences by gender, gender of deceased, family system, relationship status and duration of bereavement on psychological and social outcomes.

Hypotheses

To test the objectives, following hypotheses were formulated.

H1: Suicide bereavement is associated with psychological outcomes, more specifically.,

H1:a Suicide bereavement is positively associated with PTSD.

H1:b Suicide bereavement is positively associated with Depression.

H1:c Suicide bereavement is positively associated with Anxiety.

H1:d Suicide bereavement is negatively associated with post traumatic growth.

H2: Suicide bereavement is associated with social outcomes, more specifically;

H2: a Suicide bereavement is positively associated with stigma.

H2: b Suicide bereavement is positively related with shame.

H3: Environmental rewards moderate the relationship between suicide bereavement and psychological outcomes, more specifically;

H3: a Environmental rewards moderate the relationship between suicide bereavement and depression.

H3: b Environmental rewards moderate the relationship between suicide bereavement and anxiety.

H3:c Environmental rewards moderate the relationship between suicide bereavement and PTSD.

H3:d Environmental rewards moderate the relationship between suicide bereavement and Post traumatic growth.

H4: Environmental rewards moderate the relationship between suicide bereavement and social outcomes, more specifically;

H4:a Environmental rewards moderate the relationship between suicide bereavement and stigma.

H4:b Environmental rewards moderate the relationship between suicide bereavement and shame.

H5: There is difference between parents and siblings on psychological and social outcomes, more specifically;

H5: a Parents are high on depression as compared to siblings.

H5: b Parents are high on anxiety as compared to siblings.

H5:c Parents are high on PTSD as compared to siblings.

H5: d Siblings are high on post traumatic growth as compared to parents.

H5: e Parents are high on stigma as compared to siblings.

H5: f Parents are high on shame as compared to siblings.

H6: Duration of bereavement is positively associated with Post traumatic growth.

Sample

A total of 501 participants took part in the main study. Demographic details of each participant include their gender, age, marital status, relationship status, family system, religion, and

consultation with mental health professional and faith healer before and after suicide of deceased. It included 262 (52.3%) males and females 239(47.7%), between the age range for siblings 14-35 years (*M=17.71, SD=4.09*) and age range of parents were 38-80 years (*M = 51.71, SD = 6.82*) Age range of father were 39-80 and mother were 38-70, sister was 14-30 and brother 14-35. Bereaved parents 287 and bereaved siblings were 214 which includes Father 161(32.13%), Mother 123(24.55%), Sisters 106(21.15%), Brother 112(22.36%). Marital status includes single 175(34.9%), Married 321(64.1%), Divorced 2(.4%), widowed 2(.4%) and others 1(.2%). In family system 420(83.8%) belonged to nuclear family system and 81(16.2%) from joint family system. The religion demographics showed 496(99%) were Muslims, 3(.6%) were Christian and 2(.4%) were Hindus.

Most of the participants 470(93%) did not consult to any mental health professionals before and after suicide and 429(85.6%) not consult with faith healer. Nature of relationship with deceased 226(45.1%) participants showed the extremely positive relationship with deceased., 257 (51.3%) were somewhat positive, somewhat negative were 12(2.4%) and extremely negative were 6(1.2%). A blend of purposive convenience and snowball sampling techniques were used to select the participants. Inclusion criteria were (a) the parents/siblings had lost child/sibling to suicide; (b) Duration of bereavement within 6 months to 5 years. (c) The age of deceased should not be more than 30 years. (d)Participants with understanding of Urdu language. Everyone of bereaved family was approached to participate in study. The participation of everyone gives a unique insight to suicide bereavement based on the individual differences, personality traits and relationship status with the deceased. Participants were required to share their information by filling self-reported surveys. However, data was collected by face-to-face surveys, google forms and even on call.

Table 11

Demographic Characteristics and Frequencies of Main Study Sample parents and siblings (N=501)

Variable	***n(%)***
Gender	
Male	262(52.3%)
Female	239(47.7%)
Age	14 – 80
Sibling Age	14-35
Parents Age	38-80
Marital Status	
Single	175(34.9%)
Married	321(64.1%)
Divorced	2(.4%)
Widowed	2(.4%)
Others	1(.2%)
Family System	
Nuclear	420(83.8%)
Joint	81(16.2%)
Relationship status	
Father	161(32.13%)
Mother	123(24.6%)
Sister	106(21.15%)

Brother	112(22.36%)
Religion	
Islam	496(99%)
Christin	3(.6%)
Hindu	2(.4)
Deceased	
Age (years)	14-30
Gender	
Male	239(47.7%)
Female	262 (52.3%)
Marital Status	
Single	474 (94.6%)
Married	9 (1.8%)
Divorced	16 (3.8%)
Separated	2 (0.4%)
Bereavement Duration	
1 Year	117 (23.4%)
2 Year	273 (54.5%)
2-5 Years	111(22.2%)
Consult Psychiatrist Before Suicide	
No	470(93.8%)
Yes	31(6.2%)
Consult Psychiatrist After Suicide	
No	474(94.6%)
Yes	27(5.4%)

Faith Healer After Suicide	
No	429(85.6)
Yes	72(14.4%)
Relationship with Deceased	
Extremely Negative	6(1.2%)
Somewhat Negative	12(2.4%)
Somewhat Positive	257(51.3%)
Extremely positive	226(45.1%)

Table 11 shows the demographic details of the study. It included details of each participant like age ranges, gender, marital status, family system, duration of bereavement, religion, and consultation before and after suicide and relationship with deceased. The sample consisted of more males 52.3% than females 47.7%. The majority of the participants were married 64.1%, 34.9% were single, and 0.4% were divorced. Most of the participants 83.8% belonged to nuclear family system and 16.2% from joint family system. Most of the participants 93% did not consulted to any Mental health professional before and after suicide and 85.6% did not consult with faith healer. 45.1% participants showed the extremely positive relationship with deceased before the suicide and 51.3% somewhat positive.

Instruments

Environmental Reward Observation Scale (EROS), Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorders Scale, Impact of Event Scale (IES), Societal Stigmatization scale, Shame and Guilt scale (SSGS) and Post traumatic growth inventory-short form (PTGI-SF) scales were used for data collection. Apart from scales, a consent form and demographic sheet were used in a single booklet form. Detailed description of these scales is given below (See Appendix G to N)

Consent form

Adherence to the ethical considerations was given special attention in the present study. Consent form is a mutual agreement between the researcher and participant. The form highlight the voluntary participation, purpose of study, and confidentiality towards the participant's shared data. Participant were aware about their right of withdrawal from research in case of uneasiness while sharing information. (See appendix O and P)

Demographic information sheet

A demographic information sheet was constructed to obtain information about gender, age, mother language, family system, education, occupation, relationship status with deceased, method of suicide, the duration of bereavement along with the age and gender of the deceased. (See appendix O and P)

Instruments:

The following Instruments were used in main study. (See Appendix Q, R, S, T)

Core Bereavement Item Scale

Urdu adapted version of Core Bereavement Items scale was to use to assess suicide bereavement in the present study. This scale was originally developed by Burnett, et al;(1997) and translated version of Aziz (2012) was used and were adapted in Study-I. The scale has 17 item and has no reverse item on the scale. Response options to each statement are rated on 4-point Likert type scale with range from *'Never* (0), *A little bit of time* (1), *Quite bit of time* (2), to '*continuously*' (3). Total score on the scale is obtained by adding together the 17 items with potential score Range from 0-51. Alpha reliability for the original scale was .84 to.90 and for the present sample was .94. The scale consists of three subscales-images and thoughts, acute separation and grief. To assess relationship of bereavement with psychological and social outcomes as single phenomenon, all three subscales were used.

Posttraumatic Growth Inventory-Short form

Urdu adapted version for PTGI-SF was used to assess the post traumatic growth. It is a 10 items scale originally developed by Cann et al; (2010)) and translated by Aziz (2012) to assess post-trauma growth and self-improvement a person undergoes. It has no reverse item. In adapted version Responses are made on the following five-point scale: (0) *I did not experience this change as a result of my crisis, (5) I experienced this change to a very great degree as a result of my crisis* with potential score range of 0-50. the maximum score of PTGI is 50, higher score on this scale would indicate the higher post traumatic growth. Alpha reliability for original instrument was .86 to .89 and reliability coefficient for the scores for the present sample was .88

Impact of Event Scale

Urdu adapted version of Impact of Event Scale (IES) was used and it was originally developed by Horowitz et al;(1979). It is a short set of 15 questions to measure the impact that experience following a traumatic event. It's a 4-point Likert the score range is from 0-75 and high score would show higher post-traumatic stress symptoms. The rating of scale is '*not at all*" and is valued as 0, "rarely" rated as 1, "sometimes" rated as 3 and "often" is rated as 5. It has two subscales but present study has used it as single unidimensional scale. Alpha reliability of original scale was .82 and alpha reliability of present study is .90.

State Shame Scale

Urdu adapted version was used to assess shame and it was originally developed by Tangney and Dearing (2002). It is a self-rating scale of in-the-moment (state) feelings of shame experiences with regard to the death of their deceased loved one. For this study, items representing shame were considered. Five items of subscales shame are rated on a 5-point scale likert scale. Shame Items are 1, 3, 5, 7, 9. All items are scored in a positive direction. Response rate: 1 (not feeling this way at all) to 5 (feeling this way strongly). Shame subscale scores range from 5–25, with higher scores indicating higher shame. Scores are obtained by summing the relevant items. The scale showed high internal consistency on original scale (Cronbach's alpha = 0.89) and the alpha value for present study was .86.

Environmental Reward Observation Scale

Urdu adapted version was used which was originally developed by Armento and Hopko (2007) to assess Environmental Reward Observation Scale (EROS) to assess proxy measure of Response Contingent Positive Reinforcement by assessing the subjective experience of reinforcement. It has 10 items and items were designed to measure increased behaviors and

positive affects as consequences of rewarding environmental experiences during the last several months (e.g., “In general, I am very satisfied with the way I spend my time”, “The activities I engage in usually have positive consequences”) with scoring of 1 = Strongly disagree 2 = Disagree 3 = Agree 4 =Strongly agree. The EROS one-factor structure demonstrated good internal consistency and test-retest reliability since Cronbach alpha was .85 (Tavakol & Dennick, 2011) test-retest reliability of EROS was excellent (Armento & Hopko, 2007). Alpha reliability of instrument in current study is .62.

Societal Stigmatization Scale

Societal stigmatization scale was developed by Feigelman et al;(2009). The stigmatization scale consisting of two subscales: (a) a family and social strain and (b) a family and social harm/help subscale, both 11 items.

The strain questions asked respondents, after the loss of their child, whether relationships changed with any one of 7 different family members (spouse, ex-spouse, parents, in-laws, children, siblings, and other relatives) or 4 social groups (coworkers, closest friends, less close friends, and neighbors). Respondents could choose between the following answers: not applicable, remained the same, became closer/stronger, or became weaker/strained relations. Strain subscale scores were the sum of the number of relationships that became strained, so could range from 0 to 11.

Whereas the family and social harm/help subscale was logically similar to the strain subscale. It queried respondents’ experiences with these same 11 different family and social relationship groups in terms of how harmfully or helpfully the groups had acted after the loss of their child. Respondents answered on a 5-point scale, from 1 (very harmful) to 5 (very helpful). Harm subscale scores were the sum of the number of relationship groups that

demonstrated harm, so they could range from 0 to 11. In the present study cumulative score were used as advised and suggested by Author of the scale (appendix C). cumulative score was computed by add the two sub scale results together to get the overall rating of suicide stigma. in original scale these two subscales were moderately correlated (r=.55). The strain subscale (alpha=.72), harm subscale (alpha=.73) and overall stigma scale (alpha=.76) were internally consistent. Alpha reliability for instrument used in current study is .83.

Patient Health Questionnaire

Urdu adapted version of patient health questionnaire was used which was originally developed by Robert et al; in 1999. It is nine-item tool to measure depressive symptoms. The instrument assesses for the presence and severity of depressive symptoms and a possible depressive disorder. The patient health questionnaire takes less than three minutes to complete. Each of the nine items reflects a DSM-5 symptom of depression. Responses are on Four points scale: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3. It is scored by simply adding up the individual items' scores. The intensity of depression is in range of minimal, mild, moderate and severe depression. High score of 20-27 indicate severe depression and low score of 1-4 indicates minimal depression and Score range is from 1-27, With regard to reliability for original scale, they found that Cronbach's alpha for the patient health questionnaire was .89. The reliability was .85 for scale used in current study.

Generalized Anxiety Disorder Scale

Urdu adapted version of the 7-item Generalized Anxiety Disorders Scale (GAD-7) developed by Spitzer et al., (2006) for screening of generalized anxiety disorder. Scoring of GAD-7 anxiety severity is calculated by assigning scores of 0, 1, 2, and 3 to the response categories. The total score reflects the assessment, which is calculated by adding together the scores for

the scale of all seven items with responses getting 0 to 3 points: Not at all (0 points), several days (1 point), more than half the days (2 points), nearly every day (3 points). GAD-7 total score for the seven items ranges from 0 to 21. 0–4: minimal anxiety 5–9: mild anxiety 10–14: moderate anxiety 15–21: severe anxiety GAD-7 scale was found to have excellent internal consistency (Cronbach α = .92) as well as a good test-retest reliability (intra-class correlation = 0.83) (Amit Sapra, 2020). The alpha reliability of scale used in current study is .72.

Operational Definition

The variables of the study are defined as follows

Suicide Bereavement

Suicide Bereavement is the deep sadness and mourning that often occurs after the loss of a loved one due to suicide. It is the subjective experience after the loss of loved by committing suicide. High score on Core Bereavement Items scale indicates greater intensity of bereavement experienced by the bereaved parent or siblings and lower score indicates lower intensity of bereavement.

Post Traumatic Growth

Post traumatic growth is positive psychological changes experienced as a result of the struggle with trauma or highly challenging situations (Tedeschi et al.,2018). Post traumatic growth features positive change in self-perception, interpersonal relationships and philosophy of life, leading to increased self-awareness and self-confidence, and more open attitude towards others, a greater appreciation of life and the discovering of new possibilities (Tedeschi & Calhoun. 1996). High score on PTGI-SF indicates greater level of post traumatic growth

experienced by the bereaved parent or siblings and low scores indicates lower level of post traumatic growth.

Post-Traumatic Stress Disorder

Directly experiencing the traumatic events(s), witnessing, in person, the event(s) as it occurred to others. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental (DSM-V, 2013)**.** High score on Impact event scale shows higher post-traumatic stress in bereaved parents and siblings and low score indicates lower level of post-traumatic stress.

Shame

Shame is defined as strong negative emotions in which the feeling of global self-evisceration is experienced (Tangeny & Dearing 2002). Shame is often generated by social events in which a personal status or feeling of rejection is sensed. Higher score on state shame scale indicating higher shame in bereaved parents and siblings and low score indicates lower level of shame.

Environmental Reward

Environmental reward is referred as conceptualizing the environmental experience as positive or negative e.g. in different areas of life like relationship like having a pleasant conversation with a friend and work like receiving a promotion. The concept emphasizes to measure Response-Contingent Positive Reinforcement (RCPR) magnitude over time. It aims to measure 3 dimensions (Lewinsohn, 1974): (a) events which are potentially reinforcing, (b) In the environment availability of reinforcement (c) To elicit reinforcement the instrumental

behavior (or skill) of an individual. Higher score on environmental reward observation scale indicates higher reinforcement and lower score indicate low reinforcement.

Stigma

Stigma refers to the negative association between a person or group of people who share certain undesirable traits (Chopra & Arora, 2020). Stigma leads towards negative cognitions or expectations that cultivate various psychological challenges.

The societal stigmatization scale consists of two subscales: (a) a family and social strain and (b) a family and social harm/help subscale, both 12 items. Strain subscale scores were the sum of the number of relationships that became strained, so could range from 0 to 11. Family and social Harm/help subscale scores were the sum of the number of relationship groups that demonstrated harm, so they could range from 0 to 11. Add the two sub scale results together to get the overall rating of suicide stigma.

Depression

Depression is a state of depressed mood or loss of interest or pleasure. High score on patient health questionnaire indicate severe depression and low score indicate minimal depression.

Anxiety

It is the severity and intensity of anxiety like nervous, anxious, pre occupied with something negative will happen in future, being irritable after the traumatic event. High score on Generalized anxiety disorder scale indicates the severe anxiety and low score shows minimal anxiety.

Procedure

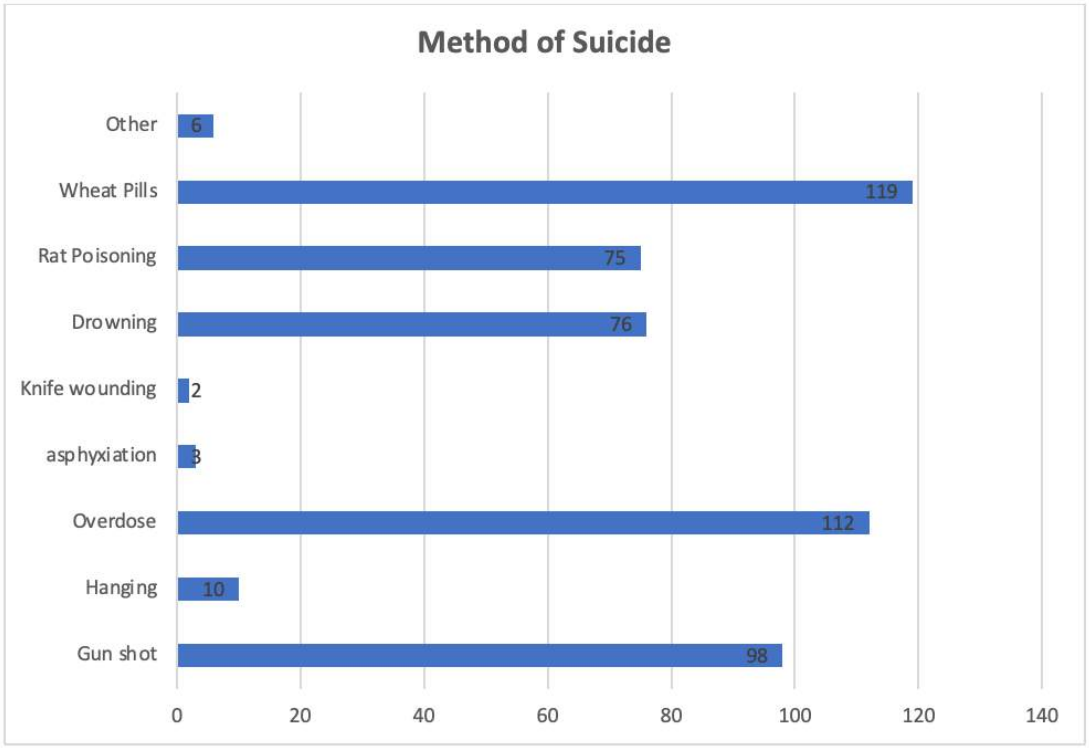
The participants were approached at their residence or workplace for data collection. Data was obtained through a set of scales with attached informed consent form and demographic sheet. The duration of data collection ranges from September 2023 to Jan 2024. Participants were informed about their voluntary participation in the study. The participant had complete authority to withdraw from the study in case of uneasiness during research. However, the scholar made sure to follow the protocols of confidentiality and anonymity. The scholar made sure that the shared information by participants will be used for research purposes only. Considering the ethical guidelines, each participant was obliged to sign the consent form before their participation. The one who accepted the terms and conditions were provided with the scales. The study requires independent voluntary participation of the participants, therefore, each participant record their responses independently.

Chapter IV

RESULTS

In the light of the study objectives, different statistical analyses, including correlations, t-tests, and moderation analyses, were conducted by using process macro in SPSS version 28. The preliminary analysis regarding the descriptive information and reliabilities for all the variables are provided in table 20.

Figure 3. *Description for Method of Suicide*



The above conceptual showed the method of suicide. In most of the cases 119 participant used wheat pills as method of suicide. The second preferable method was overdose of medicine. The third prominent method was guns shot in the present study sample.

Figure 4. *Description of the Data Collection from Different Cities*

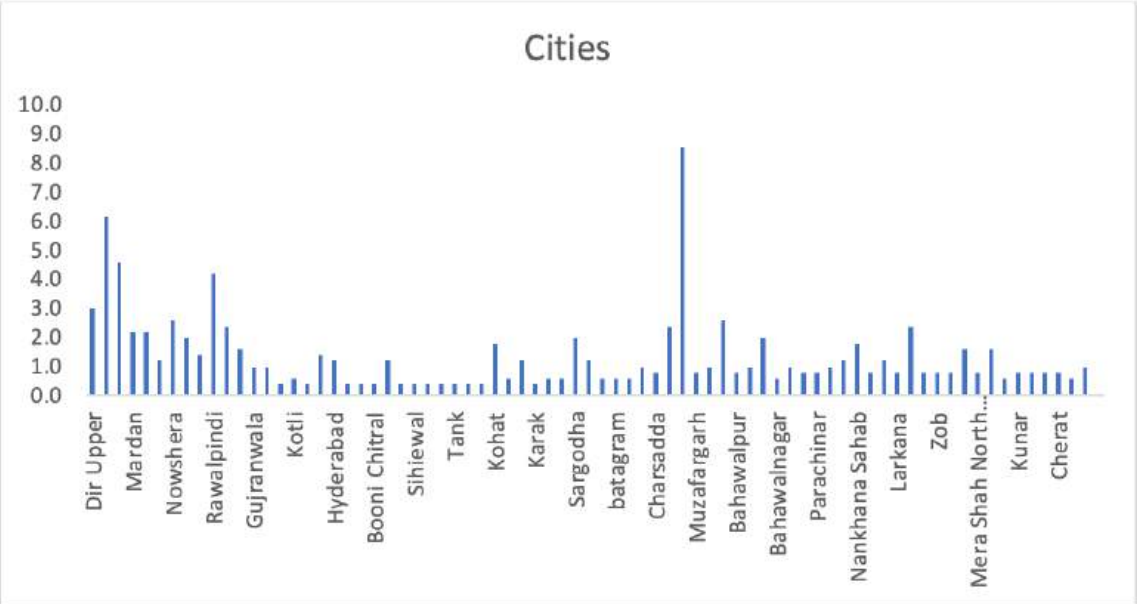


Figure 2 showed the name of the cities from where data was collected. The data was collected from 79 cities of Pakistan. It depicts the diverse sample of the present study.

Figure 5. *Confirmatory Factor Analysis of Core Bereavement Inventory*

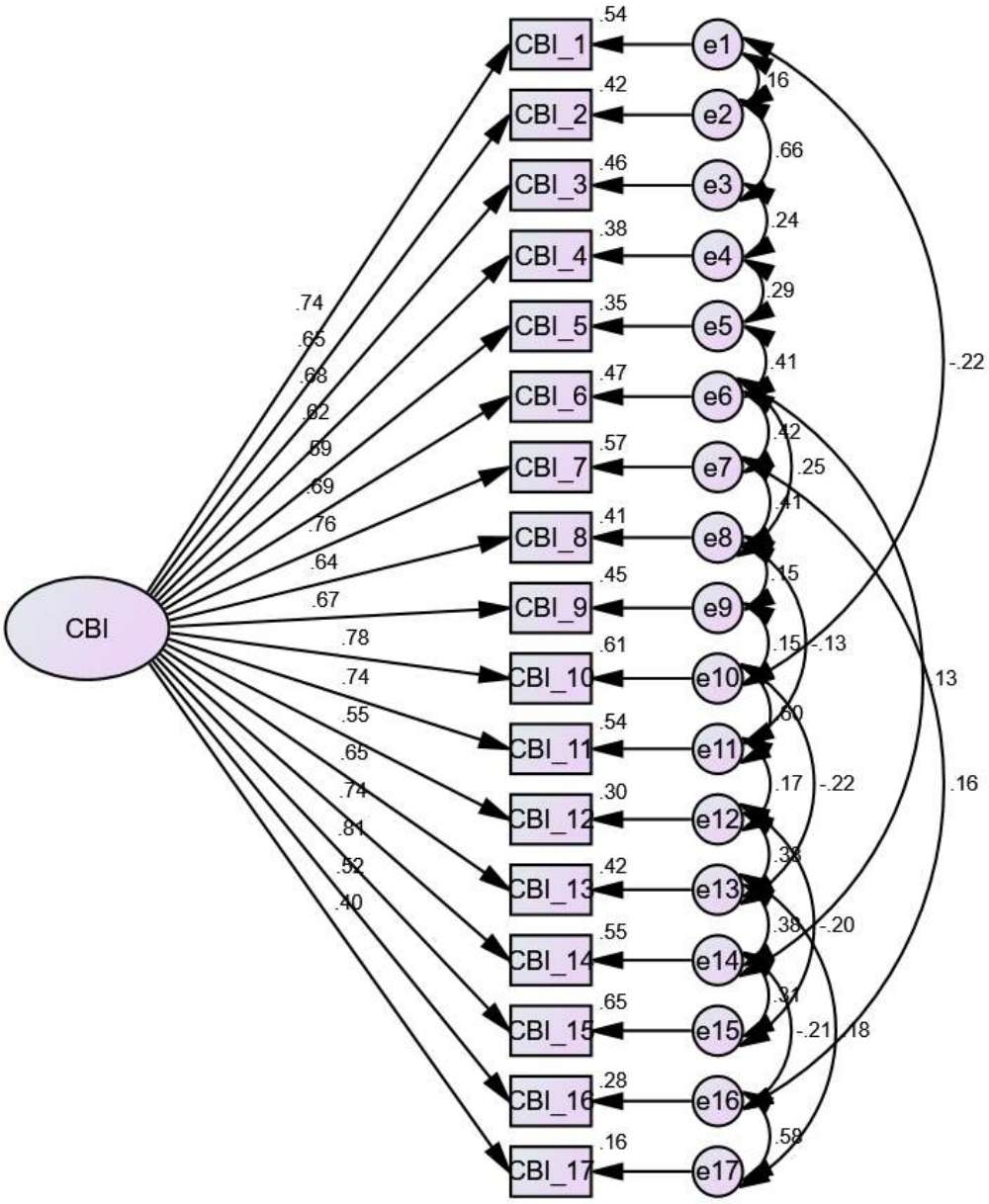


Table 12.

Confirmatory Factor Analysis for Core Bereavement Items (N = 501)

	χ2(df)	IFI	CFI	RMSEA
Model 1	2107.71(119)	.67	.67	.18
Model 2	518.82(95)	.93	.93	.06

Note. IFI = Incremental Fit Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

Table 12 indicates model fit indices for Core Bereavement Items. Model fit indices were unacceptable for the default model (Model 1). To obtain a good model fit modification was applied, which included by adding covariance between errors of the scale. Model 2, which is obtained after applying modification is the good fit with $\chi2(95) = 518.82$, IFI = .93, CFI = .93, and RMSEA = .06.

Figure 6. *Confirmatory Factor Analysis of Post Traumatic Growth Inventory*

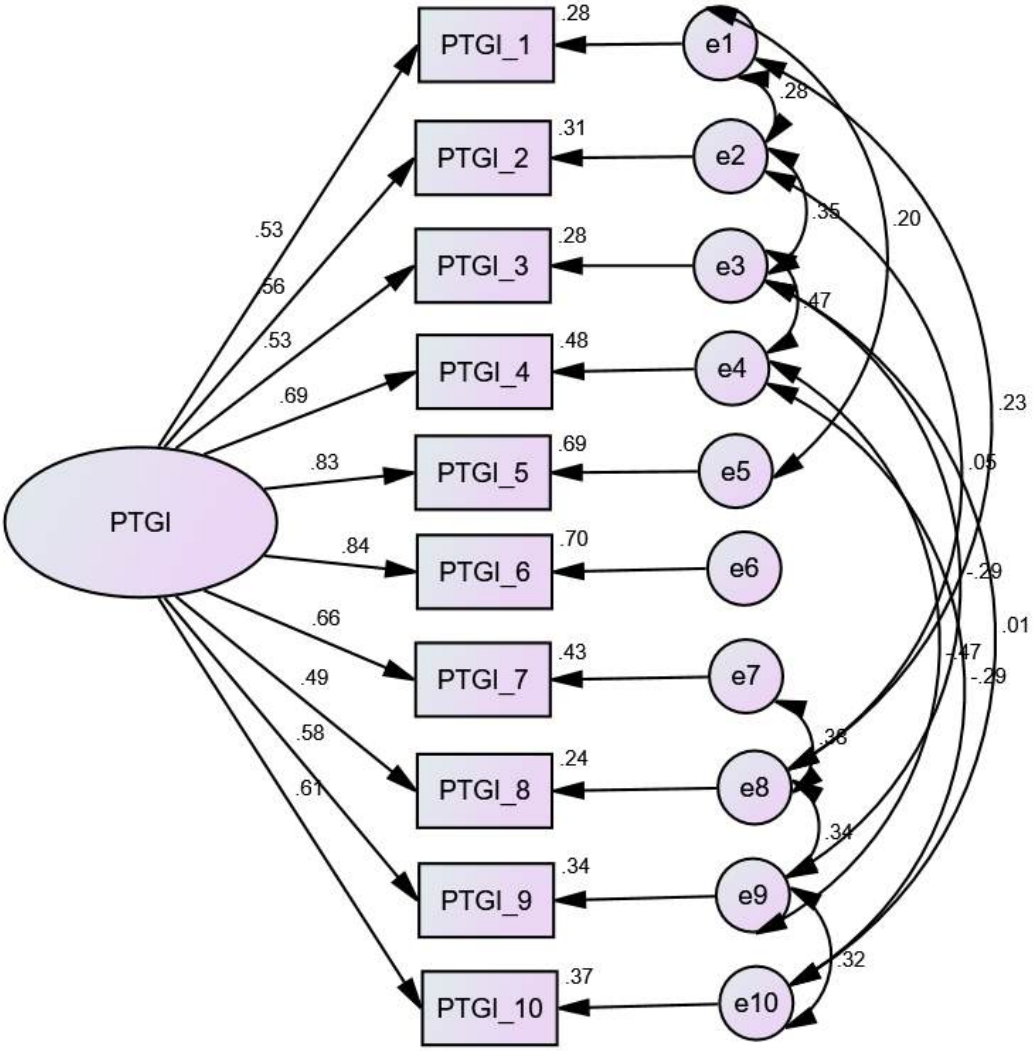


Table 13

Confirmatory Factor Analysis for Post traumatic growth Inventory (N = 501)

	$\chi 2$(df)	IFI	CFI	RMSEA
Model 1	838.66(35)	.69	.69	.21
Model 2	241.22(14)	.96	.96	.06

Note. IFI = Incremental Fit Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

To assess the validity of the posttraumatic growth inventory, confirmatory factor analysis was conducted using AMOS version 21. Default model indices indicate that it was unacceptable. To achieve goodness of fit, modification was applied by adding covariance between errors of the scale. Model 2 is a good fit with $\chi 2(14) = 241.22$, IFI = .96, CFI = .96, and RMSEA = .06.

Figure 7. *Confirmatory Factor Analysis of Impact Event Scale*

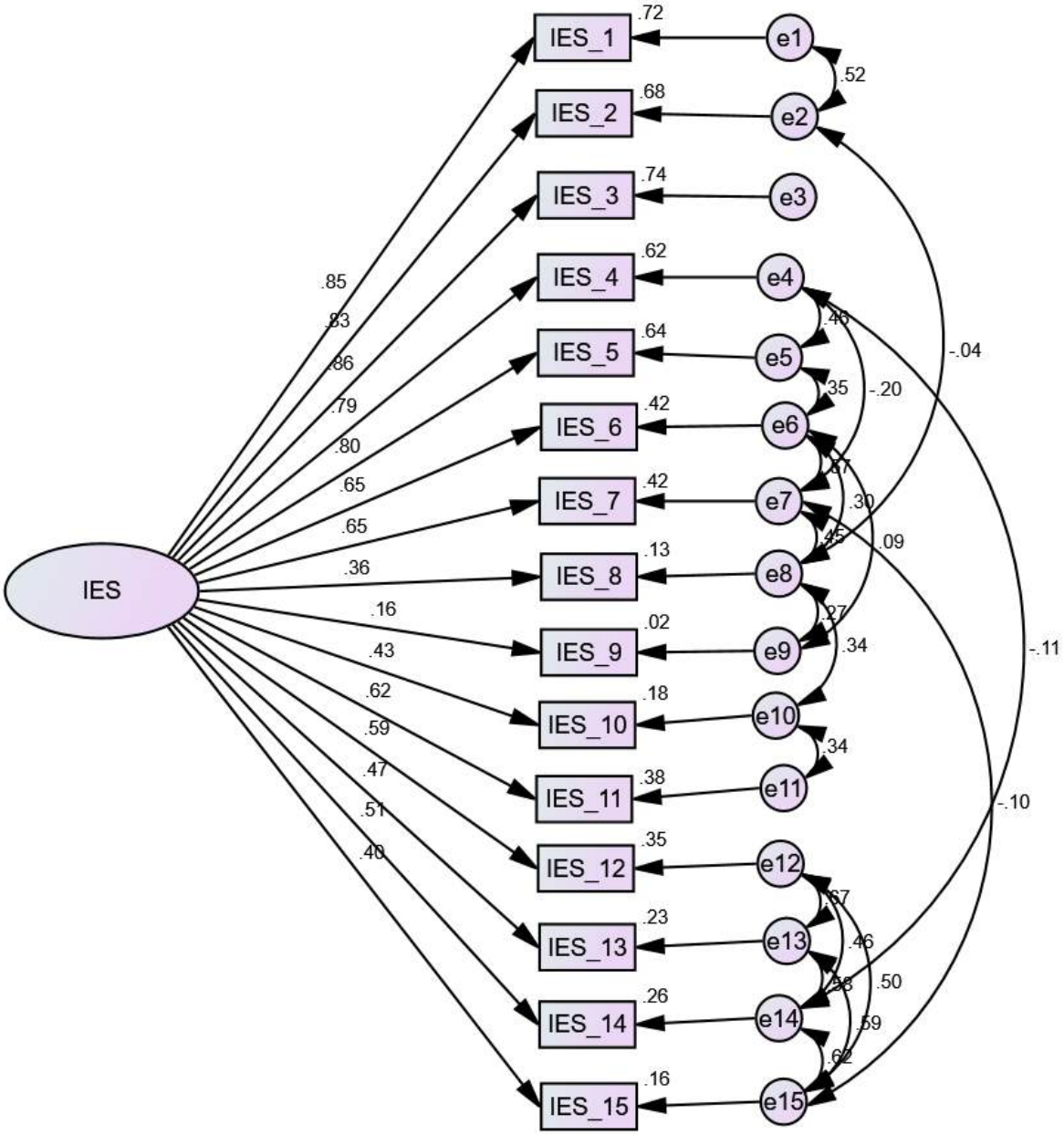


Table 14

Confirmatory Factor Analysis for Impact Event Scale (N = 501)

	χ2(df)	IFI	CFI	RMSEA
Model 1	2193.76(90)	.61	.61	.21
Model 2	315.62(70)	.95	.95	.06

Note. IFI = Incremental Fit Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

Table 14 shows values of indices which indicate that goodness of fit could not be achieved in the model 1 for Impact Event Scale. To achieve goodness of fit, modification was added by adding covariance between errors of the scale. Model 2, which is obtained after applying modification is relatively the good fit model with $\chi2(70) = 315.62$, IFI = .95, CFI = .95, and RMSEA = .06.

Figure 8. *Confirmatory Factor Analysis of Environment Reward Observation Scale*

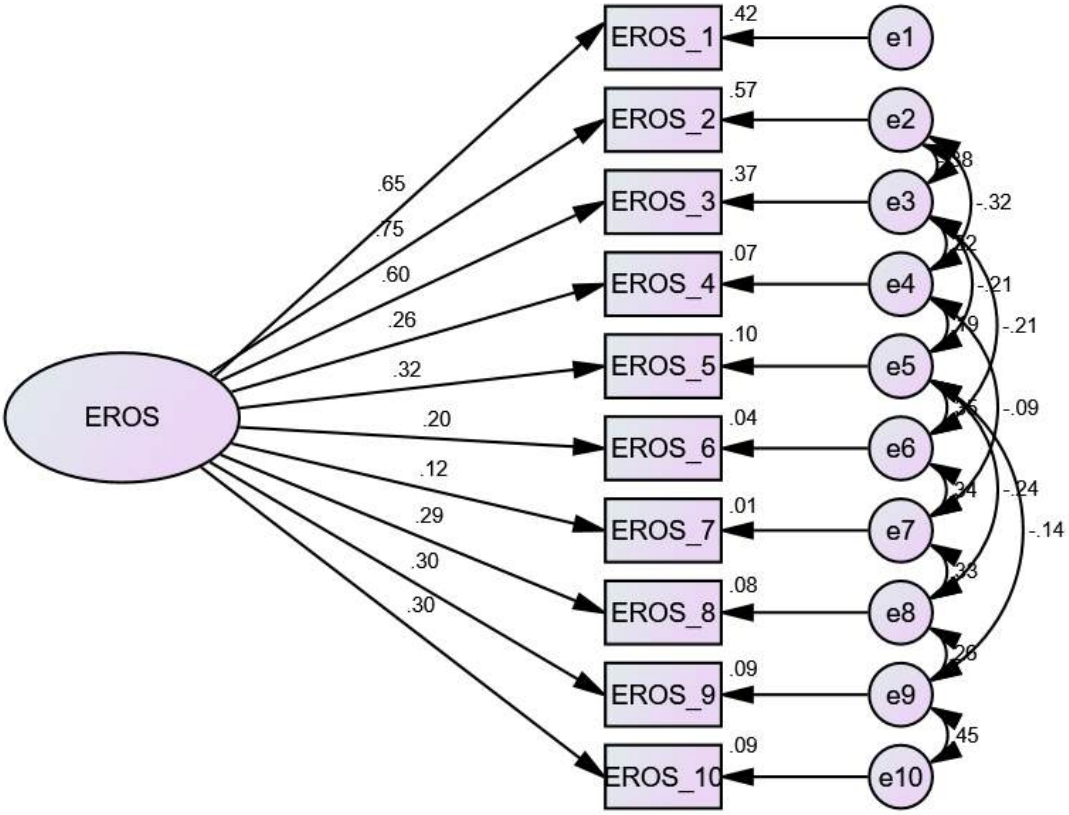


Table 15

Confirmatory Factor Analysis for Environment Reward Observation Scale (N = 501)

	χ2(df)	IFI	CFI	RMSEA
Model 1	594.83(35)	.43	.43	.17
Model 2	34.26(21)	.98	.98	.04

Note. IFI = Incremental Fit Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

Table 15 shows unacceptable fit of the model for the translated version of Environmental reward observation scale in the default model. In model 2 modification were added by adding covariance between errors of the scale. Model 2 is relatively adequate good fit model with value of, $\chi 2(21) = 34.26$, IFI = .98, CFI = .98, and RMSEA = .04.

Figure 9. *Confirmatory Factor Analysis of State Shame Scale*

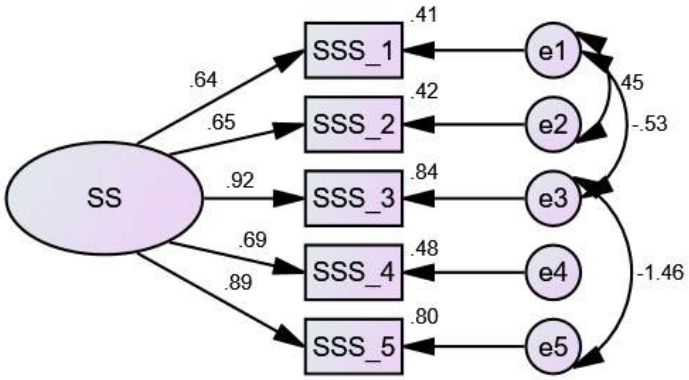


Table 16

Confirmatory Factor Analysis for State Shame Scale (N = 501)

	χ2(df)	IFI	CFI	RMSEA
Model 1	151.95(5)	.88	.88	.24
Model 2	31.05(3)	.99	.99	.04

Note. IFI = Incremental Fit Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

Table 16 presents the model fit indices for the Urdu translated version of state shame scale. Model 1 represent model fit indices which were lower than acceptable threshold. To obtain an acceptable model fit modification were applied, which included adding covariance between item number 1, 2,3 and 5. Model 2 with $\chi 2(3) = 31.05$, IFI = .99, CFI = .99, and RMSEA = .04 is relatively adequate fit model.

Figure 10. *Confirmatory Factor Analysis of Stigma Scale*

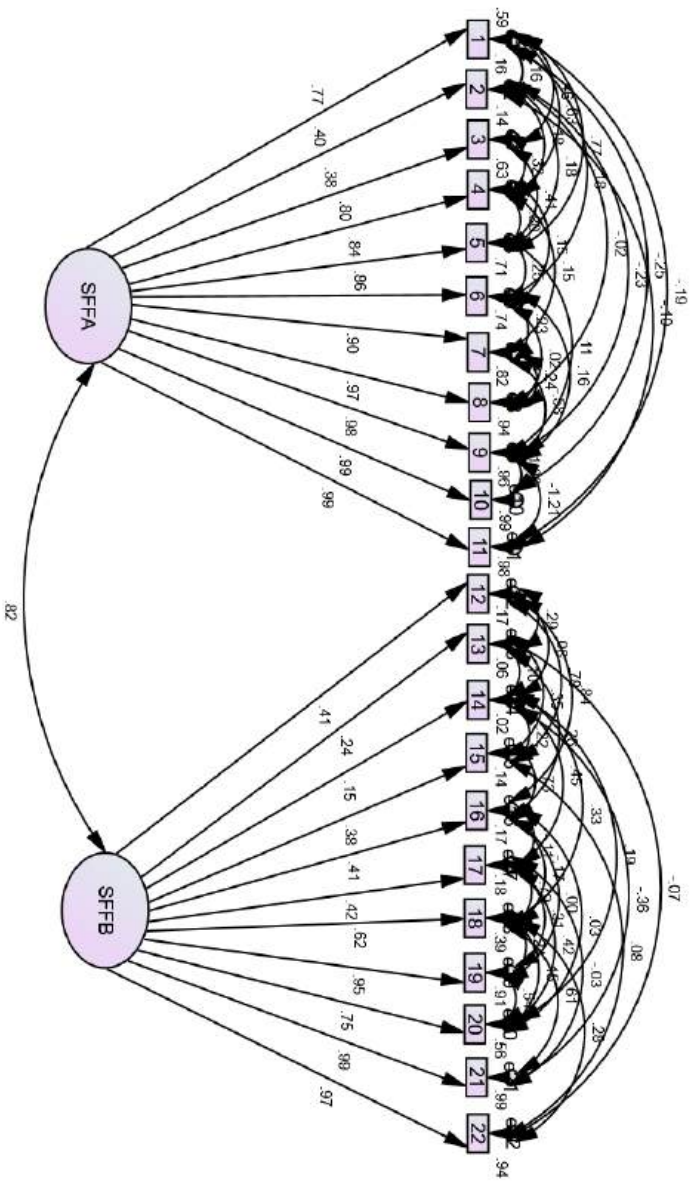


Table 17

Confirmatory Factor Analysis for Stigma Scale (N = 501)

	χ2(df)	IFI	CFI	RMSEA
Model 1	2868.96(205)	.71	.70	.16
Model 2	1532.74(196)	.90	.90	.08

Note. IFI = Incremental Fit Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

Table 17 present the model fit indices for the Urdu translated version of Stigma scale. Model 1 represent model fit indices which were lower than acceptable threshold. To obtain an acceptable model fit modifications were applied, which included by adding covariance between errors of the scale. Model 2 with $\chi 2(196) = 1532.74$, IFI = .90, CFI = .90, and RMSEA = .08 is relatively adequate fit model.

Figure 11. *Confirmatory Factor Analysis of Patient Health Questionnaire*

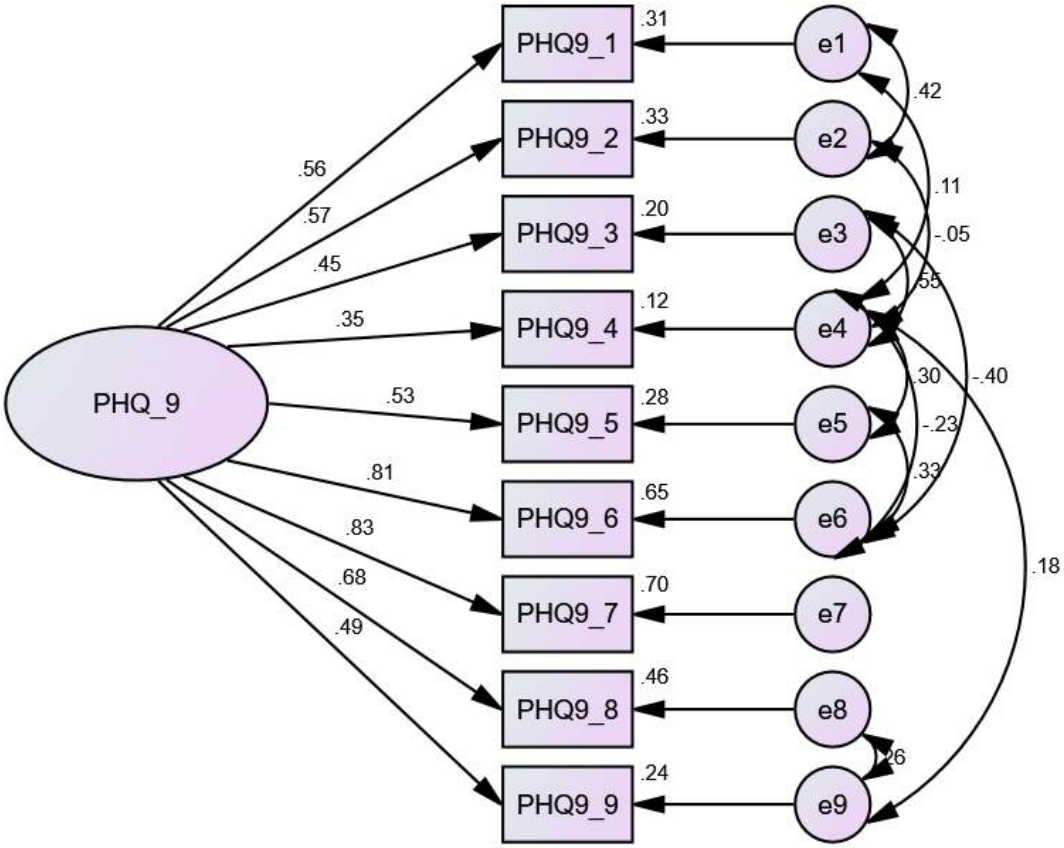


Table 18

Confirmatory Factor Analysis for Patient Health Questionnaire-9 (N = 501)

	χ2(df)	IFI	CFI	RMSEA
Model 1	693.54(27)	.67	.67	.22
Model 2	143.69(17)	.96	.96	.05

Note. IFI = Incremental Fit Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

Table 18 shows value of indices which indicate that goodness of fit could not be achieved in model for Patient Health Questionnaire. To achieve goodness of fit, modifications were added in model 2 by adding covariance between errors of the scale. Model 2, which is obtained after applying modification is relatively the good fit with $\chi 2(17) = 143.69$, IFI = .96, CFI = .96, and RMSEA = .05.

Figure 12. *Confirmatory Factor Analysis of Generalized Anxiety Disorder-7*

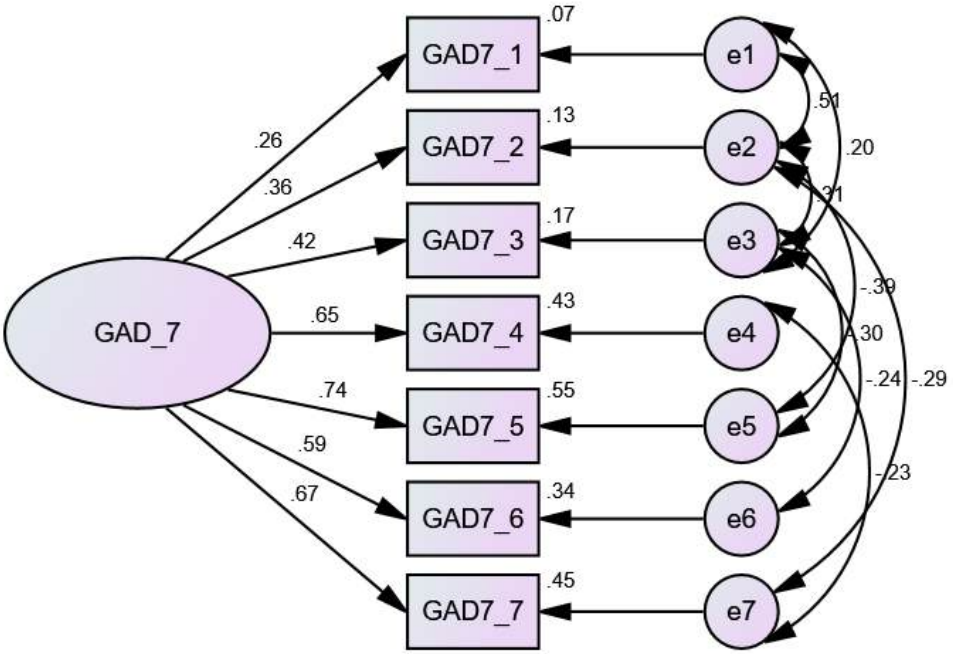


Table 19

Confirmatory Factor Analysis for Generalized Anxiety Disorder-7 (N = 501)

	χ2(df)	IFI	CFI	RMSEA
Model 1	508.67(14)	.50	.50	.26
Model 2	93.22(7)	.92	.92	.05

Note. IFI = Incremental Fit Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

Table 19 indicates model fit indices for Generalized anxiety disorder. Model fit indices were not satisfactory for the default model (model 1). To obtain a good model fit modification was applied, which included by adding covariance errors of the scale. Model 2, which is obtained after applying modification is the good model fit with $\chi 2(7) = 93.22$, IFI = .92, CFI = .92, and RMSEA = .05.

Table 20

Descriptive Statistics and Alpha Reliability Coefficients of the Study Variables (N = 501)

Variables	*Items*	*M*	*SD*	*A*	Score Range		Skewness	Kurtosis
					Actual	Potential		
Suicide Bereavement	17	38.19	8.5	.93	3-51	0-51	-0.89	0.31
PTG	10	16.56	6.49	.88	5-39	0-40	0.17	0.01
PTSD	15	38.83	16.92	.90	6-88	0-88	0.57	-0.56
Shame	5	12.52	3.84	.86	5-24	5-25	-0.13	-0.24
EROS	10	22.99	3.29	.66	13-36	10-40	-0.42	0.89
Stigma	22	36.76	8.27	.83	11-63	0-66	0.13	0.06
Depression	9	9.41	3.99	.85	3-27	0-30	0.88	1.28
Anxiety	7	8.52	2.84	.72	1-21	0-21	0.49	1.32

Note. PTG = Posttraumatic Growth; PTSD = Posttraumatic Stress Disorder; EROS = Environment Reward Observation Scale

Table 20 shows the mean, standard deviation, range of actual and potential scores, and alpha reliability coefficients of measures used in the main study. The skew values indicate the degree of symmetry in the data, and in the present study, they were found to be within an acceptable range (i.e. ± 1).

Table 21

Correlations of Bereavement, Post Traumatic Growth, Impact Event Scale, State Shame Scale, Environmental Reward Observation Scale, Societal Stigmatization, Patient Health Questionnaire, Generalized Anxiety Disorder (N = 501)

Sr.	Variables	1	2	3	4	5	6	7	8
1	Suicide Bereavement	–	-.47**	.24**	.24**	-.05	.13**	-.04	.09
2	PTG		–	.10*	.04	.32**	.09	.27**	.28**
3	PTSD			–	.23**	.29**	.39**	.36**	.32**
4	Shame				–	.15**	.13**	.25**	.32**
5	EROS					–	.21**	.14**	.08
6	Stigma						–	.12*	.16**
7	Depression							–	.59**
8	Anxiety								–

Note. PTG= Posttraumatic Growth; PTSD= Posttraumatic Stress Disorder; EROS= Environment Reward Observation Scale.

**$p < .01$, *$p < .05$

Table 21 shows the Pearson correlation among the study variables. Results indicated a significant negative correlation between bereavement and posttraumatic growth. Bereavement was also significantly positively correlated with PTSD, shame and stigma. Environmental reward was significantly positively correlated with post traumatic growth. Environmental reward was significantly positively correlated with stigma, depression, shame, and PTSD. Overall, the strength of correlation varies from low (.10) to moderate (.59).

Table 22

Mean Difference by Gender of Bereaved Parents and Siblings on Study Variables (N = 501)

	Male (n = 262)		Female (n = 239)				CI 95%		Cohen's
Variables	*M*	*SD*	*M*	*SD*	*t (499)*	*p*	*UL*	*LL*	*d*
Suicide Bereavement	37.63	8.16	38.79	8.74	-1.54	.12	-2.65	0.32	.13
PTG	17.09	6.19	15.97	6.76	1.92	.05	-0.02	2.25	.17
PTSD	35.98	15.13	41.94	18.21	-3.99	.00	-8.89	-3.03	.35
Shame	12.41	3.52	12.64	3.23	-0.75	.45	-0.82	0.37	.06
EROS	23.08	3.38	22.90	3.20	0.60	.55	-0.40	0.76	.05
Stigma	36.89	8.18	36.61	8.37	.38	.70	-1.17	1.73	.03
Depression	9.02	3.86	9.83	4.10	-2.27	.02	-1.50	-0.11	.20
Anxiety	8.66	2.82	8.37	2.87	1.13	.26	-0.21	0.79	.10

Note. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit; M = Mean; SD = Standard Deviation; PTG = Post traumatic growth; PTSD = Post Traumatic Stress Disorder; EROS=Environmental Reward Observation Scale

Table 22 shows that an independent samples t-test was conducted to examine mean differences based on gender of participants with respect to bereavement, post traumatic growth, post-traumatic stress disorder, shame, stigma, environmental reward, anxiety and depression. Result indicates that there are significant mean differences on PTSD and depression between men and women. Results show that there was a significant mean difference with respect to post-traumatic stress disorder ($t = 3.99$, $p < .001$). Women have higher scores on post-traumatic stress disorder in comparison to men. Result shows that women reported higher scores on depression than men.

Table 23

Mean Difference on Study Variables by Gender of Deceased (N = 501)

	Male (n = 239)		Female (n = 262)				CI 95%		Cohen's
Variables	*M*	*SD*	*M*	*SD*	*t (499)*	*p*	*UL*	*LL*	*d*
Suicide Bereavement	38.18	8.86	38.20	8.09	-0.03	.98	-1.51	1.46	.01
PTG	16.26	7.33	16.83	5.61	-0.98	.33	-1.71	0.57	.08
PTSD	39.55	16.57	38.17	17.24	0.91	.36	-1.59	4.35	.08
Shame	12.07	3.44	12.92	3.28	-2.84	.00	-1.44	-0.26	.25
EROS	22.87	3.64	23.10	2.95	-0.76	.45	-0.80	0.35	.06
Stigma	37.23	8.86	36.32	7.68	1.23	.22	-.54	2.36	.11
Depression	9.37	4.22	9.44	3.78	-0.21	.83	-0.78	0.63	.02
Anxiety	8.32	3.17	8.70	2.50	-1.48	.14	-0.88	0.12	.13

Note. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit; *M* = Mean; *SD* = Standard Deviation; PTG = Post Traumatic Growth; PTSD = Post Traumatic Stress Disorder; EROS=Environmental Reward Observation Scale

Group differences were also examined based on the gender of the deceased. Result shows that significant mean differences were found only for shame. Finding indicates that there was a significant mean difference between gender with respect to shame ($t = 2.84$, $p < .001$). Women have higher scores on shame as compared to men. It depicts that death of female (sister or daughter) lead to significantly more shame.

Table 2
Mean difference on study variables by family System (N = 501)

	Nuclear Family (n = 420)		Joint Family (n = 81)				CI 95%		Cohen's
Variables	*M*	*SD*	*M*	*SD*	*t (499)*	*P*	*UL*	*LL*	*d*
Suicide Bereavement	37.90	8.20	39.69	9.57	-1.75	.12	-3.81	0.22	.15
PTG	16.36	6.67	17.59	5.37	-1.57	.06	-2.78	0.31	.14
PTSD	37.22	15.95	47.14	19.32	-4.94	.00	-13.85	-5.97	.44
Shame	12.40	3.42	13.12	3.12	-1.77	.45	-1.53	0.08	.15
EROS	22.84	3.49	23.79	1.75	-2.39	.55	-1.73	-0.17	.21
Stigma	36.61	8.40	37.53	7.57	-.92	.36	-2.89	1.05	.08
Depression	8.72	3.66	12.95	3.79	-9.47	.02	-5.10	-3.35	.84
Anxiety	8.19	2.72	10.22	2.89	-6.09	.26	-2.69	-1.38	.54

Note. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit; M = Mean; SD = Standard Deviation; PTG = Post Traumatic Growth; PTSD = Post Traumatic Stress Disorder; EROS = Environmental Reward Observation Scale.

As shown in above table that independent sample t-test was conducted to explore group differences on study variables based on family of the participants. Results indicated that no significant differences were found on study variables except PTSD and depression. There was significant mean difference between family system with respect to post-traumatic stress disorder (t = -4.94, p <.001). Results show that participants living in joint family have higher scores on post-traumatic stress disorder in comparison to participants living in nuclear family system. Participants from Joint family system also reported higher scores on depression than those living

in nuclear family system. It depicts that those who live in joint family system experience greater post-traumatic stress disorder and depression as compared to nuclear family system.

Table 25

Difference across Relationship Status In Relation To Study Variables (N = 501)

Variables	Father (*n*= 164) M(SD)	Mother (*n*= 123) *M(SD)*	Sister (*n*= 103) *M(SD)*	Brother (*n*= 111) *M(SD)*	*F*	SE	CI 95% LL	CI 95% UL	η
Suicide Bereavement	41.91(5.49)	42.95(6.07)	33.41(8.39)	31.82(8.13)	82.69***	0.43	41.07	42.76	1.84
						0.55	41.87	44.03	
						0.83	31.78	35.06	
Posttraumatic Growth	15.99(5.87)	14.45(6.12)	17.82(7.44)	18.54(6.03)	10.07***	0.77	30.3	33.36	0.69
						0.46	15.09	16.9	
						0.55	13.35	15.54	
						0.73	16.37	19.28	
Posttraumatic Stress Disorder	39.88(17.51)	49.07(16.90)	32.15(13.97)	32.09(11.94)	31.24***	0.57	17.42	19.68	1.74
						1.37	37.18	42.58	
						1.52	46.06	52.09	
						1.38	29.42	34.89	

						1.13	29.85	34.34	
						0.29	12.51	13.64	
						0.25	13.37	14.35	
Shame	13.07(3.67)	13.86(2.73)	11.10(3.27)	11.51(2.91)	19.02***	0.32	10.47	11.75	0.61
						0.28	10.97	12.06	
						0.25	22.62	23.59	
						0.23	22.94	23.86	
Environment Reward	23.10(3.17)	23.39(2.59)	22.49(4.03)	22.83(3.38)	1.55	0.4	21.71	23.28	0.20
						0.32	22.2	23.47	
						.40	39.91	41.49	
						.39	40.54	42.09	
Stigma	40.70(5.12)	41.32(4.32)	30.88(8.96)	31.33(8.27)	88.65***	.88	29.13	32.64	0.35
						.78	29.78	32.89	
						0.33	8.34	9.63	
Depression	8.98(4.19)	10.29(4.18)	9.07(3.82)	9.35(3.48)	2.89*	0.38	9.55	11.04	0.27
						0.38	8.33	9.83	

						0.33	8.7	10.01	
Anxiety	8.95(2.83)	8.85(2.85)	7.58(2.70)	8.36(2.78)	5.85**	0.22	8.52	9.39	0.31
						0.26	8.34	9.36	
						0.27	7.05	8.11	
						0.26	7.85	8.89	

Note. CI = Confidence Interval; LL = lower Limit; UL = Upper Limit; M = Mean; SD = Standard Deviation; PTG = Post Traumatic Growth; PTSD= Post Traumatic Stress Disorder; EROS=Environmental Reward Observation Scale

In Table 25 One-way analysis of variance (ANOVA) was carried out to examine the mean differences on study variables with reference to status of relationship among 2 distinct categories parents (Father and Mother) and siblings (sister and brother). Results showed that the bereavement was higher in mother as compared to fathers, brothers, and sisters. Posttraumatic growth was higher in siblings (both brother and sister). Posttraumatic Stress Disorder was higher in parents as compared to siblings. The factor of shame was also higher in the parents. Stigma have higher values were higher in parents. Depression was higher in father and overall score predict the high level of depression in parents. Anxiety level was also higher in the parents as compared to siblings.

Table 26

Post-Hoc Analysis on Study Variables by Relationship Status (N= 501)

Dependent Variable			Mean Difference (I-J)	SE	*p*	95% Confidence Interval	
						LL	UL
Suicide Bereavement	Father	Sister	8.49*	0.87	0.00	6.25	10.74
		Brother	10.08*	0.85	0.00	7.89	12.28
	Mother	Sister	9.5*	0.93	0.00	7.15	11.92
		Brother	11.12*	0.91	0.00	8.79	13.46
	Sister	Father	-8.49*	0.87	0.00	-10.74	-6.25
		Mother	-9.53*	0.93	0.00	-11.92	-7.15
	Brother	Father	-10.08*	0.85	0.00	-12.28	-7.89
		Mother	-11.12*	0.91	0.00	-13.46	-8.79
Posttraumatic Growth Disorder	Father	Brother	-2.55*	0.78	0.01	-4.56	-0.55
	Mother	Sister	-3.37*	0.84	0.00	-5.55	-1.20
		Brother	-4.10*	0.83	0.00	-6.23	-1.97
	Sister	Mother	3.37*	0.84	0.00	1.20	5.55
	Brother	Father	2.55*	0.78	0.01	0.55	4.56
		Mother	4.10*	0.83	0.00	1.97	6.23
Posttraumatic Stress Disorder	Father	Mother	-9.18*	1.86	0.00	-13.97	-4.40
		Sister	7.72*	1.96	0.00	2.68	12.77
		Brother	7.78*	1.91	0.00	2.85	12.72
	Mother	Father	9.18*	1.86	0.00	4.40	13.97
		Sister	16.91*	2.08	0.00	11.56	22.28
		Brother	16.97*	2.04	0.00	11.72	22.23
	Sister	Father	-7.72*	1.96	0.00	-12.77	-2.68
		Mother	-16.91*	2.08	0.00	-22.28	-11.56
	Brother	Father	-7.78*	1.91	0.00	-12.72	-2.85

		Mother	-16.97*	2.04	0.00	-22.23	-11.72
	Father	Sister	1.96*	0.40	0.00	0.92	3.01
		Brother	1.55*	0.40	0.00	0.54	2.58
	Mother	Sister	2.75*	0.43	0.00	1.65	3.86
		Brother	2.34*	0.42	0.00	1.26	3.43
Shame	Sister	Father	-1.96*	0.40	0.00	-3.01	-0.92
		Mother	-2.75*	0.43	0.00	-3.86	-1.65
	Brother	Father	-1.55*	0.40	0.00	-2.58	-0.54
		Mother	-2.348*	0.42	0.00	-3.43	-1.26
	Father	Sister	-.616	.799	.868	-2.67	1.44
		Brother	9.818	.842	.000	7.65	11.99
	Mother	Sister	9.368	.823	.000	7.25	11.49
		Brother	.616	.799	.868	-1.44	2.67
Stigma	Sister	Father	10.434	.894	.000	8.13	12.74
		Mother	9.984	.877	.000	7.72	12.24
	Brother	Father	-9.818	.842	.000	-11.99	-7.65
		Mother	-10.434	.894	.000	-12.74	-8.13
	Father	Mother	-1.30*	0.47	0.03	-2.53	-0.08
Depression	Mother	Father	1.30*	0.47	0.03	0.08	2.53
	Father	Sister	1.37*	0.35	0.00	0.47	2.28
Anxiety	Mother	Sister	1.27*	0.37	0.00	0.31	2.24
	Sister	Father	-1.37*	0.35	0.00	-2.28	-0.47

In Table 26 Post-hoc Tukey test shows that relationship with deceased is a significant factor for bereavement, posttraumatic growth, posttraumatic stress disorder, shame, stigma, depression, and anxiety.

Table 27

Difference across Duration of Bereavement in Relation to Study Variables (N = 501)

Scale	1st Year (*n*= 117) *M(SD)*	2nd Year (*n*= 273) *M(SD)*	2-5 Year (*n*= 111) *M(SD)*	*F*	SE	CI 95% LL	CI 95% UL	η
Suicide Bereavement	39.60(7.81)	38.55(7.82)	35.79(10.06)	6.49***	0.72	38.18	41.04	0.46
					0.47	37.62	39.48	
					0.95	33.9	37.68	
Posttraumatic Growth	16.14(6.38)	15.66(6.35)	19.18(6.26)	12.52***	0.59	14.98	17.31	0.56
					0.38	14.91	16.42	
					0.59	18.01	20.37	
Posttraumatic Stress Disorder	44.76(19.37)	35.57(15.33)	40.57(16.05)	13.48***	1.79	41.21	48.31	0.93
					0.93	33.74	37.4	
					1.52	37.56	43.6	
Shame	12.69(3.43)	12.51(3.41)	12.33(3.28)	0.32	0.32	12.06	13.32	0.07
					0.21	12.11	12.92	
					0.31	11.72	12.95	

					0.32	22.06	23.31	
Environment Reward	22.68(3.41)	22.58(3.30)	24.30(2.80)	11.88***	0.2	22.2	22.98	0.40
					0.27	23.78	24.83	
					.739	35.39	38.32	
Stigma	36.85(7.99)	35.43(7.55)	39.92(9.38)	12.14***	.457	34.53	36.33	0.05
					.891	38.15	41.68	
					0.39	9.16	10.71	
Depression	9.93(4.22)	9.05(4.00)	9.71(3.54)	2.39	0.24	8.58	9.54	0.20
					0.35	9.03	10.4	
					0.28	8.69	9.79	
Anxiety	9.23(2.99)	8.23(2.82)	8.45(2.65)	5.22**	0.17	7.9	8.57	0.24
					0.25	7.96	8.96	

Note. CI=confidence Interval; LL= lower Limit; UL-=Upper Limit; M=Mean; SD= Standard Deviation; PTG=Post traumatic growth; PTSD= Post traumatic stress disorder; EROS=Environmental reward observation scale; ***p value <.001

Table 27 displays One-way analysis of variance (ANOVA) which was carried out to examine the mean differences based on the duration of bereavement into three categories (first year, second year and two to five years) on the bereavement, post traumatic growth, environmental reward, post-traumatic stress disorder, shame, stigma, anxiety and depression. It was found that level of bereavement was higher in the first year as compared to participants experienced two and more than two years. Post traumatic growth score was higher in the individuals who have experienced bereavement more than two years. Post-traumatic stress disorder was higher in the first year of bereavement. Environmental reward was also higher in the participants experiencing bereavement more than two years. Participants experienced bereavement since more than two years shown higher score on stigma. It was also shown that anxiety and depression level was also higher in the participant's experience bereavement in first years. It shows that those bereaved parents and siblings who were in first year have experienced more intense bereavement, PTSD, anxiety, depression, shame and those who have experienced it more than 2 years they were high on environmental reward and post traumatic growth and stigma.

Table 28

Post-hoc Analysis on study variables by duration of bereavement (N= 501)

Duration of Bereavement			Mean Difference (I-J)	*CI 95%*	
				LL	UL
Suicide Bereavement	1 Year	2-5 years	3.8*	1.21	6.42
	2 Year	2-5 years	2.76*	.55	4.97
	2-5 years	1 Year	-3.81*	-6.42	-1.21
		2 Year	-2.76*	-4.97	-.55
Posttraumatic Growth	1 Year	2-5 years	-3.04*	-5.02	-1.07
	2 Year	2-5 years	-3.52*	-5.20	-1.85
	2-5 years	1 Year	3.04*	1.07	5.02
		2 Year	3.52*	1.85	5.20
Posttraumatic Stress Disorder	1 Year	2 Year	9.18*	4.90	13.48
	2 Year	1 Year	-9.18*	-13.48	-4.90
		2-5 years	-5.00*	-9.37	-.64
	2-5 Years	2 Year	5.00*	.64	9.37
Shame	1 Year	2-5 years	-1.62*	-2.63	-.62
	2 Year	2-5 years	-1.71*	-2.57	-.86

	2-5 years	1 Year	1.62*	.62	2.63
		2 Year	1.71*	.86	2.57
Stigma	1 Year	2-5 years	-3.06*	-5.59	-.54
	2 Year	2-5 years	-4.48*	-6.63	-2.34
	2-5 years	1 Year	3.06*	.54	5.59
		2 Year	4.48*	2.34	6.63
Anxiety	1 Year	2 Year	1.00*	.27	1.74
	2 Year	1 Year	-1.00*	-1.74	-.27

In Table 28 Post-hoc Tukey test shows that duration of bereavement is a significant factor for bereavement, posttraumatic growth, posttraumatic stress disorder, shame, stigma, and anxiety.

Table 29

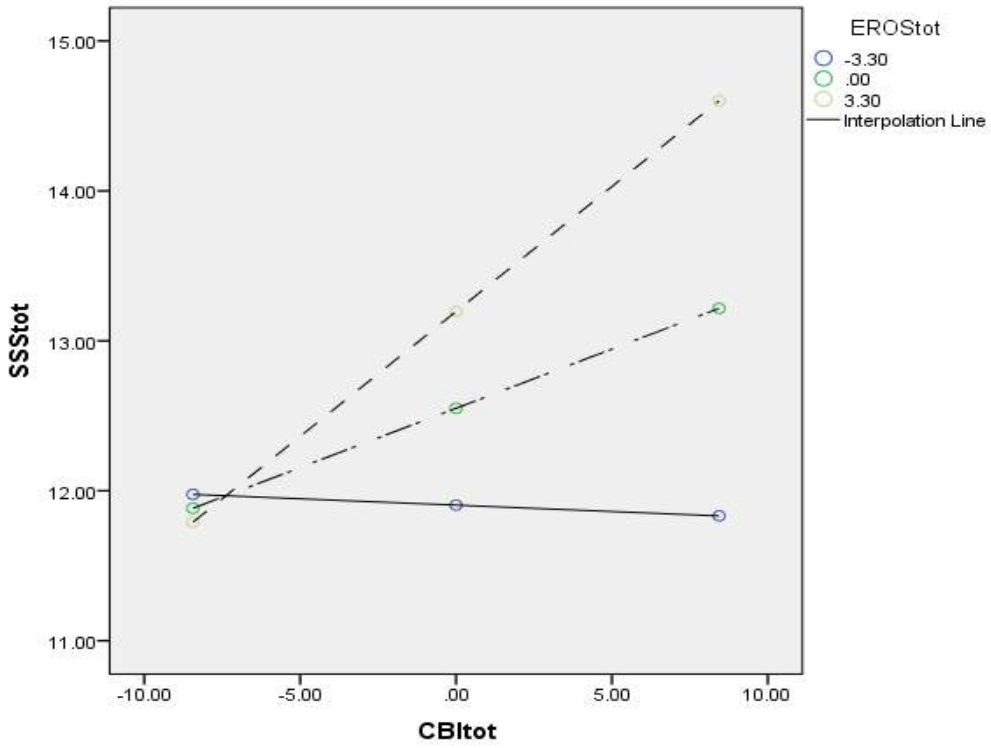
Moderating Role of Environmental Reward between Bereavement and Shame (N = 501)

					95% BC CI	
Model	B	SE	*T*	*p*	*LL*	*UL*
Constant	12.55	.14	88.13	.000	12.27	12.83
Suicide Bereavement	.07	.02	4.57	.000	,045	.113
Environmental Reward	.19	.04	4.47	.000	.109	.281
Bereavement x Environmental Reward	.03	.01	4.94	.000	.016	.037

Note. N = 501, B=unstandardized error, R^2 = .12, F = 23.29, BC = Biased-Corrected, CI = Confidence Interval.

A moderation test was conducted with suicide bereavement as the predictor, shame as the dependent variable, and environmental reward as the moderator. There was significant main effect found between suicide bereavement and shame, B = .07, B_{ca} CI [.045, .113], t = 4.57, p = .000. In addition, it was found significant main effect of environmental reward on shame, B = .19, B_{ca} CI [.109, .281], t = 4.47, p = .000. There was a significant interaction effect of environmental reward and suicide bereavement on shame, B = .03, B_{ca} CI [.016, .037], t = 4.94, p = .000.

Figure 13. *Interaction Environmental Reward and Bereavement on Shame*



It was found that participants who reported higher than average levels of environmental reward experienced a greater effect of suicide bereavement on shame, B = .166, B_{ca} CI [.123, .209], t = 7.59, p = .000 as compared to average, B = .08, B_{ca} CI [.045, .113], t = 4.57, p = .000 or lower than average levels, B = -.01, B_{ca} CI [-.06, .045], t = -.31, p = .753 of environmental rewards. Present study concluded that the effect of suicide bereavement on shame moderated by environmental reward.

Table 30

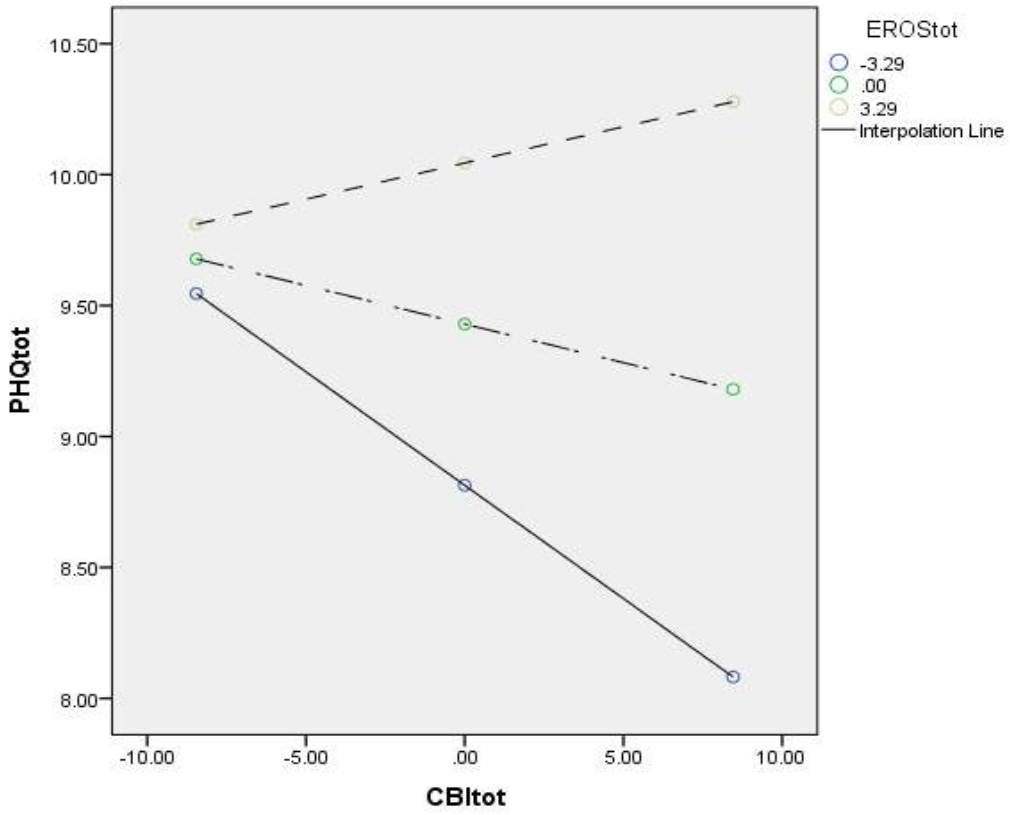
Moderating Role of Environmental Reward between Bereavement and Depression (N = 501)

					95% BC CI	
Model	B	SE	*t*	*p*	*LL*	*UL*
Constant	9.42	.17	53.55	.000	9.08	9.77
Suicide Bereavement	-.03	.02	-1.38	.168	-.071	.012
Environmental Reward	.19	.05	3.45	.001	.080	.293
Bereavement x Environmental Reward	.02	.01	2.61	.001	.004	.030

Note. $N = 501$. $R^2 = .04$, $F = 5.77$, BC = Biased-Corrected, CI = Confidence Interval.

A moderation test was conducted to examine the relationship between suicide bereavement and depression, with environmental reward serving as the moderator. The analysis revealed no significant main effect of suicide bereavement on depression, B = -.03, B_{ca} CI [-.071, .012], $t = -1.38$, $p = .168$. However, a significant main effect of environmental reward on depression was found, B = .19, B_{ca} CI [.080, .293], $t = 3.45$, $p < .01$. There was a significant interaction effect between environmental reward and suicide bereavement on depression, B = .02, B_{ca} CI [.004, .030], $t = 4.06$, $p < .01$.

Figure 14. *Interaction Environmental Reward and Bereavement on Depression.*



It was found that participants who reported lower than average levels of environmental reward experienced a greater effect of suicide bereavement on depression, B = -.09, B_{ca} CI [-.15, -.02], t = -2.57, p = .011 as compared to average, B = -.03, B_{ca} CI [-.07, .013], t = -1.38, p = .168 or higher than average levels, B = .03, B_{ca} CI [-.03, .081], t = 1.03, p = .308 of environmental rewards. Present study concluded that the effect of suicide bereavement on depression moderated by environmental reward.

Table 31

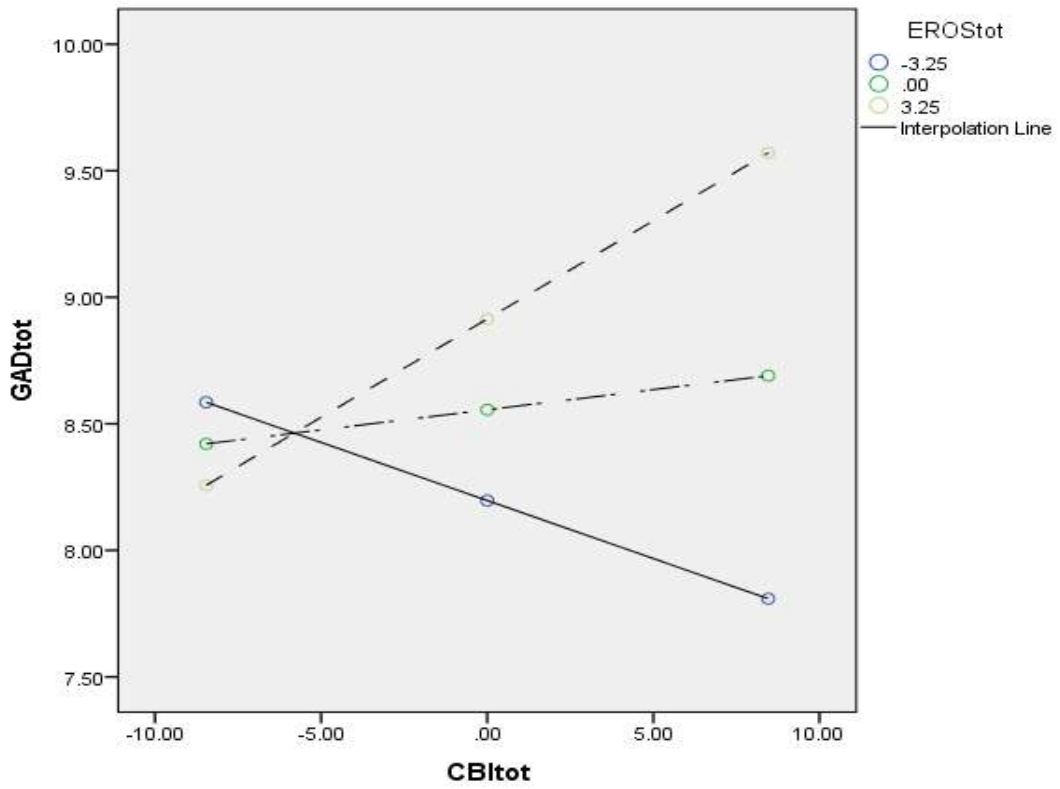
Moderating Role of Environmental Reward between Bereavement and Anxiety (501)

					95% BC CI	
Model	B	*SE*	*t*	*P*	*LL*	*UL*
Constant	8.54	.12	69.1	.000	8.29	8.78
Suicide Bereavement	.02	.01	1.05	.280	-.013	.046
Environmental Reward	.10	.03	2.86	.015	.018	.168
Bereavement x Environmental Reward	.02	.01	4.06	.000	.010	.029

Note. $N = 501$. $R^2 = .05$, $F = 8.46$, BC = Biased-Corrected, CI = Confidence Interval.

A moderation test was conducted with suicide bereavement as the predictor, anxiety as the dependent variable, and environmental reward as the moderator. There was a significant main effect found between suicide bereavement and anxiety, B = .02, B_{ca} CI [-.013, .046], $t = 1.05$, $p < .001$, and significant main effect of environmental reward on anxiety, B = .10, B_{ca} CI [.018, .168], $t = 2.86$, $p < .01$. There was a significant interaction effect of environmental reward and suicide bereavement on anxiety, B = .02, B_{ca} CI [.010, .029], $t = 4.06$, $p < .001$.

Figure 15. *Interaction Effect of Environmental Reward and Bereavement on Anxiety*



It was found that participants who reported higher than average levels of environmental reward experienced a greater effect of bereavement on anxiety, B = .08, B_{ca} CI [.045, .120], $t = 4.30$, $p < .001$ as compared to average, B = .02, B_{ca} CI [-.01, .046], $t = 1.09$, $p = .274$ or lower than average levels, B = -.05, B_{ca} CI [-.09, -.001], $t = -2.08$, $p = .038$ of environmental rewards. Present study concluded that the effect of bereavement on anxiety moderated by environmental reward.

Summary of the Results

Hypotheses	**Accepted/ Not Accepted**
H1:a Suicide bereavement is positively associated with PTSD.	Accepted
H1:b Suicide bereavement is positively associated with Depression.	Rejected
H1:c Suicide bereavement is positively associated with Anxiety.	Rejected
H1: d Suicide bereavement is negatively associated with post traumatic growth.	Accepted
H2:a Suicide bereavement is positively associated with stigma.	Accepted
H2:b Suicide bereavement is positively associated with shame.	Accepted
H3: a Environmental rewards moderate the relationship between suicide bereavement and depression.	Accepted
H3:b Environmental rewards moderate the relationship between suicide bereavement and anxiety.	Accepted
H3:c Environmental rewards moderate the relationship between suicide bereavement and PTSD.	Rejected
H3: d Environmental rewards moderate the relationship between suicide bereavement and Post traumatic growth.	Rejected
H4: a Environmental rewards moderate the relationship between suicide bereavement and stigma.	Rejected
H4: b Environmental rewards moderate the relationship between suicide bereavement and shame.	Accepted
H5: a Parents are high on depression as compared to siblings.	Accepted
H5: b Parents are high on anxiety as compared to siblings.	Accepted

H5:c Parents are high on PTSD as compared to siblings.	Accepted
H5:d Siblings are high on post traumatic growth as compared to parents.	Accepted
H5:e Parents are high on stigma as compared to siblings.	Accepted
H5:f Parents are high on shame as compared to siblings.	Accepted
H6:d Duration of bereavement is positively associated with Post traumatic growth.	Accepted

Chapter V

DISCUSSION

The objective of the present study was to explore the experiences of suicide bereaved family members. The study examined the psychological and social outcomes associated with suicide bereavement. It also investigated the moderating role of environmental reward in these relationships. Moreover, the study investigated the group differences and duration of bereavement on outcome variables between parents and siblings. The study investigated the group differences and duration of bereavement on outcome variables between parents and siblings.

Two studies with independent sample were conducted i-e study-1 and study-II. The purpose of study-1 was to explore the experiences of bereaved family members and it helped to confirm and strengthen the identified outcome variables of the suicide bereavement and to integrate this information in translation and adaptation process of the instruments and to address the psychometric properties that was to be used in the main study. The study-II (main study) was to investigate the relation of suicide bereavement with psychological and social outcomes and to examine the moderating role of environmental rewards between suicide bereavement and social and psychological outcomes using a purposive convenience and snowball sampling technique.

Due to several demographic reasons, accessing the bereaved families was a significant challenge. For instance, the prominent reasons include (a) conservative cultural customs regarding accessing and interacting with bereaved individuals in general, and bereaved women in particular, and (b) the painful nature of the bereavement phenomenon.

The first hypothesis predicted that suicide bereavement is positively associated with Post traumatic stress disorder. The results concluded that there is a significant relationship among these variables and finding were consistent with previous literature that suicide bereaved experience a greater risk of developing post-traumatic stress disorder due to experience of a major life crisis, (Mitchell & Terhorst, 2017; Wagner et al., 2021). Although bereavement is not typically considered a stressor leading to post traumatic stress disorder, if the bereavement is linked to sudden and unexpected death, as is often the case with suicide, it may lead to the development of post-traumatic stress disorder symptoms.

A similar finding stated that post-traumatic stress disorder is positively related to and higher among suicide bereaved compared to natural death (Ilanit, 2012). Individuals who experience suicide loss may exhibit signs of post-traumatic stress disorder. A suffering person is likely to experience nightmares or flashbacks if they have witnessed the death incident or funeral of their loved one. These symptoms can still appear even if the person has not witnessed the death incident. There is a likelihood that the individual cannot stop thinking about what happened, and their imagination might be worse than reality. Mitchell and Terhorst (2017) found a similar relationship, showing suicide bereavement to be linked to worse mental health quality of life, complex grieving processes, and the potential for post traumatic stress disorder symptoms to emerge.

Several studies have found significant positive relationship between bereavement and post-traumatic stress disorder. Post-traumatic stress disorder signs and symptoms may be exacerbated by grief, especially in the wake of sudden deaths like suicides. In contrast to other forms of bereavement, people who experienced the suicidal death of their loved ones exhibit significant post-traumatic stress disorder symptoms (Kristensen et al., 2012). The relationship

is supported by the sadness, violence, and stigma associated to suicide, all of which have the potential to worsen stress reactions.

The second hypothesis anticipated that suicide bereavement is positively associated with depression. Findings revealed that suicide bereavement is non-significantly correlated with depression. Suicide bereavement has often been linked to the development of other adverse mental health outcomes and emotional disorders such as anxiety and depression (Grafiadeli et al., 2022; Mitchell et al., 2009; Groot et al., 2006; Bolton et al., 2013). In a systematic review of bereaved adults in which 23 studies meet the inclusion criteria, it was found that 63% of the adults experiencing prolonged grief disorder were also suffering from depression and anxiety, respectively (Komischke-Konnerup et al., 2021). It has been noted that psychopathology and sociodemographic variables play a significant role in determining the health risks for suicide bereaved, with an elevated risk for mental symptoms and disorders for depression and anxiety were evident (Erlangsen et al., 2017).

The study concluded a non-significant relationship between suicide bereaved and anxiety or depression. Studies have shown that factors like a sense of belongingness, social support, and self-disclosure lead to individuals being less vulnerable to depression and interpersonal and social factors that might act as buffers for the onset of depressive and anxious disorders. (Levi-Belz & Birnbaum, 2022). Shame and stigma associated with suicide loss often undermine these buffering factors, especially when considering the increased stigma perceived by family and friends (Pitman et al., 2016). The impact might negatively affect help-seeking behavior, the reception of social support, a sense of belongingness, and self-disclosure. Study explored the long-term relationship between suicide bereaved and the onset of depression, noting that the risk decreases over time (de Groot & Kollen, 2013). Therefore, the finding was

supported as the sample consists of individuals from suicide-bereaved families who have been suffering for 6 months to 5 years' post-suicide. Due to the increased time lapse, the onset of depression decreased among the participants.

Research finding showed that those individuals who possess inherent resilience can recover from traumatic events easily and these traumatic events may include suicide bereavement. This resilience in individuals can results in decrease in the depressive symptoms over time and allow the individuals to cope with the traumatic events (Bonano et al., 2005). Those suicide bereaved individuals involved in meaning making and looking for the personal growth after traumatic event or a loss can contribute to the lower level of depressive symptoms (Feigelman & Jordan, 2009).

Past findings depicts that, the presence of the protective factors or the strong social support system can buffer the negative effects of suicide bereavement leading to reduction in depression. Bereaved individuals who receive practical and emotional support can better able to cope with the grief. Studies reveal that participation in support groups and community outreach can mitigate emotions of loneliness and depression among individuals bereaved by suicide (Ross et al., 2021).

If the deceased had long-term mental health problems, some people might feel relieved and accepted. This perceived relief can contribute to the decrease in depressive symptoms over time. Acceptance and understanding of the deceased struggle can lead to reduction in guilt and depression among suicide bereaved individuals (Kostromin, 2021).

Earlier study find that longitudinal studies shows that depressive symptoms may reduce over time as individuals adapt to their loss. If the bereaved individual gradually adjusts to find the new meaning in life, the level of depression would be diminished. This research provides

evidence that over the time the associated depressive symptoms and the intensity of grief can lessen and decreased as suicide bereaved individuals involves in adaptive coping strategies (Mathieu et al., 2022). Earlier study found that some may come to accept the inevitability of death and loss as a part of life which results in the decrease in depression symptoms as they reconcile with the reality of their situation (Gaffney & Hannignan, 2010).

Post traumatic growth refers to the positive psychological changes experienced as a result of struggling with highly challenging life circumstances. Some individuals may find new strengths, deeper relationships and the greater appreciation for life following the trauma of suicide bereavement, which results in the reduced depression. Another research suggests that many individuals may turn to existential beliefs or spiritual beliefs to cope with the loss of the loved one to suicide. So finding solace in spiritual and religious beliefs and provide comfort in suicide bereaved individuals and reduced depression (Krysinska et al., 2014). According to (Bushan et al., 2011) some therapeutic interventions like complicated grief therapy and cognitive behavioral therapy can effectively work on reducing the depressive symptoms in those experience complicated grief including suicide bereavement (Mathieu et al., 2022). Research indicates that cognitive reappraisal is an emotion regulation strategy where individuals change their perspectives on a distressing situation. Those suicide bereaved individuals who can successfully reframe their loss in a way that alleviates guilt or finds positive aspects that may experience less depression (Bushan et al., 2011).

Several clinical traits of suicidal bereavement are similar to anxiety and depression (Boelen, 2013). Anxiety, sadness, and symptoms of post-traumatic stress disorder are more common in suicide-bereaved individuals compared to those who died by other means. Approximately 30.5% of family members who experienced a loss had higher rates of

depression than those who had not. Suicidal thoughts and attempts are also linked to suicidal bereavement (Bolton et al., 2013).

The third hypothesis assumed that suicide bereavement is positively associated with anxiety, was not supported by the data. There is a non-significant relation of anxiety with bereavement. Therefore, the explanation extends to the intervention of several factors, such as social support, coping strategies, or the amount of time since the loss, can moderate these emotional reactions (Kaplow et al., 2010). There are numerous variations in the psychological consequences of bereavement; some people feel resilience, while others suffer from despair or anxiety.

According to Jacobson et al., (2017) strong social support can act as an effective factor for the reduction in anxiety. The suicide bereaved individuals who have strong social support system from their family, friends of community can better able to cope with this bereavement and that results in the reduction of anxiety (Jacobson et al., 2017). Findings indicate that effective coping strategies includes emotion regulation, problem solving and positive reframing used by suicide bereavement individuals can help to reduce anxiety symptoms. The suicide bereaved individuals involved in these strategies can better able to cope with their grief which results in decrease in the anxiety symptoms (Storebe et al., 2005). Study found that the continuous access to the mental health services of suicide bereavement is very important. Those suicide bereaved individuals involved in the mental health services regularly at the time of their grief can better able to cope with their trauma results in anxiety reduction (Andreissen et al., 2019).

Similarly, by a longitudinal research finding observed that the suicide bereaved individuals may cope and adapt to their environment over time. In this way, they accept the reality which results in the reduction in anxiety symptoms and leads to acceptance and peace in the suicide bereaved individuals. Individuals suffering from trauma can find the realities and new meanings in life over the time and from time to time they can adapt to the realities and emotional stressors which lead to the reduction in anxiety among suicide bereaved individuals (Kolves et al., 2020). Another research reported that those individuals who have resilience are able to cope with their grief over the time. They are resilient towards their loss and can deal with it effectively which results in the decrease in the anxiety symptoms (Kolves et al., 2018).

Suicide bereaved individuals can deal with their trauma by involving in reframing their thoughts and having the positive affirmation. These individuals can change their perspectives that the deceased is in the peace now after suffering from severe mental illnesses. This changing the perspective of situation or reframing the thought can result in reduction in anxiety among suicide bereaved individuals (Briettbart & Heller, 2023).

Earlier study found that spiritual and the cultural beliefs can also result in decrease in anxiety symptoms among suicide bereaved people. Those suicide bereaved individuals who involves in spirituality practices on daily basis can result in acceptance and inner or mental peace, cope with their grief effectively and results in the reduction of anxiety (Cepuliene et al., 2021). A theory named post-traumatic stress growth theory indicates that post-traumatic stress growth results in the positive psychological change which leads to the suicide bereaved individuals to have meaning in life, focus on the personal growth, appreciation in life and from this, suicide bereaved individual can better deal with the trauma and results in the reduction of anxiety symptoms (Belz & Krysinska, 2021).

The fourth hypothesis was that suicide bereavement is negatively associated with post-traumatic growth, and a significant negative relationship was found. Post traumatic growth has been positively correlated in previous research with positive emotion and problem-focused coping (Boals & Schuler, 2018). On the contrary, avoidance of painful aspects of loss is commonly assumed to hamper recovery from bereavement, thus affecting post traumatic growth. However, prior research in bereaved populations has shown that prolonged grief symptoms and post traumatic growth are consistently linked in both positive and negative ways (e.g., Currier et al., 2012).

The findings of the current study revealed a negative relationship between bereavement and post traumatic growth. Numerous studies have reported that bereavement is an adverse event that results in various psychological sufferings. Suhail et al. (2011) reported that anxiety, depression, and other symptoms of psychological suffering are the immediate reactions to bereavement. In the aftermath of bereavement, some individuals go through only an uncomplicated and normal grieving process which normally resolves over time (Znoj, 2005), while some bereaved individuals are more likely to experience complicated or prolonged grief (Keesee et al., 2008; Wijngaards-de Meij et al., 2005).

The empirical literature is abundant with reports of maladaptive outcomes of bereavement and other similar extremely stressful events (Humgerbuhler et al., 2011; Kreiebergs et al., 2004; Roger et al., 2008). The past research reflected two potential indicators: first, a traditional inclination toward exploring the pathological outcomes of bereavement (and other traumatic events). Bereavement is also supported by empirical findings showing a connection between pathological outcomes and traumatic events. Second, there is no direct link between bereavement (and other such stressful events) and post traumatic growth.

The negative relationship between bereavement and post traumatic growth in the present research is supported by the fact that negative events impact adversely. Secondly, an extraordinary adverse event such as the death of a loved one renders a serious blow to the physical, psychological, emotional, and social aspects of human life.

The possibility of post traumatic growth has been reported as an outcome of bereavement only because of struggling with bereavement or any other extremely stressful event. Past research has reported that bereavement does not inherently result in post-traumatic growth; rather, the outcome of the bereavement experience depends upon how the bereaved individual handles the stressful experience (Engelkemeyers & Marwit, 2008; Gamino et al., 2000; Michael & Cooper, 2013).

Among suicide bereaved, there was a decrease in the chances of positive growth after the traumatic experience of losing the deceased. Contradictory to these findings, the scant literature available on post traumatic growth for those in bereavement indicates a positive correlation. It was found that bereavement resulted in significant growth among individuals; a potential variable for people who seek social support, cope using religion, and identify the event as an essential aspect of their routine (Ryan & Ripley, 2023).

Post traumatic growth is also related to the cause of death and whether the bereaved expected the death or not. Findings by Fisher and colleagues (2020) indicate that sudden and violent deaths, as is often the case with suicide, may not follow the trend of post traumatic growth after death. Another explanation for the current findings is that sociodemographic and psychological variables are correlated with post traumatic growth. In a recent meta-analysis of 11 quantitative studies exploring the onset and conditions of post traumatic growth after suicide

bereavement, it was found that suicide bereaved were expected to grow and find meaning in their loss after the incident. However, this growth was closely tied to the time passed since the loss, their attachment style, social support, coping strategies, etc. (Levi-Belz et al., 2021).

The term "post-traumatic growth" describes a cognitive shift resulting from enduring challenging conditions in life. Research suggests that extreme negative emotions and sadness are frequently linked during the early phases of grieving, which may hinder post traumatic growth. Those who are still in the early stages of grief might not yet experience growth, as post traumatic growth often comes after a period of intense emotional processing (Calhoun et al., 2010).

The current study assumed that suicide bereavement is positively associated with stigma, which was supported by the data showing that suicide bereaved are often severely stigmatized (Feigelman et al., 2009). Stigma is linked with suicide bereavement and that lead the deceased family to suicide attempt and before one committed suicide there are multiple suicide attempts (Schomerus & Angermeyer, 2008). If bereaved family members get any bad response from immediate family, colleagues or other friends it causes grief and it bring distress, pain, discomfort for bereaved members and they learned helplessness if they don’t get any support from surrounding (Neimeyer & Jordan, 2002). According to Pitman et al., (2016) the greater is the stigma score, the more is the chances that it will bring more depression, they will attempt more suicide and will cause more anxiety to the bereaved.

Prior research showed that those individuals who have suffered any lost and especially when it is due to suicide then family face great deal of shame and it effect the reputation of family and they suffer due to it. According to socoo et al., 2019 that if society or people link

the suicide with any kind of mental disorder or pathological issue and consider that suicide is due to any person failure, or they have weakness in character this labelling also impact and cause stigma. According to Ahmed et al., (2023) Stigma which is due to suicide and bereaved suffered through grief which are they hide from society then this grief could impact the mental health of the one who are bereaved by suicide and it could have pathological impact on them.

Present study depicted that there is positive association of suicide bereavement with shame. Result showed that there is positive association between two that suicide stigmas it and consider it negative. According to LeBlanc et al., 2020 that those who bereaved due to suicide they experience guilt, rejection from society, shame and it became more increase due to the negative attitude of society and when we blame others for the loss. In indigenous point of view in Pakistan as suicide is sin and prohibited in Islam, and people discriminate with people who did suicide or have any psychological issue, which greatly affect the bereaved family. According to shoib et al., 2022 all the factors which contribute or which bring negative emotions like feeling of self-blame, shame, guilt, adversely affect the bereaved.

According to young et al., (2022), the bereaved blame themselves for the deceased and they believe that due to their negligence or they were not able to save them and to understand them which cause the death of the deceased. This cause pathological grief in bereaved and this rumination affect there thought process, they go through severe guilt, shame and it is more pertinent in society where suicide is considered as a sin.

Finding of the study showed that suicide bereavement cause shame and stigma in the deceased parents. According to Pitman et al., (2016), there was study conducted on 3,432 adults who were suicide bereaved and they find that suicide itself is stigmatizing for them and it is

linked with guilt and bring shame in them. In most of the developing countries especially in Islamic countries, suicide is sin and due to this factor stigma get heightened and family suffer. But now suicide is decriminalized once the bill was passed that those who attempt suicide they are depress they need help rather than punishment. (Sabri & Sibghatullah, 2023).

In study by Clark (2012) it was found that shame and stigma are associated significantly and shame can affect the internalization of stigma. It was also found chances of stigma, distress, pathological grief, mental disorders and not showing bond with the family increase when they get adverse reaction from others. (Westerlund et al., 2020; Shields et al., 2017; Evans & Abrahamson, 2020).

Study also showed that environmental reward is playing moderating role for relationship of depression with suicide bereavement and finding showed it in desire direction. High level of depression due to guilt, shame and self-blame and less social interaction were also present in bereaved parents (Ali, 2015). Positive activities can minimize depressive symptoms, acting as a positive moderator between suicide bereavement and depression.

Results indicated that environmental reward is a significant predictor of depression. The interactive effect of bereavement and environmental reward on depression wIas significant. Increased environmental rewards can reduce the risk of depression and foster resilience, aiding psychological fitness (Vazquez et al., 2019).

The model of behavioral activation suggests that patients with depression would feel better if they engaged in enjoyable activities (Lewinsohn, 1973). Environmental rewards involve participation in activities and the degree of interest a person expresses in these

activities. Research shows that supportive environments and positive reinforcement can buffer depressive symptoms (Eisma et al., 2013).

Grief is often followed by anxiety and other depressive symptoms. The present study also investigated the relationship between environmental rewards and anxiety, revealing a non-significant positive relationship. Exposure to previously avoided stimuli and activities can reduce discomfort and loneliness, aiding in the resumption of normal life. However, a supportive environment might also bring back memories of the deceased (Acierno et al., 2011).

The present study hypothesized that environmental rewards moderate the relationship between suicide bereavement and anxiety and results supported this assumption. Physical activity is one strategy to enhance mental health; some research has shown that it can help lessen conditions like anxiety and depression (Elliot et al., 2014; Mahon et al., 2017). Symptoms of PTSD, aggression and quality of life is improved with exercise (Shacher et al., 2016; Sato et al., 2016).

The findings of this current study affirms that environmental reward has moderate to strong and significant positive relationship with Anxiety. This paper accredits that there is a negative moderating relationship between anxiety and environmental reward. Batch (2015) conducted the study on which the focus has been placed on the environmental aspect of reward and tension on persons who are grieving as a result of suicide losses. The researcher found out that pursuits, participation in the activities that are fun, presence in the areas that are safe, and interactions with other people in the healthy ways all are the forms of environment that can assist in the reduction of anxiety. The people that are subjected to high levels of environmental improvement may be better placed to handle stress and other related disorders.

The findings of the current study suggest that an environmental reward for a shame may moderate suicide bereavement. In particular, studies by Pitman et al. (2018) shows or revealed that the the social support and meaningful activity factors within the environmental reward element of bereavement are effective predictors for shame following that are following loss to the suicide. Similarly, among participants or the individuals who experienced lower or decrease levels of environmental rewards and high or increase level bereavement (those whose experiences closely matched the survey-derived latent class “shame”), stigma was higher in those that internalized negative beliefs about themselves.

According to a study done by Martinet et al H. (2016) found some support for the fact that Shame does increase or arise in response to an environmental cue of norm and also have a reactive changing cues as when reactions are provided. . Stigma and shame are helpful for any depressive disorder, post traumatic stress disorder or anxiety, while the environmental reward can contribute to either of them. Pepper et al. (2013) in a similar way much of the previous research has not explored environmental rewards and their associations with suicide bereavement such as in this study. Surprisingly, despite how few numerous research of the moderating results have established that environmental rewards may be changed in a favorable manner (Jansenn et al., 2020; Dimidjian et al., 2014; Sturmey et al., 2009).

One has to agree with the author that the amount of stress those who lost a loved one to suicide experiences is very high and it is rather impossible to state that the symptoms of post traumatic stress disorder could be at some point reduced or reduced at all. The research findings of this current research study also revealed that there was no correlation between environmental reward and post- traumatic stress disorder. The fact that the event is a tragedy and is sudden affect suicide bereaved in a drastic way. These are some of the drawbacks of environmental strategies and management decisions, and it can also be seen that environmental rewards or

benefits are not capable of eradicating these disadvantages. The study carried out by Wagner et al. (2018) showed that the Post traumatic stress disorder emanates from the details of suicide loss including violence and shock. It is equally also appears improbable that the degree of psychological shock experienced by those who survive a suicide bereaved can reduce or alleviate the manifestation of post traumatic stress disorder. The study done by Pompilli et al (2013) showed that the effectiveness of environmental rewards in managing post traumatic stress disorder may be reduced in suicide bereaved persons because of hardcore psychosocial and psychological impact.

Earlier research has also presented evidence that perceivers who have lost a loved one to suicide characteristically experience chronic pain and mourning, which suggests that the ability of environmental reinforcers to reduce or alleviate the symptoms of the post traumatic stress disorder may be hindered or at least be reduced. Studies showed that environmental rewards may be prevented from occupying a large degree of moderation in Suicide Bereaved individuals because of the chronicity of trauma and grieving (Zisook & Shear, 2009). In another research, the people who lost a loved one to suicide often experience helplessness because of the inability to control the tragic events or circumstances this can lead to post traumatic stress disorder which environmental reward may not be the best remedy for. Reporting and analysis of research evidence shows that the moderating effects of environmental rewards on PTSD may be blunted or negated by such effects of losing control over the traumatic experience Harwood et al., (2002).

Social isolation and social withdrawal are the common symptoms among suicide bereaved individuals which can result in post-traumatic stress disorder. These factors of social withdrawal and isolation can limit the ability of suicide bereaved individuals to engage with environmental rewards, thereby reducing the moderating effect on post-traumatic stress

disorder (Pitman et al., 2018). Individual differences in personality traits, coping strategies and resilience can influence to the effectiveness of environmental rewards in moderating PTSD. Sob the variability among individual differences and to trauma and to loss can affect the moderating affect and role on the symptoms of PTSD (Belz & Yasish, 2022).

Past studies also indicates that the negligence in therapeutic interventions to the suicide bereaved can result in decreased effectiveness of environmental reward in moderating post-traumatic stress disorder. So the comprehensive interventions may play an important role to benefit the suicide bereaved people which the environmental reward alone may not be sufficient to deal with it (Pompilli et al., 2013). Research indicates that suicide bereaved people when experiences multiple losses and traumas can result in the symptoms of post-traumatic stress disorder which can make environmental rewards less effective. These multiple losses among suicide bereaved people can have reduced the moderating effect of environmental reward on post-traumatic stress disorder (Young et al., 2012).

Past studies suggest that the quality and the context of environmental reward is very important. The insufficient and meaningless environmental rewards for the suicide bereaved cannot moderate the post-traumatic stress disorder symptoms (Azorina at al., 2019). Quality of social support and interpersonal relationships also effective in dealing with post-traumatic stress disorder and alone environmental reward is not necessarily effective. Thus, the lack of understanding of these factors results in the reduced effectiveness on environmental reward (Zisook & Shear, 2009).

The suicide bereaved frequently suffered from emotional dysregulation and this can limit the effectiveness of environmental reward in moderating post-traumatic stress disorder. The difficulties in the emotional regulation make it harder for the environmental rewards for moderating effects (Pitman et al., 2017). Research also suggest that repetitive negative thinking

(rumination), is common in suicide bereaved people that can have cause high intensity of post-traumatic stress disorder can less likely to be reduced even in the presence of environmental reward and reduced or undermine the benefits of environmental reward (Mitchelle & Terhorst, 2017).

Past research results showed a significant positive relationship, indicating that avoiding problems and detachment are variables that sustain post-traumatic stress disorder symptoms (Dimidjian et al., 2011). Sudden and violent losses, such as suicide, are associated with slower recovery and an increased risk of mental health disorders like post-traumatic stress disorder (Kristensen et al., 2012).

Suicide-bereaved individuals are likely to experience negative emotions, PTSD, and other mental health concerns. Some may show resilience in coping, and the study hypothesized that environmental reward is positively correlated with post-traumatic growth (PTG). Findings confirmed this, suggesting that environmental rewards, which include new experiences and a deeper sense of self, play a crucial role in PTG (Calhoun et al., 2010).

Earlier research shows that suicide bereaved individuals often have the symptoms of post-traumatic stress disorder. This does not mean that due to environmental reward, these symptoms may reduce. Suicide bereaved people may experience persistent and continuous re-experiencing of traumatic events, hyper-arousal and avoidance of trauma related stimuli. These symptoms among suicide bereaved people can reduce the effects of environmental rewards and the individuals cannot take benefits from environmental rewards (Wamser & Howell, 2018).

Previous study suggests that suicide bereaved individuals also have the symptom of emotion numbing which indicates post-traumatic stress disorder may not always reduce due to

environmental rewards. However, in the presence of environmental reward, this emotion numbing among suicide bereaved individuals may not compel people to experience any emotion of pleasure and joy from the environmental rewards and this leads to increase in post-traumatic stress disorder (Maccalum & Bonano, 2016).

Past finding indicates that suicide bereaved individuals may have the symptoms of hyper-arousal and hypervigilance which can interfere their ability to relax and enjoy the positive experiences which can impact the environmental rewards. The physiological arousal among suicide bereaved people can result in the lack of interest in the presence of environmental rewards which results in the maintaining of these post-traumatic stress disorder symptoms (Kakarala et al., 2020).

Previous finding demonstrate that suicide bereaved people may experience emotional and cognitive dysregulation which results in post-traumatic stress disorder. This way they are able to process and regulate emotions and may not process the positive and pleasurable feelings from environmental rewards which results in increased persistent post-traumatic stress disorder symptoms even in the presence of environmental rewards. Research suggests that post-traumatic stress disorder can co-morbid with depression and anxiety can lead to the diminished effects of environmental rewards. So suicide bereaved people have the co-morbid symptoms of depression and anxiety with post-traumatic stress disorder, which can complicate the relationship of environmental reward and may result in alleviating the post-traumatic stress disorder symptoms (Wakefield at al., 2007). Similar to those with depression and anxiety, suicide bereaved people who suffer from post-traumatic stress disorder, may experience cognitive biases, the negative judgment of any circumstance and pleasurable event. These cognitive biases among suicide bereaved people can result in diminished relaxation and

engagement in environmental reward, which may lead to persistent post-traumatic stress disorder symptoms.

Past literature indicates that suicide bereaved individuals having post-traumatic stress disorder symptoms may also include the symptoms of social isolation and social withdrawal. These symptoms of social isolation and social withdrawal can result in the detachment from the social interaction influenced by environmental reward and even in the presence of environmental reward, may lead to the alleviating symptoms of post-traumatic stress disorder (Wamser et al., 2018). Research also indicated that the suicide bereaved people often involved in maladaptive activities such as substance abuse. They suffered from post-traumatic stress disorder and from getting rid of their over thinking and negative thoughts; they are indulged in the substance abuse which can result in reducing the impact of environmental reward and they cannot benefit from the positive aspects of the environmental reward (Pitam et al., 2024).

Past study showed that suicide bereaved people who have post-traumatic stress disorder, have the fear of being exposed and becoming vulnerable in the rewarding activities that can require emotional openness. This fear among suicide bereaved people can limit the effectiveness of environmental reward (Crueze et al., 2022). Research indicates that sometimes the environmental rewards may lead to the trauma reminders that can trigger the suicide bereaved people. These trauma reminders from environmental rewards may trigger the post-traumatic stress disorder symptoms among suicide bereaved people (Silven, 2020).

Research conducted by (Berradeli et al., 20200) reveal that suicide bereaved people often have post-traumatic stress disorder symptoms and that may also lead to the lack of motivation. This lack of motivation among suicide bereaved people results in the lack of feeling pleasure in the activities and also lack of engagement and interest in environmental rewards leads to the persistent symptoms of post-traumatic stress disorder (Berrardeli et al., 2020).

Environmental rewards can break the cycle of suicidal grief by lowering psychological consequences. Positive reinforcement and encouraging social settings help individuals reinterpret traumatic experiences, fostering PTG (Grace et al., 2015; Harmon & Venta, 2021). However, environmental rewards can also add social pressures due to stigmatization (Pescosolido et al., 2015).

The hypotheses that environmental reward moderates the relationship between suicide bereavement and post traumatic growth were non-significant. Post traumatic growth is multi-faceted and a complex process that require deep emotional and cognitive work. Post traumatic growth emerge from cognitive restructuring processes and meaning making the alone the environmental rewards cannot be helpful and facilitate (Betz, 2022).

Post traumatic growth often involves confronting of the difficult emotions and emotional processing which the environmental reward alone cannot be effective. The cognitive and emotional process are necessarily being dealt with post traumatic growth and that the environmental reward may not necessarily support these emotional and cognitive processes (Betz & Ari, 2018). Research also suggests that post traumatic growth often associated with the meaning making in life which is important for the suicide bereaved individuals and this meaning making process cannot be done alone with environmental rewards. The meaning making process is the important component of post traumatic growth which cannot be necessarily enhanced by environmental reward (Delgado et al., 2023).

Past research also indicates that the supportive relationships are the crucial factors of post traumatic growth and that the presence of environmental reward may not be necessarily able to address this lack of strong social support among suicide bereaved people. The quality of relationships and social support are the important factors of post traumatic growth which the

environmental reward may not adequately addressed (Fisher et al., 2020). New perspectives about the traumatic event or the altered perspectives are essential factors of post traumatic growth and cannot be influenced by environmental reward.

Individual differences in coping styles or resilience significantly influence post traumatic growth and the environmental rewards may not be deal with these differences (Fisher et al., 2020). Another research also indicates that religious and spirituality beliefs can significantly influence post traumatic growth and environmental rewards may not have the impact on these aspects among suicide bereaved individuals. The religious and the spirituality factors are the key components of post traumatic growth which environmental reward alone may not effectively addressed (Hanna, 2021).

Past finding demonstrate that the effective mental health strategies and interventions are necessary for the suicide bereaved people in order to promote post traumatic growth and that the environmental reward does not play a role top provide effective therapeutic interventions among suicide bereaved people. Comprehensive mental health is important for suicide bereaved people and that the environmental reward may not provide this comprehensive mental health strategies (Wellmen et al., 2020). Another research indicates that the personal agency and the individual's ability to take proactive steps towards the personal growth and meaning are the important factors of post traumatic growth for empowering the suicide bereaved individuals. Environmental rewards may not be useful for empowering and strengthening the suicide bereaved people towards personal growth (Delgado et al., 2023).

Findings revealed that there is non-significant moderating effect of environmental reward with stigma. According to the Theoretical Model (Martell et al., 2001), a life event that results in grieving may support mental diseases only if life is devoid of fulfilling activities, such as

interacting with others. People experiencing stigma are bullied out of positive activities like meeting and interacting with people. Parents who lost their child to suicide may spend years avoiding any kind of discussion on the topic. There is a likelihood that they may show anger and bitterness. They use suppression and blaming as coping strategies and show social withdrawal. These parents tend to avoid family and social gatherings. Prominently, fathers try to avoid negative feelings by being engrossed in their work. For siblings, it is difficult to talk about their sibling's death even after years (Entilli, 2021).

Stigma is deeply rooted among suicide bereaved people and environmental reward may not be sufficient to deal with this deeply rooted stigma among suicide bereaved people (Pompilli et al., 2013). Research also indicates that cultural and religious beliefs can cause stigma among suicide bereaved people and that it reduces the effectiveness of environmental reward in moderating its effects. So the cultural and religious condemnation make it difficult for the suicide bereaved people to cope with environmental reward (Hanna, 2021).

Suicide bereaved people have the tendency to isolate themselves and to tend be alone due to the fear stigma and judgment from the society they are not actively engaged in the environmental rewards activities which also is the reason to limit the moderating effect of environmental reward between suicide bereavement and stigma (Pitam et al., 2017). Another research also indicates that the lack of social support can also lead to stigma among suicide the suicide bereaved and that environmental reward may not be sufficient to provide social support for these suicide the bereaved (Pitamn et al., 2016).

Nature and the quality of environmental reward also matters. If the environmental rewards perceived as purposeless and meaningless this can have less likely to moderate the impact of stigma among suicide bereaved people. In this way, the effectiveness of

environmental reward may also be recognized according to its perceived nature of meaningful strategies (Moore, 2022). Research also indicates that the coping strategies are very important factor among suicide bereaved people to cope with the stigma. These coping strategies also includes resilience. If the suicide bereaved people are not resilient towards their trauma and grief so it iss less likely to be treated alone in the presence of environmental reward which also limit the effectiveness of moderating relationship between suicide bereaved people and stigma (Fisher et al., 2020).

Those suicide bereaved people who have the negative self-perception of themselves due to the cultural stigmas cannot be easily cured with the environmental rewards and thus limiting the moderating effect of environmental reward. Thus, the persistent and the continuous negative thinking verb missing about one self-reduced the positive affect of environmental rewards (Pompilli et al., 2013). Research indicates that due to stigma, guilt and shame are common among suicide bereaved people and that cannot be easily addressed by environmental rewards and thus limit the moderating effect of environmental reward (Pitaman et al., 2016).

The suicide bereaved can face regular stigmas in their lives due to the societal and cultural taboos. These stigmas among suicide bereave people are deeply ingrained and they may find resistant to change through environmental rewards. These stigmas include judgment and blame among thes suicide bereaved people that cannot easily be reduced by the environmental rewards (Crueze et al., 2020).

According to (Chapple et., 2015) cultural attitudes towards suicide can influence the effect of stigma among suicide bereaved people. These attitudes from the culture and the society are deeply rooted in the individual who is in bereavement and it is difficult to change with the interventions like the environmental reward (Chapple et al., 2015). Research also indicates that the suicide bereaved people internalize these stigmas from the society and

cultural attitudes which results in the self-stigma. This self-stigma includes shame and guilt factors among suicide bereaved people which cannot be reduces even in the presence of environmental rewards (Pitam et al., 2018).

Previous study suggests that the structural biases which includes lack of the support services towards the stigma may include fear in the suicide bereaved people which results in the least effectiveness of environmental reward (Pitman et al., 2016). Research also suggests that stereotype endorsement about suicide such as considering this act as moral failing that results in the contribution of stigma among the suicide bereaved individuals. These stereotypes cannot be easily being coped with or challenged with the environmental rewards (Walter et al., 2017).

Research conducted by chapple et al., (2020) shown that increasing education and awareness about suicide can help to have the better understanding of the causes and impacts of suicide which can reduce the stigma. But if there is lack of education, the stigma would enhance among suicide bereaved people and along environmental reward will not be effective for dealing with this stigma (Chapple et al., 2020). Research also depicts that media portrays negative perceptions about suicide which may contribute to stigma among suicide bereaved people. These negative portrayals from the social media side cannot be reduced by environmental rewards. So even in the presence of environmental rewards, the media that portrays negativity about suicide can result in the stigma in bereaved families (Andriessen & Krysisnks, 2011).

Earlier investigation by Hallam et al., (2005) indicates that the social identity of suicide bereaved people can also be affected through stigma which results in the social isolation and social withdrawal and exclusion. Environmental rewards cannot address these group dynamics (Hallam et al., 2005). Research also indicates that fear of rejection and judgmental behavior

can also prevent the suicide bereaved people to engage in the environmental reward activities (Reed et al., 2015). Research also contributes that there are many psychological and social effects the suicide bereaved people have after losing the loved one to suicide. These psychological and social effects can become severe when compounded by stigma. So they cannot be reduced even in the presence of environmental reward (Stroebe, 2002).

Suicide bereaved individuals may face discrimination. This discrimination can result in stigma among suicide bereaved people and reduce the effectiveness of environmental rewards (Pitam et al., 2018). Research also suggests that the suicide bereaved people often suffer from the stigma related to the substance abuse and the stigma of mental health which can result in complicating the relationship between stigma reduction and environmental reward (Drabwell et al., 2020).

Both public stigma which is external stigma and the private stigma which is internal stigma can have the negative affect on suicide bereaved people and alone the environmental reward is not sufficient to treat it. In this way, both private or the public stigma mitigate the effects of environmental rewards among suicide bereaved people (Pitman et al., 2018). Research also indicates that the suicide bereaved people suffer from trauma and complicated grief, and this trauma and complicated grief cause stigma in these suicide bereaved people which make it difficult for the moderating effect of environmental rewards (Socco et al., 2019). Berjot and Gillet (2011) observed a relationship between stigma and environmental reward in humans coping with distinct stressors. There was no discernible moderation effect with stigma. Although environmental reward is a substantial predictor of psychological well-being, which includes decreased tension and despair, these findings indicate that the relationship between mental effects and stigma is not substantially impacted by environmental reward. Research by Bach (2015) looked at how environmental reward affected bereaved people's tension levels by

moderating the relationship between bereavement and tension. In addition, environmental reward acts as a buffer for anxiety, manifesting resilience among them. They feel less traumatized when confronted with any loss.

The process of bereavement differs from individual to individual; thus, the consequences of bereavement differ. The present study predicted that there is a significant difference between parents and siblings in psychological and social outcomes and parents are high on depression as compared to siblings. Findings revealed that parents were significantly high on depression as compared to siblings. Suicide grieving is linked to unfavorable health outcomes, although this is reliant on how close the bereaved person was to the deceased (Mitchell et al., 2009). Mothers who have lost a child have a greater depression and suicide rate than other parents. These mothers tend to exhibit signs of uncontrollably intense grief.

The current study hypothesized that parents would experience higher levels of depression compared to siblings. It was partially accepted that mothers were more depressed compared to fathers and siblings. In comparison to non-bereaved parents, Li, Laursen, Precht, Olsen, and Mortensen (2005 found that parents who had experienced a loss, particularly women, had a higher chance of experiencing their first mental hospitalization. Indeed, five years or more after the death, the risk of hospitalization for mothers with depression remained markedly raised (Rogers et al., 2008).

It was hypothesized that parents would experience higher levels of anxiety compared to siblings, and finding were significant. The level of anxiety was high in parents compared to siblings. Research conducted by Keyes et al. (2014) examined anxiety symptoms in people who had lost a loved one to suicide. Findings revealed that parents, especially mothers,

frequently feel more anxious than siblings. The elevated anxiety levels experienced by parents after a suicide loss were attributed to the parental role, emotional attachment to the deceased, and worries about the well-being of surviving family members.

Finding reported that parents experience higher levels of post-traumatic stress disorder compared to siblings. Understanding the meaning behind suicide causes immense psychological suffering to bereaved people as they tend to overstate the complexity of their relationship with the deceased and place the blame on themselves. Consequently, they experience adverse psychological problems. In addition to mental illnesses, bereaved family members also face personal struggles and emotional states of confusion. However, ambiguity and confusion pose a serious risk of psychological suffering since bereaved people may spend their whole lives justifying these issues (Berardelli et al., 2020). People who lose a loved one typically withdraw from social interactions and lead passive lives, which exacerbates suicidal thoughts and psychological distress that worsens over time. These circumstances led to the development of post-traumatic stress disorder, which must be treated right away and they may be provided with psychiatric and psychological services to prevent to prevent suicidal thoughts or other negative consequences (Young et al., 2012).

Parent’s world revolves around their children, and losing a child is the most distressing event for parents. Murphy and Johnson's (2002) study found that five years following a child's death, the parents of the deceased child met the diagnostic criteria for post-traumatic stress disorder and mental distress. It was clear that post-traumatic stress disorder was more common among them. Surprisingly, even five years after the death, symptoms of post-traumatic stress disorder still existed among them. These facts illustrate how deeply parents are affected by the

trauma. In contrast, the diagnostic criteria for post-traumatic stress disorder were met by twice as many studied fathers and three times as many studied mothers.

It was hypothesized that siblings would exhibit higher levels of post-traumatic growth compared to parents. Siblings were indeed higher in post-traumatic growth. According to Levi-Belz (2015, 2016), grieving individuals are more likely to experience personal growth in the wake of a suicide catastrophe if they self-disclose, receive social support, and practice positive self-regulation. One study showed that parents bereaved by suicide had lower post traumatic growth ratings than those of parents of deceased individuals from other causes, placing them in the low-moderate category. This also justifies our prior finding that parents in this study had higher levels of depression, anxiety, post-traumatic stress disorder, shame, and stigma, which inversely correlated with lower post traumatic growth scores. A study by Connerty and Knott (2013) indicates that post-traumatic growth occurs in people who experience trauma when losing a sibling. He found that, male siblings experience significant post-traumatic growth compared to female siblings, validating the finding that brothers experience more post-traumatic growth than sisters.

The hypotheses that parents are high on stigma as compared to siblings was significant and was supported by the data. Parents reported more intense feelings of stigma compared to siblings. According to empirical research on perceived stigma (the subjective awareness of others' stigmatizing attitudes), suicide bereavement due to sudden loss is stigmatized. Higher stigma scores help explain some associations between suicide bereavement and unfavourable outcomes like anxiety, depression, and suicide attempts (Pitman et al., 2016). Due to strong bonds with the deceased, parents and siblings experience stigma more than other groups.

People who experience psychological anguish, anxiety, or depression due to stigma often prefer to stay away from society to avoid being stigmatized. Parents feel hurt if their deceased child's siblings are stigmatized because they do not want society to make their child feel ashamed, increasing the likelihood that the child would attempt suicide after experiencing all the shame and stigma. Therefore, parents experience more psychological anguish and social stigma (McClelland et al., 2020).

It was found that stigma was higher among parents compared to siblings. These finding are consistent with past study that parents, mainly mothers, regularly bear more social and familial stress and harm than siblings. The present findings confirm that parents experienced more family and social stress and damage than siblings (elland et al., 2020).

The hypotheses that parents experience higher level of shame compared to siblings, was supported by the findings. Individuals who have a close relationship with the deceased are more likely to be shame victims. Past research showed that overall, shame is experienced by both parents and siblings in similar ways (Grad et al., 1997). However, this study reported that parents feel more shame compared to siblings because parents are more closely connected to their children and feel more responsible. Strong emotions of shame frequently play a crucial role in the suicide bereavement process. They may heighten the sense of negative self-stigmatization (Clark, 2012), impeding the process of seeking assistance and resulting in social distancing. The tendency of parents who feel shame to be less inclined to ask for or accept social help from others leads to their social isolation (LeBlanc et al., 2020). According to Cândea and Szentagotai-Tătar (2018), parents who experience significant shame exhibit psychological discomfort, which includes elevated levels of anxiety, despair, and grieving. A study by Sudak et al. (2008) indicated that factor of shame was more in parents and others

whose loved ones committed suicide. He found that, shame is felt more by mothers than fathers or any protective factors like friends and siblings.

The hypotheses that duration of bereavement is positively associated with post traumatic growth was supported by the data. Findings revealed that there is a significant mean difference between the duration of bereavement on outcome variables anxiety, depression, post-traumatic growth, post-traumatic stress disorder, shame, stigma. It was found that the level of bereavement was high among the bereaved during the first year compared to those experiencing bereavement for two or more years. A study by Lobb et al. (2010) highlighted how people who have lost a loved one to suicide experience their grief over time. In light of their findings, bereaved individuals frequently undergo the first year of their loss with increased grief intensity, and then their symptoms gradually lessen. These results support the current findings, which show that among participants who experienced two or more years of bereavement, the risk of bereavement was higher in the first year.

Past research showed that the primary year of bereavement is marked by heightened grief intensity, which can be attributed to the initial shock and emotional loss. A longitudinal study carried out by Boelen et al. (2016) highlighted the grieving process among individuals who have lost a loved one. He found that, grief symptoms usually heighten within the first few months after a loss and then gradually lessen over the course of the next 12 months. Finding also determined that many people show resilience and adaptation over the years. However, some people continue to have severe grief symptoms for a long time. The findings demonstrate the temporal dynamics of grief intensity after a loss. finding suggest that the intensity of bereavement is higher within the first 12 months compared to individuals grieving for two or five years.

The findings of the present research showed that the post-traumatic growth was higher among those who have experienced bereavement for more than a few years. The first 12 months after mourning were marked by higher levels of stress. Research by Ryan and Ripley (2023) examined the phenomenon of post-traumatic growth in individuals who have experienced bereavement and other traumas. Their studies indicate the optimal level of post traumatic growth among individuals who come to terms with their loss and extract meaningfulness from it. They perceive the period of depression and anxiety as an opportunity to manifest resilience and growth.

Michael and Cooper (2013) studied how post-traumatic growth changes over the years in bereaved individuals. Finding showed that post-traumatic growth may continue to develop and change years after a loss, with individuals growing more as they incorporate the loss into their identity and story. This is consistent with the finding that people who have been grieving for longer than two years have higher post traumatic growth scores. Duration of suicide bereavement is positively associated with post-traumatic growth. Results showed more intense bereavement in the first year than in the 2-5 years' duration, and more post-traumatic growth in the 2-5 years compared to the first year, with less bereavement and higher environmental reward in the 2-5 years than in the first year. Feigelman's study (2009) showed that the turning point often occurs between three and five years, at which point the intense mourning challenges that follow a suicide loss start to lessen. While there seem to be slightly higher levels of guilt after suicide bereavement compared to other types of loss in the first 18 months, the differences decrease over time, according to a systematic review that examined the grief reactions of suicide survivors (Sveen & Walby, 2008).

According to the present research, post-traumatic stress disorder symptoms continue to change after the loss. Right after the loss, post-traumatic stress disorder symptoms are higher and more severe, and they decrease after 12 months of the bereavement period which is consistent with past literature (Huang et al., 2013), that early in the bereavement process, post-traumatic stress disorder symptoms can be greater due to factors such as the sadness and traumatic nature of the loss. This present finding confirms that the first year following a loss is associated with higher levels of post-traumatic stress disorder.

The finding of the current study suggests that there is a higher environmental reward in people who have experienced bereavement for more than two years. Eisma et al. (2023) indicate that after a loss, environmental reward, which they describe as positive experiences and reinforcement from their surroundings, tends to grow over the years. Comparing those in the early stages of bereavement to those who have been bereaved for longer than two years, the latter group often reports higher levels of environmental reward. He found that, individuals tend to experience happiness from their surroundings. Such individuals come to terms with their loss and move forward with the hope of a sound future, resulting in a greater sense of environmental reward.

The present findings supported that participants who experienced bereavement for more than two years showed higher scores on stigma. Chapple et al. (2015) examined the stigma that society placed on individuals who had lost a loved one to suicide over an extended period. He found that stigma may prolong or even worsen the pain among suicide-bereaved individuals, especially those who have been bereaved for more than two years. Finding found that ongoing cultural perceptions and attitudes regarding suicide could be a factor in the stigma that suicide bereaved continue to face even after a prolonged period. Aoun et al. (2018)

highlighted the stigma that bereaved individuals experience within their extended families and communities. Finding showed that, increased stress and harm may result from family and social situations, particularly for those who have been grieving for longer than two years. The present finding confirms that individuals who have experienced bereavement for longer than two years scored higher on stigma. Finding proposed that after a prolonged period of loss, bereaved individuals are likely to be affected by chronic strain and harm due to ongoing interpersonal difficulties and disruptions in social relationships.

The present findings have identified significant fluctuations in anxiety and depression among individuals grieving during the first year. A study by Lichtenthal et al. (2015) explored anxiety symptoms in individuals who were grieving in the early years. His finding revealed that anxiety is greater within the first year. The study predicts that increased anxiety symptoms during this time might be attributed to the shock, uncertainty, and difficulties adjusting that come with early-stage bereavement.

Schwartz et al. (2018) examined the trajectory of depression in people who have experienced a loss over the years. Finding showed that, depression symptoms generally peak in the first year after a loss and then gradually decrease. Utz et al. (2012) studied depression predictors after loss and found that the early stages of mourning are associated with multiple depressive symptoms. Finding revealed that the initial period following a loss can be related to the onset of depression symptoms due to the shock, disbelief, and emotional turmoil experienced during this time.

Finding suggest that suicide bereaved people suffers from prolonged and complicated grief that can be the results of depressive symptoms. So some of the suicide bereaved people suffers

from chronic grief that cannot be last for a short time but it can be persistent that leads to the symptoms of depression (Latham & Prigarson, 2014).

Losing the loved one to suicide is a trauma and this traumatic nature of this incident has a long lasting psychological impact on suicide bereaved people. This long psychological impact can cause depressive symptoms and emotional distress among the suicide bereaved (Spillane et al., 2018). Research indicates that suicide bereaved people have the tendency of social isolation and social withdrawal. They isolate themselves from the society and their community leading to the depressive symptoms among suicide bereaved people (Moline et al., 2019).

Suicide bereaved people face many unanswered questions in their minds. These unanswered questions force them to over think for the long period of bereavement regarding the meaning and the purpose of suicide attempt. These persistent and over thinking causes depressive symptoms among the suicide bereaved (Kokou et al., 2018). Research indicates that the death anniversary of the deceased make the suicide bereaved people more depressive regardless of the length of bereavement (Joling et al., 2018).

If there are secondary problems like the financial issues arises after the death of loved one to suicide can cause many problems. These secondary issues emerge over the time of bereavement and may cause stressors. If severe, they may cause depressive symptoms as well (Spillane et al., 2018). Research indicated that those suicide bereaved people that maintain the continuous bond with the deceased over the time can have the negative impact. These maintaining of the continuous bond with the deceased can emerge many problems among suicide bereaved people and can causes many of the depressive symptoms (Pitman et al., 2016). Research indicates that those suicide bereaved people who are resilient can cope with this trauma over the time but those suicide bereaved people who do not have the quality of resilience

are not able to cope with this trauma even for the long period of time and that may also lead towards the depressive symptoms among suicide bereaved people (Schwartz et al., 2018).

Past study suggest that some of the time the feelings of guilt and blame among suicide bereaved people become worsen over the time that may leads to depression among them (Duncane et al., 2015). Research indicates that cognitive processes such as negative thinking that we call rumination can be significantly increase among suicide bereaved people of thinking negative day by day and their negative thinking may worsen as the time increase. This may also lead to the symptoms of depression in these suicide bereaved people (Moline et al., 201

The present findings suggest that bereaved parents and siblings who have been grieving for at least 12 months tend to experience post-traumatic stress disorder, anxiety, stigma, and shame. Those who have been bereaved for more than two years were found to have higher levels of environmental reward and post-traumatic growth. The psychological experiences of bereaved parents and siblings during the first year of mourning were investigated by Herberman et al. (2013). Their research found that excessive grief, post-traumatic stress disorder symptoms, anxiety, depression, and feelings of shame are frequently experienced by individuals in their early years of loss. The increased mental distress during this time is precipitated by shock, disbelief, and emotional imbalance encountered in the early stages of bereavement. Eisma et al. (2019) studied the growth trajectories and long-term adaptability of bereaved individuals over an extended period. Findings reflect that those who have experienced bereavement for longer than a year tend to gain greater meaning from their surroundings. These individuals learned to live with their loss and find purpose and progress through the grieving process.

The present study finding confirms that the length of time since the loss was the most significant predictor of the outcome. This outweighs variations in grieving processes based on the type of loss. Suicide bereaved grieving processes steadily diminished over three to five years following their loss. Finnish prospective long-term research involving relatives who committed suicide found similar findings (Saarinen et al., 2000). After the suicide, psychological suffering peaked during the acute phase of the death and subsided three years later.

Duration of bereavement is a significant factor for bereavement intensity, post-traumatic growth, post-traumatic stress disorder, shame, stigma, and anxiety. Burke and Neimeyer (2013) looked into the outcomes of the length of bereavement on various psychological effects for those who have experienced bereavement. Bereavement intensity, post-traumatic growth, post-traumatic stress disorder symptoms, emotions of shame, stigma, and anxiety were all significantly influenced by the duration of bereavement. Specifically, those who experienced bereavement for a longer time witnessed prompt changes in their mental functioning. The first noticeable change these individuals tend to experience is the intensity of grief. Research by Neimeyer (2019) indicated that, the duration of bereavement was a major predictor of post-traumatic growth, post-traumatic stress disorder symptoms, guilt, anxiety and stigma. People who have been grieving for various periods are prone to higher specific types of mental adjustment.

The current study suggests that suicide bereavement is negatively associated with environmental rewards. The individual tends to refrain from participating in pleasurable activities. They experience less joy as compared to healthy individuals. Consequently, individuals who are depressed receive less positive reinforcement than other people (Ekers et

al., 2014). When an individual receives environmental rewards, he learns to recognize the relationship between his actions and emotions. Considering, the vital relationship, they utilize their understanding to plan activities that foster positive reinforcement followed by addressing daily life challenges (Dimidjian et al., 2011). The more environmental rewards are there, the less will people feel and face the consequences of suicide bereavement. However, the process differs from individual to individual and gender to gender respectively.

One of the objective of the present study was regarding gender differences and significant mean difference in post-traumatic stress disorder was observed. Results show that there was a significant mean difference concerning post-traumatic stress disorder. Women have higher scores on post-traumatic stress disorder compared to men. In a meta-analysis of gender variations in post-traumatic stress disorder prevalence across a range of traumatic events. Olff (2017) found that women consistently had higher rates of post-traumatic stress disorder than men. It has been noted that women are generally more prone to post traumatic stress disorder in several populations, including those who have experienced loss. Research supported that the intensity of bereavement also varies among parents who have lost a child to suicide. Mothers of those who commit suicide experience grief more intensely than fathers (Pohlkamp et al., 2019). Hourani et al. (2015) investigated gender variations in post-traumatic stress disorder symptoms among people who have lost a sibling. Finding supported that mothers are more likely than fathers and siblings to have higher levels of post-traumatic stress disorder symptoms. This supports the finding that mothers experience post-traumatic stress disorder at higher rates than fathers and siblings.

Results showed that there is a significant mean difference in depression between men and women. Women reported higher scores on depression than men. Martin et al. (2013) presented

a review on gender differences in depression. Women reflected higher scores on depression compared to men. Several biological, psychological, and social factors, such as variations in coping mechanisms and social support systems, have been implicated in the gender gap in depression prevalence. Studies focusing on suicide bereavement support gender disparities. The traumatic nature of suicide loss engraves bereaved, especially women, to experience symptoms of post-traumatic stress disorder and depression. Research conducted by Sanford and Cerel (2016) revealed that female bereaved of suicide experience greater rates of post-traumatic stress disorder and depression symptoms than male suicide bereaved.

One of the objective was to explore group difference based on the gender of the deceased. The result shows that significant mean differences were found only for the shame and stigma. Studies carried out by Feigelman and Cerel (2020) showed that the bereavement of an individual who lost a loved one to suicide is significantly influenced by gender.

Research reveal that women often experience more feelings of shame than men. There is a strong correlation between disparity, and cultural norms and expectations. Women are expected by society to take responsibility for other people conduct. Another research indicates that women often experience sentiments of guilt as a result of family dynamics and social interaction (Leibow, 2016). Ercan and Ucar (2021) study concentrated on the ways in which men are impacted by societal expectations, specifically with regard to social stress and family. According to the study males may feel more pressure to maintain traditional notions of what it means to be a man which could disrupt their bond with others and their families. Research by Sonnentag and Fritz (2015) indicated that this pressure can result in an increased stress and strain especially following the death of loved one.

The results show that there was a substantial mean difference in shame between genders. When it comes to shame, so the women scores are higher than men do. Studies shows that women are more likely than males to feel significant and higher levels of guilt and shame (Zimmerman & Morrison, 2021). The differences between genders in sentiments of shame is probably due to gender stereotypes, cultural expectations or social conventions. Furthermore, another research indicated that the women might experience increased guilt after the loss because they feel more accountable for upholding family bond (Ludwig et al., 2017).

Men scored higher on stigma than women did. This suggest that the death of a male either a son or a brother results in more stigma while the death of a women either a daughter or a sister result in noticeably greater shame. Previous researches indicated that men who lose a loved one to suicide frequently experience higher level of family strain than their family counterparts (Bennet, 2023). Research also suggests that the men are held accountable for the loss in these circumstances and because of the false societal expectation of masculinity they tend to internalize their grief and find it difficult to seek emotional support. Another research by Goulah (2023) brought intention to the enormous pressure from society on men who lose a loved one to suicide. Because of the limited stigma, lower social acceptance faced by men that results in an increased in their mental problems.

According to the researcher keyes et al. (2014), survivors of a son or a brother's suicide may face greater stigma from the community or society. Cultural views and gender conventions that associate emotional strength and fortitude with masculinity may be the cause of this stigma, leading to inaccurate opinions about the deceased and their family. According to another research by Clapperton et al. (2019), the death of a female either a sister or a daughter by suicide may result in the variety of societal reactions such as opinions about the family's capacity to care for its female members which may intensify feelings of shame and stigma.

One of the objectives of the study was to compare group variations in study variables by the participant's families. As for the other study factors, there was no statistically significant difference found with the results except for depression and post-traumatic stress disorder. Tracy et al (2011) in their research pointed that the effects demonstrated by changes in one family in relation to symptoms of post-traumatic stress disorder in men and women who had experienced suicide loss. Outcomes suggest that the suicide loss survivors are at a greater risk of developing post-traumatic stress disorder if the survivors themselves come from homes with history of mental health issues and problems or dysfunctional families.

In this study, another research shows that the kind of relationship between the family members may influence the onset as well as the severity of the post-traumatic stress disorder in the individuals who have lost their loved one to suicide. Pitman et al. (2017) conducted a research on the relationship between functioning of family and depression in individuals who have ever experienced the suicide of their loved ones. This means that prior other studies suggest that people who have lose the source of emotional support, people who have issues in their relationships and people who speak ill of each other are most likely to get depressed if they have suffered a suicide loss. This demonstrates the significance and the necessity of the family related processes in understanding how depression emerges in the context of the suicide loss.

The other study shows that those people who are suicide bereaved or loss their loved one to suicide their symptoms of post-traumatic stress disorder can decrease or lower due to the social interaction. Pitman et al. (2017) conducted the study which indicated that the there is a connection between those people who experiences suicide loss and the functioning of a proper family. According to the other research, those suicide bereaved people who lose communication, social interaction and lose the social gatherings seem to have more depressive

symptoms. This all indicates that how the family role and functioning and family support is important for the suicide bereaved people.

The current research result explained about the significant mean difference between post-traumatic stress disorder and family system. the results indicated that as compared to those suicide bereaved people who live in nuclear family system, the suicide bereaved people who live in joint family system had greater mean score on the symptoms of depression and post traumatic stress disorder. The other study by Sharma and Kumar (2024) found individuals with Post traumatic stress disorder scores were more in joint family system.

According to the number of researches and studies, those individuals who have lost a loved one to suicide who come from blended families are more likely to suffer from aversive interpersonal conflicts and stress, which raises and increase the risk of post-traumatic stress disorder. Other research by Shopi (20180 investigated the relationship between depression and family structure in persons who have experienced suicide. The results of his study confirmed the hypothesis that in joint family structures scored higher on depression than those in nuclear families showing that those in joint family structures felt more depressed than those in nuclear families.

Implications of the Study

The present study has implications for theory and practice in the sociocultural and mental health context of Pakistan. The findings hold significant implications for understanding the association of suicide bereavement with various outcomes among parents and siblings. Identifying suicide bereavement as a predictor variable and common mental health disorders along with social outcomes as dependent variables sheds light on the complex interplay between loss and psychological well-being. The moderating role of environmental reward

underscores the importance of contextual factors in influencing the impact of bereavement on individuals' experiences. This research Utilize both qualitative and quantitative approach which helped to look though model testing and to explore the lived experiences of suicide bereaved individuals.

The present research translated and empirically validated the scales used for assessing the study variables and also included a qualitative study to find indigenous factors. The adaptation and validation of instruments in local language and across non-western context ensured cultural relevance and increased the accuracy of the measurements and it will be helpful to further explore the issues related to suicide bereavement. It also renders a significant contribution to future research related to bereavement as the present research provides adapted scales of Environmental Reward, Stigma, and Shame in the Urdu language, which were not previously available.

The study also contributed to the psychological and social outcomes among different demographic characteristics and group differences among parents and siblings provides a comprehensive understanding of the factors influencing bereavement outcomes.

To examine the outcomes of bereavement including social and psychological factors of stigma, shame, post traumatic growth, anxiety depression, and post-traumatic stress disorder, it gives impact of suicide bereavement and helped to capture the diverse experiences and support required by bereaved people by offering a holistic view of the bereavement experience.

Conducting the study across Pakistan covering all the ethnic and sociocultural background including participants bereaved from 6 months to 5 years, depicts that the sample was

representative and strengthens the validity of the study and increases the generalizability of the finding.

From a theoretical perspective, this study contributes to existing literature by elucidating the multifaceted nature of suicide bereavement and its differential effects on individuals over time. The incorporation of qualitative research findings enriches our understanding of the subjective experiences and coping mechanisms of bereaved parents and siblings. By integrating quantitative and qualitative approaches, this study advances a more holistic understanding of the complex interplay between bereavement, mental health, and social outcomes.

The findings of the present research have several possible applied implications. Mental health practitioners, policy-making departments, and communities can be alerted and sensitized to view the holistic picture of trauma and coping mechanisms in the socio-cultural and religious context of this society. Engaging in environmental rewards or behaviorally engaging oneself can help adaptively deal with traumatic experiences such as bereavement. In Pakistan, existing therapeutic practices accommodating clients of suicide bereavement and other traumas are extremely polarized and mutually confrontational, operating in complete isolation from each other. Psychiatrists rely solely on medication, religious scholars rely on their paradigm, and the community relies on ritualistic but sometimes counterproductive approaches. There is a significant gap between the need for psychiatric intervention following bereavement and the actual utilization rates. With 93% of individuals not seeking post bereavement psychiatric support, there is a clear necessity for tailored outreach programs aimed at promoting mental health awareness and destigmatizing help-seeking behaviors among bereaved individuals and their families.

In Pakistan, practicing psychologists are rarely consulted nor weighted by the community and other mental health-related professionals. Lack of awareness about official patronage for psychological services and therapeutic approaches is a significant obstacle. The present research findings draw attention to the need for therapeutic practices that are inclusive of psycho-socio-religious considerations along with medication.

Understanding the diverse outcomes of suicide bereavement, ranging from common mental health disorders to social consequences, allows for the development of targeted interventions. Mental health professionals can use these findings to tailor support services that address specific needs such as coping with shame, stigma, and post-traumatic stress disorder while fostering post-traumatic growth and social reintegration.

Moreover, understanding the moderating influence of environmental rewards offers valuable insights into the factors that may buffer or exacerbate the impact of bereavement on psychological well-being. Policymakers in the mental health sector can utilize this research to advocate for increased resources for suicide bereavement support programs. By recognizing the complex interplay of environmental factors, such as social support networks, policymakers can work towards implementing holistic and culturally sensitive bereavement support initiatives.

Limitations and Suggestion for Future Research

The present research has some limitations which are highlighted below.

One of the limitations of the present research is the nature of cross-sectional design. The use of a cross-sectional design limits the ability to establish causal relationships between variables.

There is a need for longitudinal research designs to evaluate the duration of bereavement over time, as the current study assessed participants at only a single point. Longitudinal study would help address temporal issues and assess the long term effects of bereavement.

The sample of the research included bereaved parents and siblings only. Future studies should include sample that also includes other family members, relatives, and friends of the deceased. It would not only help in understanding variations in the experience of bereavement and environmental reward across relationships but would broaden the scope of the generalizability of the findings.

The duration of bereavement among participants ranged from 6 months to 5 years, which is quite diverse. This wide range may have affected the outcomes, as participants who have had more time to recover may respond differently. A shorter and more consistent duration of bereavement would be preferable.

The use of self-report scales may introduce bias, as participants may underreport or over report their symptoms due to social desirability or recall bias.

One limitation of this study is the potential for common method variance. Since all participants completed the instruments at a single time point, the responses may have been influenced by the measurement method.

Future studies should investigate specific Environmental reward which were not addressed by Environmental reward observation scale and also other dimensions of suicide bereavement such as cognitive aspects of bereavement, like rumination, intrusive thoughts, and decision-making processes to identify more effective factors influencing bereavement. This

will provide understanding of the factors that affect the bereavement process and enhance the overall findings.

The study findings highlight the need of incorporating cultural, religious, and spiritual components into the practices or interventions used by mental health service providers. This may involve in counseling, support groups, and psychoeducation programs. Mental health professionals can also use these findings to tailor support services that address specific needs such as coping with shame, stigma, and post-traumatic stress disorder, while fostering post-traumatic growth and social reintegration.

Conclusion

The purpose of the present research was three fold: First, the relationship of suicide bereavement with psychological and social outcomes was examined. Second, the moderating role of Environmental reward, in relation between suicide bereavement and the psychological and social outcomes was investigated. Third, the difference between parents and siblings on psychological and social outcomes as well as the differences on the basis of duration of bereavement, family system and relationship status were explored.

Overall, the present research has demonstrated that suicide bereavement is an important predicator of psychological and social outcomes. The suicide bereavement is significantly positively related to Post traumatic stress disorder, Post traumatic growth, Shame and stigma. The findings provided some support for the moderating role of environmental rewards in relation between anxiety, depression and shame-and some of the predication related to the moderating role of environmental reward in mitigating/exacerbating the negative effects were supported. The results also

demonstrated that duration of suicide bereavement played a significant role. In the first year, post-traumatic stress disorder, shame, anxiety, and depression were higher, while post-traumatic growth and environmental reward increased with the duration of suicide bereavement. While examining the relationship status of parents and siblings, parents exhibited higher levels of intense bereavement, post-traumatic stress disorder, shame, anxiety, depression, and stigma. Whereas siblings showed higher levels of environmental reward and post-traumatic growth. Regarding gender differences, females experienced higher levels of depression and post-traumatic stress disorder as compared to males. Group differences based on family system showed significant differences on post-traumatic stress disorder and depression. While, those living in joint family systems experienced greater depression and post-traumatic stress disorder as compared to those living in nuclear families.

The study makes a significant contribution to the existing body of knowledge in the field of suicide bereavement and its impacts, specifically in non-western context, to understand how cultural, religious, and societal elements effect bereavement in Pakistan, and culturally sensitive issues were addressed. The qualitative component has provided an understanding of the lived experiences of bereaved individuals and families. It gives the insight into understanding the role of environmental reward.

The study findings highlight the need of incorporating cultural, religious, and spiritual components into the existing intervention delivered by mental health services and information gained from group differences on outcome variables among parents and siblings. This entails assessing the desire for support required for families from mental health professionals, refinement in policy and understanding of their grief which contributed in theoretical and

incorporating finding in practices or intervention used by mental health service providers in the field of clinical psychology and specifically for bereavement and mental health. Study also highlighted the challenges bereaved families face like legal implications, stigma, not having social support, and disenfranchised grief. Due to these factors, most of the bereaved families do not seek post-bereavement psychiatric support, there is a dire need for awareness-raising programs, especially about mental health and stigmatization and to make culturally sensitive outreach program.

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Permission for Core Bereavement Items

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warmid@tpg.com.au <warmid@tpg.com.au> Fri, Jun 28, 2024 at 2:10 PM
To: Amna Noureen <amnanoureen10@gmail.com>

Dear Amna,

Of course.

Feel very free to use it.

Kind regards,

Wartwick

……..
Professor Warwick Middleton
MB BS, FRANZCP, MD.
Suite 4D, 87 Wickham Tce
Brisbane 4000
Chair, Cannan Institute
Past President, ISSTD
Ph: (07) 3831 4466
Fax: (07) 3831 4477
Mobile: 0417 629813
Email: warmid@tpg.com.au
……
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the use of the individual or entity to whom
they are addressed. If you have received
this email in error please notify us.
……

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Permission for Urdu versıon of Core Bereavement Items

Scale use permission in research

Agha Aziz <aziz.a.psycp.phd@gmail.com> Tue, Jan 31, 2023 at 6:44 PM
To: Amna Noureen <amnanoureen10@gmail.com>

w.salam.
Permission granted. Best of Luck
Dr. Syed Aziz
Assistant Professor
Department of Psychology
University of Balochistan, Quetta

[Quoted text hidden]

Permission for Post Traumatic Growth Inventory-Short form

Gmail

Amna Noureen <amnanoureen10@gmail.com>

Request for Permission to use post Traumatic Growth Inventory Short Form scale for Research Purpose

Rich Tedeschi <rich.tedeschi@bouldercrest.org> Sun, Mar 3, 2024 at 11:48 PM
To: Amna Noureen <amnanoureen10@gmail.com>

Dear Amna--

You have my permission to use the PTGI-X in your research study.

Richard G. Tedeschi, Ph.D.
Executive Director
Boulder Crest Institute for Posttraumatic Growth
33735 Snickersville Turnpike
Bluemont, Virginia 20135 USA
www.bouldercrest.org

See my latest publications:

Transformed by Trauma: Stories of Posttraumatic Growth (2020)

Posttraumatic Growth: Theory, Research, and Applications (2018) at
https://www.taylorfrancis.com/books/9781315527444

The Posttraumatic Growth Workbook (2016) at
https://www.newharbinger.com/posttraumatic-growth-workbook

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Gmail

Permission for Societal Stigamtization Scale

Feigelman, William T. <William.Feigelman@ncc.edu> Thu, Jan 26, 2023 at 9:51 AM
To: Amna Noureen <amnanoureen10@gmail.com>

Dear Amna:
Thank you for your interest in our Death Studies article on Stigmatization and suicide bereavement. We developed the stigmatization scale that is mentioned in this article. You are welcome to use this easy-to-administer scale in your own research. On page 595 of the article we explain how we measured each of the scale's two dimensions. Should you have any additional questions about how we asked our respondents about feeling stigmatized please feel free to contact me again. You will also find our survey instrument published in the appendix of the book Devastating Losses: How Parents Cope With the Loss of a Child from Drugs or Suicide (NY: Springer, 2012). Good luck to you in your own researches!
Warmly,
Bill F.

William Feigelman, Ph.D.
Emeritus Professor of Sociology
Nassau Community College
Garden City, New York 11530
718-380-8205

From: Amna Noureen <amnanoureen10@gmail.com>
Sent: Thursday, January 26, 2023 11:58 AM
To: Feigelman, William T. <William.Feigelman@ncc.edu>
Subject: Stigmatization and Suicide Bereavement

[Quoted text hidden]

Gmail

Amna Noureen <amnanoureen10@gmail.com>

Stigmatization and Suicide Bereavement

Feigelman, William T. <William.Feigelman@ncc.edu> Thu, Jun 13, 2024 at 2:25 PM
To: Amna Noureen <amnanoureen10@gmail.com>

Dear Amna
You add the two sub scale results together to get the overall rating of suicidal stigmatization. Good luck with your work. Contact me if you have any further questions.
Warmly,
Bill F.

Sent from my T-Mobile 4G LTE Devic

Permission for State Shame Scale

Gmail

Amna Noureen <amnanoureen10@gmail.com>

Request for Permission to use the State Shame and Guilt scale for Research Purpose

June Tangney <herlmeasures@gmail.com> Thu, Mar 7, 2024 at 11:05 PM
To: Amna Noureen <amnanoureen10@gmail.com>

Greetings,

You are more than welcome to use our measures. I am attaching the SSGS (our most recent measure of state shame and guilt for adults) along with scoring instructions. You can also find some information on the reliability and validity of the SSGS in:

Tangney, JP & Dearing, RL (2002). Shame and Guilt. NY: Guilford Press.

The book is available through www.guilford.com, www.amazon.com, and in some university libraries.

I should mention that I am not at all confident that the SSGS assesses shame and guilt as distinct constructs. These are very difficult emotions to assess and differentiate at the state level. If your research question and design pertains to shame-proneness and guilt-proneness as cross-situational dispositions, I'd suggest our TOSCA-4 measure.

If you are going to translate the measure, I would recommend that one person translate the items from English to the other language, and another person back translate the items to English. Then compare the back translated version to the original version. If you would like, we'd be happy to consult on the comparison and resolution of differences between the original and back translated versions.

Please do keep in touch and let us know how your research develops. I would be grateful for a summary of the results whenever they become available.

Best Wishes,

June T.

June Tangney, Ph.D.
University Professor
and Professor of Psychology

George Mason University
Department of Psychology
MSN 3F5
Fairfax VA 22030
703 993 1365 (Office)
703 993 1335 (Fax)
jtangney@gmu.edu

[Quoted text hidden]

6 attachments

SSGS.doc
21K

SSGS scoring.doc
25K

Anxiety and Shame as Risk Factors for Depression, Suicidality, and Impairment in BDD and OCD (Weingarden et al., 2016).pdf
305K

RCT of a Values-Based Mindfulness Group Intervention with Jail Inmates- Evidence for Reduction in Post-Release Risk Behavior.pdf
479K

TOSCA-4 Final 5-15-2020.doc
61K

Gmail Amna Noureen <amnanoureen10@gmail.com>

Permission to use Scale Impact Event scale urdu version

Naeem Aslam <naeemaslam@nip.edu.pk> Fri, Aug 16, 2024 at 5:43 PM
To: Amna Noureen <amnanoureen10@gmail.com>

Amna Noureen you can use Urdu translation of impact of event scale. Goodluck for your research
[Quoted text hidden]

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Since the questionnaires rely on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10 of the PHQ-9) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

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SCALES: CORE BEREAVEMENT ITEMS

Burnett, P.C., Middleton, W., Raphael,B., & Martinek, N. (1997). Measuring core bereavement phenomena. Psychological Medicine, 27, 49-57.

Name:		**Age:**	
		Gender:	

These questions are about your experience in relation to the recent loss of your loved one, whose name in these questions will be signified by the symbol X.

1. Do you experience images of the events surrounding X's death?
   ☐Continuously ☐Quite a bit of the time ☐A little bit of the time ☐Never

2. Do thoughts of X come into your mind whether you wish it or not?
   ☐Continuously ☐Quite a bit of the time ☐A little bit of the time ☐Never

3. Do thoughts of X make you feel distressed?
   ☐Always ☐Quite a bit of the time ☐A little bit of the time ☐Never

4. Do you think about X?
   ☐Continuously ☐Quite a bit of the time ☐A little bit of the time ☐Never

5. Do images of X make you feel distressed?
   ☐Always ☐Quite a bit of the time ☐A little bit of the time ☐Never

6. Do you find yourself preoccupied with images or memories of X?
   ☐Continuously ☐Quite a bit of the time ☐A little bit of the time ☐Never

7. Do you find yourself thinking of reunion with X?
   ☐Always ☐Quite a bit of the time ☐A little bit of the time ☐Never

8. Do you find yourself missing X?
   ☐ A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

9. Are you reminded by familiar objects (photos, possessions, rooms etc) of X?
   ☐A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

10. Do you find yourself pining for/yearning for X?
    ☐A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

11. Do you find yourself looking for X in familiar places?
    ☐A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

12. Do you feel distress/pain if for any reason you are confronted with the reality that X is not coming back?
    ☐A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

13. Do reminders of X such as photos, situations, music, places etc cause you to feel longing for X?
    ☐A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

14. Do reminders of X such as photos, situations, music, places etc cause you to feel loneliness?
    ☐A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

15. Do reminders of X such as photos, situations, music, places etc cause you to cry about X?

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☐A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

16. Do reminders of X such as photos, situations, music, places etc cause you to feel sadness?
☐A lot of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

17. Do reminders of X such as photos, situations, music, places etc cause you to feel loss of enjoyment?
☐A lost of the time ☐Quite a bit of the time ☐A little bit of the time ☐Never

SCORING CRITERIA:
The responses for all items will be scored using the format:

[3] Continuously Always A lot of the time [2] Quite a bit of the time [1] A little bit of the time [0] Never

- Items 1 to 17 are added together to form a total score for the CBI (Range 0-51, alpha = 0.91).
- Items 1 to 7 are added together to form the Images and Thoughts Subscale (Range 0-21, alpha = 0.74).
- Items 8 to 12 are added together to form the Acute Separation Subscale (Range 0-15, alpha = 0.77).
- Items 13 to 17 are added together to form the Grief Subscale (Range 0-15, alpha = 0.86).

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Appendix-H

Original Post Traumatic Growth Inventory-short form(PTGI-SF)

Indicate for each of the statement below the degree to which this change occurred in your life as a result of your crisis, using the following scale.

Scoring the PTGI Participants indicate their scores on a 6-point scale where:

• 0 implies – I did not experience this as a result of my crisis.

• 1 implies – I experienced this change to a very small degree as a result of my crisis.

• 2 implies – I experienced this change to a small degree as a result of my crisis.

• 3 implies – I experienced this change to a moderate degree as a result of my crisis.

• 4 implies – I experienced this change to a great degree as a result of my crisis.

• 5 implies – I experienced this change to a very great degree as a result of my crisis

1. I changed my priorities about what is important in life.
2. I have a greater appreciation for the value of my own life.
3. I am able to do better things with my life.
4. I have a better understanding of spiritual matters.
5. I have a greater sense of closeness with others.
6. I established a new path for my life.
7. I know better that I can handle difficulties.
8. I have stronger religious faith.
9. I discovered that I'm stronger than I thought I was.
10. I learned a great deal about how wonderful people are.

Appendix-I

Original Impact of Event scale

		Not at all	Rarely	Sometimes	Often
1.	I thought about it when I didn't mean to.	0	1	3	5
2.	I avoided letting myself get upset when I thought about it or was reminded about it.	0	1	3	5
3.	I tried to remove it from memory.	0	1	3	5
4.	I had trouble falling asleep or staying asleep because of pictures or thoughts about it that came to my mind.	0	1	3	5
5.	I had waves of strong feelings about it.	0	1	3	5
6.	I had dreams about it.	0	1	3	5
7.	I stayed away from reminders about it.	0	1	3	5
8.	I felt as if it hadn't happened or was un real.	0	1	3	5
9.	I tried not to talk about it.	0	1	3	5
10.	Pictures about it popped into my mind.	0	1	3	5
11.	Other things kept making me think about it.	0	1	3	5
12.	I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	3	5
13.	I tried not to think about it.	0	1	3	5
14.	Any reminder brought back feelings about it.	0	1	3	5
15.	My feelings about it were kind of numb.	0	1	3	5

THE ENVIRONMENTAL REWARD OBSERVATION SCALE (EROS)

With reference to the past several months, please rate each of the following items using the following scale and record your answer in the space to the left of the item:

Scale:
1 = STRONGLY DISAGREE
2 = DISAGREE
3 = AGREE
4 = STRONGLY AGREE

_____ 1. A lot of activities in my life are pleasurable.

_____ 2. I have found that many experiences make me unhappy.

_____ 3. In general, I am very satisfied with the way I spend my time.

_____ 4. It is easy for me to find enjoyment in my life.

_____ 5. Other people seem to have more fulfilling lives.

_____ 6. Activities that used to be pleasurable no longer are gratifying.

_____ 7. I wish that I could find more hobbies that would bring me a sense of pleasure.

_____ 8. I am satisfied with my accomplishments.

_____ 9. My life is boring.

_____ 10. The activities I engage in usually have positive consequences.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9) Appendix-K

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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A2662B 10-04-2005

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Appendix - M

Original State Shame Scale (SSS)

State Shame Scale is a self-rating scale of in-the-moment (state) feelings of shame experiences. Five items are rated on a 5-point scale Likert scale. The following are some statements which may or may not describe how you are feeling right now. Please rate each statement using the 5-point scale below. Not feeling this way-1, feeling this way very strongly-5. Remember to rate each statement based on how you are feeling right at this moment

ITEMS OF SCALES	**Rating**		
	Not feeling this way at all	**Feeling this way somewhat**	**Feeling this way very strongly**
1. I want to sink into the floor and disappear.			
2. I feel small			
3. I feel like I am a bad person.			
4. I feel humiliated, disgraced.			
5. I feel worthless, powerless.			

Appendix- N

Societal Stigmatization

1. Family and Social Strain sub-Scale: (Feigelman et al., 2009)

Sometimes people experience change in their social relationships after the loss of a loved ones. Sometimes family members or close associates become uncomfortable after the death and avoid further discussion about the deceased. Or they may say insensitive or hurtful things. In other cases, they may express kind words and offer a compassionate response. Below are mentioned various groups of people in your life. Please indicate whether your relationship to these people has changed any since the loss of your child. [On each line below circle the most appropriate response for each person or group.] Not Relationship stayed Closer/stronger Weaker/ Applicable the same Relationship Strained relations

S.no	Relationship	Not Applicable	Relationship stayed the same	Closer/stronger relationship	Weaker/strained relationship
38 a)	Spouse	0	1	2	3
38 b)	EX-spouse	0	1	2	3
38 c)	Parents	0	1	2	3
38 d)	In-laws	0	1	2	3
38 e)	Children	0	1	2	3
38 F)	Siblings	0	1	2	3
38 g)	Other relatives	0	1	2	3
38 h)	Coworkers	0	1	2	3
38 I)	Closest friends	0	1	2	3
38 J)	Less Close Friends	0	1	2	3
38 k)	Neighbors	0	1	2	3

2. **Family and Social Harm/Help subscale**

How helpful have each of the following groups mentioned below been in helping you to deal with your loss during the first 12 months? Please use these numbers: 1 for very harmful, 2 for mildly harmful, 3 for neutral, 4 somewhat helpful, and for 5 very helpful. For example, if you felt your relationship with your parents has been somewhat harmful, you might circle the number 2 in that row. [On each line below circle the most appropriate response for each person or group. Circle 0 for not applicable responses.] NA Very Harmful ---------- - Very Helpful

S.no	Relation	NA	Very harmful	Mildly harmful	Neutral	Somewhat helpful	Very helpful
a)	Spouse	0	1	2	3	4	5
b)	Ex-spouse	0	1	2	3	4	5
c)	Parents	0	1	2	3	4	5
d)	In-laws	0	1	2	3	4	5
e)	Children	0	1	2	3	4	5
f)	Siblings	0	1	2	3	4	5
G)	Other relatives	0	1	2	3	4	5
h)	Coworkers	0	1	2	3	4	5
i)	Closest friends	0	1	2	3	4	5
j)	Casual friends	0	1	2	3	4	5
k)	Neighbors	0	1	2	3	4	5

Appendix- O

English Consent form and Demographic sheet

I am a PhD student at National University of Modern Languages. I am conducting a research studyas part of my degree completion. I want to know about the psychological and social impact on parents and siblings who lost their loved one due to suicide. You are being requested to fill the questionnaire. If you are interested to be part of this research, please read carefully each statement and then respond accordingly. The collected information will be used for research purposes only and will be kept confidential. Kindly have your signatures below:

Signatures:_____

Date:

Demographics:

Question regarding parent/sibling

1. Name (optional):
2. Gender: 1) Male (2) Female
2. Age:
3. Marital status: 1) Single 2) Married 3) divorced 4) separated 5) widowed 6) any other
4. Mother tongue:
5. Education:
6. Profession:
7. Language:
8. **Family system:** 1) Nuclear (2) Joint
9) No. of family members:
10) Religion:
12) Monthly Household income:
13) Have you consulted any psychiatrist after this incident of suicide? 1)Yes (0) No
14) Have you consulted any psychiatrist before this incident of suicide? 1)Yes (0) No
15) Have you consulted any faith healer after this incident of suicide? 1)Yes (0) No
16) How would you describe your relationship with deceased immediately prior to their death [check or circle one] 1) extremely positive 2) somewhat positive 3) unclear or uncertain 4) somewhat negative 5) extremely negative
17) To the best of your knowledge had deceased made any prior suicide attempts. check or circle one (1) no (2) yes

Questions regarding deceased individual

1. Relationship with the deceased: 1) Parent (2) Sibling
2. Age of the deceased:
3. Gender of the deceased: 1) Male (2) Female
4. Method for suicide:
5. Time passed since the death: Months/years
6. Please specify year of death and month if remember:
7. Marital status of the deceased: 1) Single (2) Married (3) divorced 4) separated 5) widowed 6) any other
8. Deceased having any mental/psychiatric illness: 0) No 1) yes
-If yes, which mental/psychiatric illness? _____

ID No._____ **Appendix- P** Family No._____

رضامندی کا فارم اور ڈیموگرافک شیٹ

ہدایات:

میں نیشنل یونیورسٹی آف ماڈرن لینگویجز میں پی ایچ ڈی کی طالب علم ہوں۔ میں اپنی ڈگری کی تکمیل کے حصے کے طور پر ایک تحقیق کر رہی ہوں۔ میں ان والدین اور بہن بھائیوں پر نفسیاتی اور سماجی اثرات کے بارے میں جاننا چاہتی ہوں جنہوں نے خودکشی کی وجہ سے اپنے پیارے کو کھو دیا۔ اگر آپ اس تحقیق میں اپنا حصہ ڈالنا چاہتے ہیں، تو براہ کرم ہر بیان کا بغور جائزہ لیں۔ آپ کے جوابات صحیح یا غلط تک محدود نہیں ہیں۔ بلکہ، ایسے بیانات کا انتخاب کریں جو آپ کے جذبات اور ذاتی تجربات کے مطابق ہوں۔ جمع کردہ معلومات کو صرف تحقیقی مقاصد کے لیے استعمال کیا جائے گا اور اسے خفیہ رکھا جائے گا۔ برائے مہربانی اپنا دستخط کریں

دستخط(optional):_____

تاریخ:_____

ڈیموگرافکس:

والدین/بہن بھائی سے متعلق سوال

1	**نام(optional):**					
2	**جنس:**	1) مرد	2) عورت			
3	**شہر:**					
4	**آپ کی عمر کیا ہے؟**					
5	**شادی شدہ حیثیت:**	1) غیر شادی شدہ	2) شادی شدہ	3) طلاق یافتہ	4) علیحدگی	5) بیوہ/رنڈوا
6	**آپ کی مادری زبان کیا ہے؟**					
7	**آپ کی تعلیم کیا ہے؟**					
8	**گھر میں سب سے زیادہ تعلیم یافتہ فرد کی تعلیم کیا ہے؟**					
9	**آپ کا پیشہ کیا ہے:**					
10	**خاندانی نظام:**	1) انفرادی	2) مشترکہ			
11	**گھر کی ماہانہ آمدنی کیا ہے؟**					
12	**خاندان کے افراد کی تعداد کیا ہے؟**					
13	**آپ کا مذہب کیا ہے؟**					
14	**کیا آپ نے خودکشی کے اس واقعے کے بعد کسی ماہر نفسیات سے مشورہ کیا ہے؟**			(1) نہیں		(2) ہاں
15	**کیا آپ نے خودکشی کے اس واقعے سے پہلے کسی ماہر نفسیات سے مشورہ کیا ہے؟**			(1) نہیں		(2) ہاں
16	**کیا آپ نے خودکشی کے اس واقعے کے بعد کسی روحانی معالج سے مشورہ کیا ہے؟**			(1) نہیں		(2) ہاں
17	**آپ مرحوم کے ساتھ اپنے تعلقات کو ان کی موت سے فوراً پہلے کیسے بیان کریں گے ؟**					
	1) بہت منفی	2) کچھ حد تک منفی	3) کچھ حد تک مثبت	4) بہت مثبت		
18	**کیا مرحوم نے اس سے پہلے خودکشی کی کوئی کوشش کی تھی؟**			(1) نہیں		(2) ہاں

مرحوم سے متعلق سوالات

1	**مرحوم سے آپ کا رشتہ کیا ہے؟** 1)والد 2)والدہ 3)بہن 4)بھائی
2	**مرحوم کی عمر وفات کے وقت کیا تھی؟**
3	**مرحوم کی جنس:** 1)مرد (2)عورت
4	**مرحوم کی خودکشی کا طریقہ کیا تھا؟** بندوق کی گولی، پھانسی / پھندا، زیادہ مقدار میں دوائیوں کا استعمال، دم گھٹنا / گلا گھونٹ کر، چاقو / تیز دھار آلے سے مارنا، کود کر مر جانا، ڈوب کر مر جانا، چوہے مار ادویات کا استعمال، گندم میں رکھنے والی گولیاں، دیگر
5	**مرحوم کی وفات کو کتنا وقت ہو چکا ہے سال اور مہینہ لکھیں۔**
6	**مرحوم کی ازدواجی حیثیت:** 1)غیر شادی شدہ 2)شادی شدہ 3) طلاق یافتہ 4) علیحدگی 5) بیوہ / رنڈوا
7	**مرحوم کے ساتھ کسی قسم کی ذہنی / نفسیاتی بیماری کا ہونا:** (1)نہیں (2)ہاں

Adapted version of Environment Reward observation Scale **Appendix-Q**

5) پچھلے کچھ ماہ کو مد نظر رکھتے ہوئے نیچے دیے گئے پیمانے کا استعمال کریں اور ہر ایک آئٹم کی درجہ بندی کریں اور دیئے ہوئے پیمانے کے مطابق کسی ایک پر ٹک (✓) کا نشان لگائیں۔

شمار نمبر	بیانات	بلکل غیر متفق	غیر متفق	متفق	بلکل متفق
1	میری زندگی میں بہت سی سرگرمیاں خوشگوار ہیں۔				
2	میں نے محسوس کیا ہے کہ بہت سے تجربات مجھے ناخوش کرتے ہیں				
3	عام طور پر، میں اپنا وقت گزارنے کے طریقے سے بہت مطمئن ہوں				
4	میرے لیے اپنی زندگی میں لطف تلاش کرنا آسان ہے۔۔				
5	ایسا لگتا ہے کہ دوسرے لوگوں کی زندگی زیادہ بھرپور ہے				
6	جو سرگرمیاں مجھے پہلے خوشی دیتی تھیں اب نہیں دیتیں				
7	کاش میرے پاس ایسے مشاغل ہوتے جو مجھے خوشی کا احساس دلا سکتے				
8	میں اپنی کامیابیوں سے مطمئن ہوں				
9	میں زندگی سے اکتایا ہوا ہوں				
10	جن سرگرمیوں میں میں مصروف ہوتا ہوں، عمومی طور پر ان کے مثبت اثرات مرتب ہوتے ہیں				

4) شرم کے احساسات کے تجربات کا خود درجہ بندی کا پیمانہ ہے۔ اس میں دیئے گئے بیانات کو 5 نکاتی پیمانے پر درجہ بندی کے لیے دیا گیا ہے۔ یہ بیانات اِس بات کی وضات کر سکتے ہیں کے آپ ابھی کیسا محسوس کر رہے ہیں۔ براہِ کرم اِس 5 نکاتی پیمانے کا استعمال کرتے ہوئے ہر بیان کی درجہ بندی کریں اور اور یہ کرتے ہوئے یاد رکھیے کے آپ اِس وقت کیسا محسوس کر رہے ہیں۔ ہر بیان کو غور سے پڑھیں اور دیئے ہوئے پیمانے کے مطابق کسی ایک پر ٹک (✓) کا نشان لگائیں۔

Adapted Version of State Shame Scale

شمار نمبر	بیانات	ایسا بلکل بھی محسوس نہیں ہو رہا۔	بہت کم حد تک ایسا محسوس ہو رہا ہے۔	کچھ حد تک ایسا محسوس ہو رہا ہے۔	زیادہ حد تک ایسا محسوس ہو رہا ہے۔	بہت زیادہ حد تک ایسا محسوس ہو رہا ہے۔
1	میرا دل چاہتا ہے کہ زمین کھلے اور میں اس میں دفن ہو جاؤں۔					
2	مجھے اپنا آپ حقیر محسوس ہوتا ہے۔					
3	مجھے ایسا محسوس ہوتا ہے کہ میں ایک بُرا انسان ہوں۔					
4	میں بے عزت اور رسوا محسوس کرتا ہوں۔					
5	میں بے وقعت، اور بے اختیار محسوس کرتا ہوں					

6A) بعض اوقات لوگ اپنے پیاروں کے کھو جانے کے بعد اپنے سماجی تعلقات میں تبدیلی محسوس کرتے ہیں۔ بعض اوقات خاندان کے افراد یا قریبی ساتھی کسی کے انتقال کے بعد بے چین ہو جاتے ہیں اور مرنے والے کے بارے میں مزید گفتگو کرنے سے گریز کرتے ہیں۔ یا وہ بے حس یا تکلیف دہ باتیں کہہ سکتے ہیں۔ بعض اوقات وہ شفقت بھرے الفاظ کا اظہار کر سکتے ہیں اور ہمدردانہ جواب دے سکتے ہیں۔ ذیل میں آپ کی زندگی میں لوگوں کے مختلف گروہوں کا تذکرہ کیا گیا ہے۔ براہ کرم اس بات کی نشاندہی کریں کہ آیا آپ کے بچے / بہن / بھائی کے کھونے کے بعد ان لوگوں سے آپ کے تعلقات میں کوئی تبدیلی آئی ہے۔ ہر بیان کو غور سے پڑھیں اور دیئے ہوئے پیمانے کے مطابق کسی ایک پر ٹک (✓) کا نشان لگائیں۔

شمار نمبر	تعلق	قابلِ اطلاق نہیں۔	رشتہ ویسا ہی رہا	تعلق قریب / مضبوط ہوا۔	تعلق کمزور / کشیدگی کا شکار ہوا۔
1	شریک حیات				
2	سابق شریک حیات				
3	والدین				
4	سسرال				
5	بچے				
6	بہن بھائی				
7	دیگر رشتہ دار				
8	ساتھ کام کرنے والے				
9	قریبی دوست				
10	کم قریبی دوست				
11	دوست رسمی				
12	ہمسائے				

6B) پہلے 12 ماہ کے دوران آپ کے دکھ سے نکلنے میں درج ذیل میں سے ہر ایک گروہ آپ کے لیے کتنا مددگار رہا؟ برائے مہربانی یہ نمبر استعمال کریں۔ (1) انتہائی نقصان دہ، (2) کچھ حد تک نقصان دہ۔ (3) غیر جانبدار کے لیے، (4) کچھ حد تک مددگار، (5) بہت زیادہ مددگار۔ ہر بیان کو غور سے پڑھیں اور دیئے ہوئے پیمانے کے مطابق کسی ایک پر ٹک (✓) کا نشان لگائیں۔ مثال کے طور پہ اگر آپ کو لگتا ہے کہ آپ کے والدین کے ساتھ آپ کا رشتہ کچھ تکلیف دہ رہا ہے، تو آپ اس قطار میں نمبر 2 کو ٹک (✓) لگا سکتے ہیں۔

شمار نمبر	تعلق	قابلِ اطلاق نہیں	انتہائی نقصان دہ	کچھ حد تک نقصان دہ	غیر جانبدار کے لیے	کچھ حد تک مددگار	بہت زیادہ مددگار
1	شریک حیات						
2	سابق شریک حیات						
3	والدین						
4	سسرال						
5	بچے						
6	بہن بھائی						
7	دیگر رشتہ دار						
8	ساتھ کام کرنے والے						
9	قریبی دوست						
10	کم قریبی دوست						
11	دوست رسمی						
12	ہمسائے						

1) مندرجہ ذیل سوالات آپ کے اُس تجربہ سے متعلق ہے جو کچھ عرصہ پہلے آپکے بیٹے، بیٹی، بہن، بھائی کی وفات کی وجہ سے آپ کو ہوا جس کا نام ان سوالات میں X کی علامت سے ظاہر کیا جائیگا۔

اس سوال نامے میں کچھ بیان لکھے ہوئے ہیں۔ ہر بیان کو غور سے پڑھیں اور دیئے ہوئے پیمانے کے مطابق کسی ایک پر ٹک (✓) کا نشان لگائیں۔

Urdu Versions of Scales

شمار نمبر	Appendix- T بیانات	مسلسل	زیادہ تر وقت	کبھی کبھار	کبھی نہیں
1	کیا 'X' کی وفات سے متعلقہ واقعات کا تصور آپ کے ذہن میں آتا ہے؟				
2	کیا آپ کے چاہنے نہ چاہنے کے باوجود 'X' سے متعلق خیالات آپ کے ذہن میں آتے ہیں؟				
3	کیا 'X' کے خیالات آپ کو رنجیدہ کر دیتے ہیں؟				
4	کیا آپ 'X' کے بارے میں سوچتے ہیں؟				
5	کیا 'X' کے تصورات (images) آپ کو رنجیدہ کر دیتے ہیں؟				
6	کیا آپ اپنے آپ کو 'X' کے تصورات یا یادوں میں گھرا ہوا پاتے ہیں؟				
7	کیا آپ 'X' سے دوبارہ ملنے کے بارے میں سوچتے ہیں؟				
8	کیا آپ 'X' کی کمی محسوس کرتے ہیں؟				
9	کیا 'X' کی شناسا (Familiar) اشیاء (تصویریں، زیر استعمال چیزیں، کمرہ وغیرہ) آپ کو اسکی یاد دلاتی ہیں؟				
10	کیا آپ دکھ سے 'X' کی آرزو کرتے ہیں؟				
11	کیا آپ شناسا جگہوں پر 'X' کو تلاش کرتے ہیں؟				
12	کیا آپ رنج محسوس کرتے ہیں اگر کسی وجہ سے آپ کو اس حقیقت کا سامنا کرنا پڑے کہ اب 'X' واپس نہیں آئے گا؟				
13	کیا 'X' کی یاد دلانے والی اشیاء (تصاویر، حالات، موسیقی، جگہوں وغیرہ) کی وجہ سے آپ کو 'X' کی خواہش محسوس ہوتی ہے؟				
14	کیا 'X' کی یاد دلانے والی اشیاء (تصاویر، حالات، موسیقی،، جگہوں وغیرہ) کی وجہ سے آپ کو تنہائی محسوس ہوتی ہے؟				
15	کیا 'X' کی یاد دلانے والی اشیاء (تصاویر، حالات، موسیقی،، جگہوں وغیرہ) کی وجہ سے آپ اس کے لئے روتے ہیں؟				

16	کیا 'X' کی یاد دلانے والی اشیاء (تصاویر، حالات ، موسیقی ،، جگہوں وغیرہ) کی وجہ سے آپ اداسی محسوس کرتے ہیں؟					
17	کیا 'X' کی یاد دلانے والی اشیاء (تصاویر، حالات ، موسیقی ، ، جگہوں وغیرہ) کی وجہ سے آپ کی زندگی کا مزہ (enjoyment) ختم ہو گیا ہے؟					

2) اس سوالنامے کے جواب دیتے وقت اس بات کو ذہن میں رکھیں کہ موت کے اس صدمے کے بعد آپ کے اندر کس قدر تبدیلی آئی ہے۔ ہر بیان کو غور سے پڑھیں اور دیئے ہوئے پیمانے کے مطابق کسی ایک پر ٹک (✓) کا نشان لگائیں۔

شمار نمبر	بیانات	بالکل نہیں	بہت کم	درمیانے درجے تک	کافی حد تک	بہت زیادہ
1	زندگی میں کیا اہم ہے اس کے لئے میں نے اب اپنی ترجیحات بدل دی ہیں۔					
2	میرے لئے اپنی زندگی کی بہت اہمیت ہے۔					
3	میں اپنی زندگی میں بہتر کام کرنے کی صلاحیت رکھتا / رکھتی ہوں۔					
4	میں روحانی معاملات کو زیادہ اچھی طرح سے سمجھنے لگی / لگا ہوں۔					
5	میں اپنے آپ کو دوسروں کے زیادہ قریب سمجھنے لگی / لگا ہوں۔					
6	میں نے اپنی زندگی کے لئے نیا راستہ چن لیا ہے۔					
7	میں اچھی طرح جانتی / جانتا ہوں کہ میں مشکلات کو حل کر سکتی / سکتا ہوں۔					
8	میرا مذہبی عقیدہ زیادہ پختہ ہو گیا ہے۔					
9	مجھے لگتا ہے کہ میں اپنی سوچ سے بھی زیادہ مضبوط ہوں۔					
10	میں نے اچھی طرح جان لیا ہے کہ لوگ بہت اچھے ہوتے ہیں۔					

3) نیچے دی گئی فہرست میں کسی پریشان کن واقعہ میں (یعنی کہ خودکشی کی وجہ سے اپنے پیارے کو کھو دینے کے بارے میں) لوگوں کے بیانات دیئے گئے ہیں۔ اس سوالنامہ کو استعمال کرتے ہوئے نشاندہی کریں کہ پچھلے چھ ماہ میں یہ بیانات آپ کے لئے کتنے صحیح ثابت ہوئے ہیں ۔ ہر بیان کو غور سے پڑھیں اور دیئے ہوئے پیمانے کے مطابق کسی ایک پر ٹک (✓) کا نشان لگائیں۔

شمار نمبر	بیانات	کبھی نہیں	بہت کم	کبھی کبھار	اکثر
1	میں نہ چاہنے کے باوجود بھی اس واقعہ (یعنی کہ خودکشی کی وجہ سے اپنے پیارے کو کھو دینے کے بارے میں) کے بارے میں سوچتا رہا / رہی ہوں۔				
2	جب مجھے اس کے بارے میں یاد کرایا جاتا ہے تو میں پریشانی سے بچنے کی کوشش کرتا / کرتی ہوں۔				
3	میں نے اس واقعے کو اپنی یاداشت سے مٹانے کی کوشش کی ہے۔				
4	جب مجھے اس واقعہ کے خیالات اور اس کی تصویریں ذہن میں آتی ہیں تو مجھے نیند کے مسائل رہتے ہیں۔				
5	میرے اس واقعہ کے بارے میں شدید احساسات ہیں۔				
6	مجھے اس واقعہ کے بارے میں خواب آتے ہیں۔				
7	مجھے جو چیز اس واقعہ کی یاد دلاتی ہیں میں اس سے دور رہتا / رہتی ہوں۔				
8	میں محسوس کرتا ہوں کہ گویا یہ واقعہ ہوا ہی نہیں ہے یا یہ سب حقیقت نہیں تھا۔				
9	میں کوشش کرتا ہوں کہ اس واقعے کے بارے میں بات نہ کروں۔				
10	میرے ذہن میں اس واقعے کی تصویر ابھرتی رہتی ہیں۔				
11	مختلف چیزیں مجھے اس کی یاد دلاتی ہیں۔				

12	مجھے معلوم ہے کہ میں اس واقعے کے بارے میں بہت کچھ محسوس کرتی / کرتا ہوں لیکن میں ان احساسات پر توجہ نہیں دیتی / دیتا۔					
13	میں کوشش کرتا / کرتی ہوں کہ اس واقعہ کے بارے میں نہ سوچوں۔					
14	جب کوئی چیز مجھے اس واقعہ کی یاد دلاتی ہے تو میرے احساسات لوٹ آتے ہیں۔					
15	اس واقعہ نے مجھے بے حس کر دیا ہے۔					

7) گزشتہ کچھ ماہ کے دوران آپ کو درج ذیل مسائل کی وجہ سے کتنی مرتبہ مشکلات پیش آئی ہیں ؟ ہر بیان کو غور سے پڑھیں اور دیئے ہوئے پیمانے کے مطابق کسی ایک پر ٹک (✓) کا نشان لگائیں۔

شمار نمبر	بیانات	بالکل نہیں	کئی دن	آدھے دن سے زیادہ	تقریبا روزانہ
1	کچھ بھی کرنے میں بہت کم دلچسپی یا خوشی ہوتی ہے				
2	اداس، افسردہ یا ناامید ہونا				
3	سونے یا سوئے رہنے میں مشکل ہونا یا بہت زیادہ سونا				
4	تھکان محسوس کرنا یا بہت کم توانائی محسوس کرنا				
5	بھوک میں کمی یا بہت زیادہ کھانا				
6	اپنے متعلق برا محسوس کرنا۔ یا یہ کہ کہ آپ نے خود کو یا اپنے خاندان کو مایوس کیا ہے۔				
7	کسی کام میں توجہ مرکوز کرنے میں مشکل ہونا، جیسے کہ اخبار پڑھنا یا ٹی وی دیکھنا				
8	اتنا آہستہ حرکت یا بات کرنا جسے دوسرے لوگ محسوس کر سکتے تھے ؟ یا اس کا الٹ، اتنی بے چینی محسوس کرنا کہ آپ معمول سے زیادہ حرکت کریں				
9	اس قسم کے خیالات آنا کہ آپ کا مرجانا ہی بہتر ہے یا خود کو کسی طریقے سے تکلیف پہنچانے کے بارے میں سوچنا۔				
10	اگر آپ نے نے مذکورہ بالا مسائل پر نشان لگائے ہیں تو ان مسائل نے آپ کے کام کرنے، گھر میں صورتحال سے نمٹنے یا دوسرے لوگوں کے ساتھ تعلقات رکھنے کو کتنا مشکل بنایا ہے	بالکل مشکل نہیں بنایا	کچھ حد تک مشکل بنایا	بہت مشکل بنایا	حد سے زیادہ مشکل بنایا

8) گزشتہ 6 مہینے کے دوران آپ کو درج ذیل مسائل کی وجہ سے کتنی مرتبہ مشکل پیش آئی ؟

شمار نمبر	خانے میں اپنے جواب کی نشاندہی کے لئے درست کا نشان لگائیں	بالکل نہیں	کئی دن	آدھے دان سے زیادہ	تقریباً روزانہ
1	حواس باختہ ، مضطرب، یا بے بس محسوس کرنا۔				
2	فکر کرنا بند نہ کرنا، یا پریشانی پر قابو نا پانا				
3	مختلف چیزوں کے بارے میں بہت زیادہ فکر کرنا				
4	آرام کرنے میں مشکل محسوس کرنا				
5	اتنا بے چین محسوس کرنا کہ ایک جگہ بیٹھنا مشکل ہو				
6	بہت آسانی سے ناراض یا غصہ ہو جانا				
7	یہ ڈر محسوس کرنا کہ کچھ برا ہونے والا ہے				

Appendix- U

Topic Guide (English & Urdu)

Topic Guide

Objective: To explore individual's experiences of losing someone close by suicide. Thank you for participating in the study and explain the study and the aims of the research

Topic Guide:

Clarify confidentiality and check consent and inform about audio recording.

Invite and answer any questions

Thanks for agreeing to take part in this interview. Introduce the aims of the interview.

Parents

1. **What was the age of your child?**
2. **gender**
3. **What was the method of suicide?**

   Prompts:

   1) Gun shot 2) hanging 3) overdose 4) asphyxiation 5) knife wounding 6) jumping 7)drowning 9) Rat Poisoning 10) wheat pills 11) other

4. **Has the child ever attempted suicide before this incident?**
5. **What are your thoughts on how people react when they lose someone by suicide?**
6. **Can you please talk about the incident of losing your loved one?**

   Prompts:
   Emotional
   reactionTried
   to hide it
   Labeled as normal death

7. **Any suicide note from the deceased for parents, friends or general public?**
8. **Does the deceases ever talked about death with anyone?**

Prompt:
Parents, friends, relatives

9. **How would you describe his/her physical health before this incident?**

Prompts:
Loss of appetite, changes in eating and sleeping patterns, crying, body-aches

10. How the death of your loved one affected your life?
Prompt:
Impact on yourself / others / children Relationships and social life Finances
Mental /physical Health

11. How it affected you psychologically?
Prompts:
Stressed, anxiety, depression, suicide ideation, traumatization, weeping, isolation

12. What were the social challenges that you faced after the incident?
Prompts:
- General people response
- Family & friends' response
- Stigmatization
- Guilt & shame
- Curiosity (e.g., asking about cause of suicide)
- Personal questions/intruding privacy/comments
- Any misconceptions about suicide people came up with?

13. What do you think are the factors due to which someone ends her/his life?
Prompts:
Interpersonal conflict/relationship difficulties financial difficulties
Lack of support
Barriers in accessing help Impact of media/social media other factors

14. What were the protective factors/particular activities that helped you in coping with the trauma faced after the loss?
Prompts:
- Social relationships
- Spirituality
- Personal strength
- Going out with the family
- Seeking pleasurable activities
- Going to a friend for catharsis
- Involvement in productive routine tasks
- Talking about that person with your friends/relatives' Family/ friend support
- Religion (religious or other practices)/spiritual
- Time (like time/ days also some time help in coping with situation) Any other thing/strategy you want to talk about

15. Do you feel above mentioned activities helped you in coping with psychological challenges that you mentioned before?

16. Do you feel above mentioned activities helped you in coping with social challenges that

you mentioned before?

17. What role does a religious belief play in coping with this trauma?

18. Do you think people cope differently when they lose someone because of natural death and the cases when they lose someone by suicide?
Prompts:
Reasons such as stigma in case of suicide

19. Can you please tell us about how people around you reacted to this incident?
Prompts:
Curiosity (e.g., asking about cause of suicide) Personal questions/intruding privacy/comments
Any misconceptions about suicide people came up with?

20. Did you get any support after this incident?
Prompt
Family
Friends
Doctors
Relatives
Neighbor

20.1) What type of support you got? Was it helpful?

21. Have you faced any specific challenges after this incident?

Prompt
Societal pressure, stigma,
shame
Hospital investigations (post-martum) Police investigation
Funeral/ or some response from masjid imam
Stigma
Print /social media involvement

22. What do you think how we can prevent suicide?
Prompts:
Awareness Prevention guidelines
Accessibility
Media Role
Psychological help / intervention Training

23. Any regrets in your mind that if I would have done this or that for him/ her?

24. What would you advice to other parents who has gone through this like you.

- ***This research***

  How do you feel about participating in this research?
  How do you feel about participating in this

interview?Is there anything else you might want to add?
Is there anything you would want to ask?

At the close of the interview briefly summarize the main points to confirm interpretation with theparticipant. Ask if they wish to expand any responses or add anything else to the discussion.

A debriefing session will be provided to the participants if required.

Siblings

1. What was the age of your sibling?

2. gender

3. How close you were with your deceased sibling?

4. What would be your advice to others like you who lost their siblings due to suicide.

From question 3 onwards use same questions of parents.

موضوع گائیڈ

مقصد: اس تحقیق کا مقصد خودکشی کے نتیجے میں اپنے قریبی عزیز کو کھونے والے فرد کے تجربات تک رسائی ہے۔ اس سرگرمی میں حصہ لینے، تحقیق و مطالعے کے مقاصد کے متعلق بات کرنے کا شکریہ۔

موضوع گائیڈ:

اس عمل کو صیغہ راز میں رکھنے کے متعلق آگاہ کریں۔ سوالات سے قبل رضامندی لیں اور آڈیو ریکارڈنگ کے بارے میں بتائیں۔ سوالات پوچھنے کی اجازت دیں اور انکے جوابات دیں۔۔

اس انٹرویو میں حصہ لینے پر رضامندی کا شکریہ۔ انٹرویو کے مقاصد کا تعارف کروائیں۔

والدین

1. آپ کے بچے کی عمر کیا تھی؟
2. جنس
3. خودکشی کا طریقہ کیا تھا؟

اشارے:

(1بندوق کی گولی 2) پھانسی/پھندا 3) زیادہ مقدار میں دوائیوں کا استعمال 4) دم گھٹنا /گلا گھونٹ کے 5) چاقو/تیز دھار آلے سے مارنا 6) کودنا 7) ڈوب کر9) چوہے مار ادویات کا استعمال 10) گندم میں رکھنے والی گولیاں11) دیگر

4. کیا اس واقعے سے پہلے بچے نے کبھی خودکشی کی کوشش کی ہے؟
5. آپ کے خیال میں جب لوگ خودکشی کے نتیجے میں کسی کو کھو دیتے ہیں تو کیا رد عمل ظاہر کرتے ہیں؟

6. کیا آپ اپنے عزیز کو کھونے کے واقعے کے بارے میں بات کر سکتے ہیں؟

اشارے:

فوری جذباتی رد عمل

رد عمل چھپانے کی کوشش

عام موت کی طرح قبول کرلیا

7. خودکشی سے قبل بچے کی طرف سے والدین، دوستوں یا عام لوگوں کیلئے کوئی آخری پیغام/تحریر؟

8. کیا بچے نے کبھی کسی سے موت کے متعلق بات کی؟

فوری طور پر:

والدین، دوست، رشتہ دار

9. اس واقعے سے پہلے، مرحوم کے جسمانی صحت کو کیسے بیان کریں گے؟

اشارے:

بھوک میں کمی، نیند ، رونا، نیند اور بھوک کی روٹین میں تبدیلی

10. آپ کے پیارے کی موت نے آپ کی زندگی کو کیسے متاثر کیا؟

فوری طور پر:

اپنے آپ/دوسروں/بچوں پر اثر

تعلقات اور سماجی زندگی

مالیات

ذہنی/جسمانی صحت

11. اس نے آپ کو نفسیاتی طور پر کیسے متاثر کیا؟

اشارے:

تناؤ،

اضطراب،

ڈپریشن،

خودکشی کا خیال،

صدمہ،

رونا،

تنہائی

12.اس واقعے کے بعد آپ کو کن سماجی چیلنجوں کا سامنا کرنا پڑا؟

اشارے:

عام لوگوں کا رد عمل

خاندان اور دوستوں کا جواب

بدنامی

جرم اور شرم

تجسس (مثلاً خودکشی کی وجہ پوچھنا)

/تبصرے۔ ذاتی سوالات/ نجی زندگی میں مداخلت

13.آپ کے خیال میں وہ کون سے عوامل ہیں جن کی وجہ سے کوئی شخص اپنی زندگی کا خاتمہ کرتا ہے؟

اشارے:

تعلقات کے مسائل/لڑائی جھگڑے/مالی مشکلات حمایت کا فقدان

میڈیا/سوشل میڈیا کے دیگر عوامل کے اثرات/مدد تک رسائی میں رکاوٹیں

.14وہ کون سے حفاظتی عوامل تھے /سرگرمیاں تھیں جنہوں نے نقصان کے بعد درپیش صدمے سے نمٹنے میں آپ کی مدد کی؟

فوری طور پر:

سماجی تعلقات

روحانیت

خاندان کے ساتھ باہر جانا

خوشگوار سرگرمیوں کی تلاش

بات چیت کے لیے کسی دوست کے پاس جانا

معمول کی تعمیری سرگرمیوں میں شرکت اپنے دوستوں/رشتہ داروں کے خاندان/دوست کے تعاون سے اس شخص کے بارے میں بات کرنا

مذہب (مذہبی یا دیگر عبادات)/روحانی

.15کیا آپ محسوس کرتے ہیں کہ مذکورہ بالا سرگرمیوں نے آپ کو نفسیاتی چیلنجوں سے نمٹنے میں مدد کی ہے جن کا آپ نے پہلے ذکر کیا ہے؟

.16کیا آپ محسوس کرتے ہیں کہ مذکورہ بالا سرگرمیوں نے آپ کو سماجی چیلنجوں سے نمٹنے میں مدد کی ہے جن کا آپ نے پہلے ذکر کیا ہے؟

.17اس صدمے سے نمٹنے میں مذہبی عقیدہ کیا کردار ادا کرتا ہے؟

.18کیا آپ کو لگتا ہے کہ جب لوگ قدرتی موت کی وجہ سے کسی کو کھو دیتے ہیں اور جب وہ کسی کو خودکشی کے نتیجے میں کھو دیتے ہیں تو دونوں طرح کے لوگ مختلف طریقے سے حالات کا مقابلہ کرتے ہیں؟ ؟

اشارے:

خودکشی کی صورت میں بدنما داغ جیسی وجوہات

.19کیا آپ ہمیں بتا سکتے ہیں کہ آپ کے آس پاس کے لوگوں نے اس واقعے پر کیا رد عمل ظاہر کیا؟

اشارے:

تجسس (مثلاً خودکشی کی وجہ کے بارے میں پوچھنا) ذاتی سوالات/ نجی زندگی میں دخل اندازی / تبصرے

خودکشی کرنے والوں کے بارے میں کوئی غلط فہمی سامنے آئی؟

.20کیا اس واقعے کے بعد آپ کو کوئی سہارا ملا؟

فوری طور پر

ڈاکٹر رشتہ دار پڑوسی خاندان یا دوست

.20کس قسم کی مدد فراہم کی گئی؟ کیا وہ مددگار ثابت ہوئی؟

.21کیا آپ کو اس واقعے کے بعد کسی خاص چیلنج کا سامنا کرنا پڑا ہے؟

فوری طور پر

سماجی دباؤ، بدنامی،

شرمندگی

ہسپتال کی تحقیقات (پوسٹ مارٹم)

پولیس تفتیش

نماز جنازہ/ یا مسجد کے امام کا کوئی رد عمل

پرنٹ/سوشل میڈیا

.22آپ کا کیا خیال ہے کہ ہم خودکشی کو کیسے روک سکتے ہیں؟

:اشارے

آگاہی کی روک تھام کے متعلق ہدایات

میڈیا کا کردار

ذہنی صحت کی تربیت

.23آپ کے ذہن میں کوئی پچھتاوا ہے کہ اگر میں نے اس کے لیے کچھ اور کیا ہوتا ؟

.24آپ دوسرے والدین کو کیا مشورہ دیں گے جو آپ کی طرح مشکل حالات گزر چکے ہیں؟

یہ تحقیق:

اس تحقیق میں حصہ لینے کے بعد آپ کیسا محسوس کررہے ہیں؟-

اس انٹرویو میں حصہ لینے کے بارے میں آپ کو کیسا لگا ہے؟-

کیا کچھ اور ہے جو آپ شامل کرنا چاہتے ہیں؟-

کیا آپ کچھ پوچھنا چاہیں گے؟-

انٹرویو کے اختتام پر مختصر طور پر اہم نکات کا خلاصہ کریں تاکہ شریک کے ساتھ تشریح کی تصدیق کی جا سکے۔ پوچھیں کہ کیا وہ کسی جواب کو بڑھانا چاہتے ہیں یا بحث میں کچھ اور شامل کرنا چاہتے ہیں۔

شرکاء کو ایک ڈیبریفنگ سیشنگ فراہم کیا جائے گا۔

بہن بھائی

1. آپ کے بہن/بھائی کی عمر کیا تھی؟

2. جنس

3. آپ اپنے مرحوم بہن/ بھائی کے ساتھ کتنے قریب تھے۔

4. آپ جیسے دوسروں کو کیا نصیحت کریں گے جنہوں نے خودکشی کی وجہ سے اپنے بہن بھائیوں کو کھو دیا۔

سوال 3 کے بعد والدین کے وہی سوالات استعمال کریں۔

National University of Modern Languages
Faculty of Social Sciences
Department of Applied Psychology
Tel: 092-051-9265100-110, (Ext,2092)

Appendix- V

Dated: 01-09-2021

ML.1-7/2020/PSY

To: **Amna Noureen,**
889 PhD/Psy/F19

Subject: **APPROVAL OF PhD THESIS TOPIC AND SUPERVISOR**

1. Reference to letter No. M.L.1-2/2021-Psy dated 03-05-2021, the Higher Authority has approved your topic and supervisor/s on the recommendation of Faculty Board of Studies vide its meeting held on 06th May 2021 and validation in 11th BASR Meeting dated 02-06-2021.

a. **Supervisor's Name & Designation**
Prof. Dr. M. Anisul Haque
Professor & Head, Department of Applied Psychology
NUML, Islamabad.

b. **Topic of Thesis**

Association of Suicide Bereavement of Parents and Siblings with Outcomes: The Role of Social and Psychological Factors

2. You may carry out research on the given topic under the guidance of your Supervisor/s and submit the thesis for further evaluation within the stipulated time. It is to inform you that your thesis should be submitted within the prescribed period by **30th June 2024** positively for further necessary action please.

3. As per policy of NUML, all MPhil/PhD theses are to be run through Turnitin by QEC of NUML before being sent for evaluation. The university shall not take any responsibility for high similarity resulting due to thesis prior run by any other individual.

4. Thesis is to be prepared strictly on NUML's format that can be taken from the MPhil & PhD Coordinator, Department of Applied Psychology.

Telephone No: 051-9265100-110 Ext: 2098
E-mail: trehna@numl.edu.pk

Prof. Dr. M. Anisul Haque
Head,
Department of Applied Psychology

Cc to:
Dr. Tasnim Rehna

Scanned with CamScanner

Thematic table about overview of Themes Across Parents and Siblings(N=15)

Themes	**Subthemes**	**Categories**
Emotional Distress and Social Disconnection	Emotional Turmoil and social Isolation	Intense grief, emotional overload
	Emotional and Functional Impairment	Difficulty performing daily tasks
	Persistent Trauma and Intrusive Thoughts	Recurring memories, flashbacks
	Feelings of Helplessness	Withdrawal, lack of social engagement
	Preceding Warning Signs and Communication.	guilt over unspoken concerns
Navigating Posttraumatic Growth and Personal Transformation	Finding Meaning and Purpose	Personal growth, redefined life purpose
Coping Strategies and Resilience	Spiritual and Religious Coping	Reliance on faith, prayer
	Social Support and Friendship	Close networks, community support
	Avoidance and Reluctance to Confront Grief	Denial, distraction, postponing grief
	Hope for Healing and Recovery	Optimism, belief in recovery
Environmental Rewards for Coping	Environmental Reinforcement	Positive activities, nature-based recovery
	Maintaining Routine and Structure	Daily routines, work-life structure
Overcoming Stigma and Barriers to Seek Professional Help	Social Stigma and Judgment	Fear of judgment, cultural stigma
	Concern for the Well-being of Survivors	Overprotection, stress over others' coping
	Social Isolation and Loss of Support	Community withdrawal, loss of key relationships
	Shifting Responsibilities and Support Dynamics	Changing family roles, emotional burden
Understanding Mental Health Struggles in the Context of Socioeconomic Challenges	Treatment and Self-Medication	Access to care, reliance on substances
	Changing family roles, emotional burden	Financial burden, family conflicts

Promoting Social Support for Mental Health Awareness	Advocacy and Awareness Initiatives	Outreach, mental health programs
	Financial burden, family conflicts	Encouraging understanding and compassion
Understanding the Complexities of Suicide Bereavement	Psychological and Behavioral Characteristics of the Deceased	Mental health history, behavioral patterns
	Encouraging understanding and compassion	Conflicts, unresolved family tensions