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**UNDERSTANDING THE IMPACT OF SUICIDE ON
FAMILIES OF PEOPLE WHO WERE IN RECEIPT
OF MENTAL HEALTH SERVICES**

FARZANA M ALI

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements
for the degree of Doctor of Philosophy

17 May 2019

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Abstract

The aim of this thesis is to understand the impact of suicide on families of people who were in receipt of mental health services. Suicide survivors are often researched as a homogenous group and considering only a quarter of the decedents in the UK were in receipt of mental health services prior to their suicide, their family members have been subject to few studies. Suicide is a distinctive form of death and suicide survivors are at an increased risk of poorer physical and mental health so they may wish to access health services, such as counselling. However, a generic response by services fails to address family member's individual needs because of the different personal, social and cultural factors influencing suicide bereavement.

For family members, a key feature of dealing with a suicide is making sense of the death by drawing on their life with the deceased prior to the suicide. By focusing on the mental health context, this study highlights how some family members may have experienced personal challenges in caring for or supporting the deceased, and/or encountered difficulties with health services in providing effective treatment and support. However, not all family members will have had knowledge of the mental health context of the deceased. Therefore, gaining a deeper understanding of the impact of a suicide requires exploration of the family members' and decedents' personal, social and cultural context. Considering that a limited amount empirical literature is available in this area, the following objectives for this thesis were:

- To identify the individual needs and experiences of suicide survivors.
- To investigate suicide survivors' perceptions of the health service support, which they and the deceased received before the suicide.
- To generate recommendations for improving health services for suicide survivors.

The study was designed utilising constructivist grounded theory, a method that involves a cyclical process of data collection and analysis. Participants were recruited via the NHS and a Survivors of Bereavement by Suicide group, leading to 17 semi-structured interviews and a focus group with 7 participants. Data analysis resulted in the development of a conceptual model incorporating 'life before the suicide', 'the suicide', and 'the impact on life after suicide'. The model highlights the mental health context of the study, particularly the importance of prior knowledge of and involvement with mental health services, and emphasises the 'private' and 'public' ways of 'dealing with the stigma of the suicide and the mental illness', 'changing perceptions of the suicide', 'creating symbolic ties with the deceased', 'personal ways of coping', and 'dealing with grief'.

Recommendations from this study include stronger collaborative working between mental health services, families/carers and the patient in order to provide effective support and to

prevent future suicides. Moreover, health services should proactively share information on support to families/carers to cope with the challenges of care. Finally, after a suicide, health services should provide suicide survivors with information on support to ensure they receive timely and effective interventions to address their individual needs and minimise negative health outcomes.

Sadly, a suicide has changed the lives of these participants and focusing on the mental health context of the study has demonstrated that there is significant diversity in their experiences. Most participants believed that the suicide was preventable and hope that these findings can prevent future suicides or help other suicide survivors.

Table of Contents

Abstract	3
List of Tables	10
List of Figures	11
List of Diagrams	11
Dedications and Acknowledgements.....	12
Disseminated Findings.....	13
List of abbreviations.....	14
Glossary and Key Terms.....	15
<i>Describing a suicide - Historical context in England</i>	16
Thesis Overview	17
Chapter One: Introduction.....	19
1.1 UK wide recording of suicides	19
1.2 Suicide statistics in England.....	20
1.3 The number of people affected by a suicide	21
1.4 Support for families affected by suicide.....	21
1.5 The mental health context for the research.....	23
1.5.1 Caring for and supporting a relative with a mental illness	24
1.5.2 Investigations by NHS Trusts into patient suicides	26
1.6 Summary	26
Chapter Two: Review of the Literature	28
2.1 Understanding 'normal' grief.....	28
2.1.1 The problem with medicalising grief	32
2.1.2 Understanding grief from an individual perspective	33
2.2 The impact of suicide on family members.....	35
2.2.1 Making sense of the suicide.....	36
2.2.2 Personal characteristics of suicide survivors and the deceased.....	37
2.2.3 The distinctiveness of suicide	40

2.2.4. Post-traumatic growth in suicide survivors	45
2.3 <i>The mental health context of the deceased prior to the suicide</i>	46
2.3.1 Life before the suicide: prior involvement with mental health services	47
2.3.2 Life before the suicide: the personal experiences of families caring for and supporting people with a mental illness.....	49
2.4 <i>Types of support and postvention for suicide survivors</i>	53
2.4.1 Criticisms of postvention and support.....	55
2.5 <i>Summary, rationale and context of the study</i>	58
2.6 <i>The aim and objectives of the study</i>	60
Chapter Three: Methodology and Methods	62
3.1 <i>The study design overview</i>	62
3.1.1 A qualitative research approach.....	63
3.1.2 Constructivist grounded theory.....	65
3.1.3 Process of analysis in constructivist grounded theory	66
3.1.4 A pluralistic approach to data collection	67
3.1.5 Ensuring quality in qualitative research	68
3.2 <i>Study population</i>	70
3.3 <i>Recruitment</i>	70
3.3.1 Recruitment of participants via the Patient Safety Team (PST)	70
3.3.2 Recruitment of participants via SOBS	72
3.3.3 Recruitment of focus group participants.....	73
3.4 <i>Sampling</i>	74
3.5 <i>Data collection methods</i>	75
3.5.1 Developing questions for the interviews and focus group	75
3.5.2 Semi-structured interviews	76
3.5.3 The focus group.....	80
3.6 <i>Ethical considerations for the study</i>	85
3.6.1 Gaining approval from Research Ethics Committees (RECs).....	87
3.7 <i>Reflexivity</i>	90
3.7.1 Insider/outsider perspective as a researcher	91

3.7.2 Dealing with distress	93
3.7.3 The focus group.....	95
Chapter Four: Data Analysis	99
4.1 <i>Process of developing the conceptual model</i>	99
4.1.1 Memo writing	100
4.1.2 Coding the data.....	105
4.1.3 Sampling strategy.....	110
4.1.4 Developing theoretical sensitivity.....	113
4.1.5 Analysis of the focus group	121
4.1.6 Re-conceptualising the final model.....	124
Chapter Five: Findings	126
5.1 <i>Introduction to the chapter</i>	126
5.2 <i>Introduction to the final model</i>	129
5.3 <i>Case studies</i>	132
5.3.1 Case study 1: Charlotte: (Limited awareness / no involvement with health services)	132
5.3.2 Case study 2: Iris (some involvement but concealment of facts by the deceased)	134
5.3.3 Case Study 3: Helen (fully aware and involved with mental health services)	136
5.4 <i>Life before the suicide</i>	137
5.4.1 The family member's involvement in mental health services	138
5.4.2 Family member's involvement in supporting the "deceased".....	142
5.5 <i>The 'suicide'</i>	147
5.5.1 The anticipation or unexpectedness of the suicide	150
5.6 <i>Impact on life after suicide</i>	151
5.6.1 "Piecing the puzzle"	152
5.6.2 'Dealing with the stigma of the suicide and mental illness'	157
5.6.3 'Changing perceptions of the suicide'.....	159
5.6.4 'Creating symbolic ties with the deceased'	163
5.6.5 'Personal ways of coping'	166

5.6.6 'Dealing with grief'	172
Chapter Six: Discussion.....	178
6.1 Summary of finding and contribution to knowledge	178
6.2 'Life before the suicide'	180
6.3. Impact on life after suicide	183
6.4 Challenges of ethical issues and the importance of hearing the voices of suicide survivors	190
6.5 Implications for research and practice.....	192
6.6. Limitations and strengths of the study	196
Chapter Seven: Conclusion	199
Appendices	203
Appendix 1a: Interview schedule for family participants	203
Appendix 1b: Interview topic guide for health professionals	203
Appendix 2: Study research leaflet.....	205
Appendix 3a: Participant information sheet for PST family members	206
Appendix 3b: Participant information sheet for NHS health professionals	209
Appendix 4: PST family member contact details form for researcher	211
Appendix 5a: PST family members consent form	212
Appendix 5b: Participant consent form for NHS health professionals.....	213
Appendix 6a: PST family members letter of invitation.....	214
Appendix 6b: Letter of invitation for NHS health professionals to take part in the study	215
Appendix 7: Support organisations list for PST participants	216
Appendix 8: PST process of recruiting participants	217
Appendix 9: PST family participant nomination form for health professional	219
Appendix 10: SOBS research leaflet.....	220
Appendix 11: Participant information sheet for SOBS family members.....	221
Appendix 12: Letter of invitation for PST family members to take part in the study	224
Appendix 13: SOBS family members helpline list	225
Appendix 14: PST retrospective cases invitation letter for family participants	226
Appendix 15: PST retrospective cases summary to Lead Investigators.....	227

<i>Appendix 16: Covering letter to SOBS helpline workers</i>	<i>228</i>
<i>Appendix 17: Participant information sheet for SOBS helpline workers</i>	<i>229</i>
<i>Appendix 18: Participant consent form for SOBS helpline workers.....</i>	<i>232</i>
<i>Appendix 19: Interview schedule for SOBS helpline workers</i>	<i>233</i>
<i>Appendix 20: Study leaflet for the focus group</i>	<i>234</i>
<i>Appendix 21: Participant information sheet for focus group.....</i>	<i>235</i>
<i>Appendix 22: Letter of invitation for focus group participants</i>	<i>238</i>
<i>Appendix 23: Participant consent for focus group.....</i>	<i>239</i>
<i>Appendix 24: Interview schedule for focus group.....</i>	<i>240</i>
<i>Appendix A: University of Huddersfield SREP Ethics Approval</i>	<i>241</i>
<i>Appendix B: Ethics approval from NRES Committee Yorkshire & The Humber</i>	<i>242</i>
<i>Appendix C: Ethics approval from South West Yorkshire NHS Partnership</i>	<i>245</i>
<i>Appendix D: South West Yorkshire Partnership NHS Foundation Trust letter of access for research</i>	<i>248</i>
References.....	251

List of Tables

Table 4.1: Sub-themes and additional questions added to the interview schedule in order to develop the element of 'Changing Nature of Relationships' (self).....104

Table 4.2: Sub-themes and additional questions added to the interview schedule in order to develop the element of " Piecing the Puzzle"107

Table 4.3: Sub-themes and additional questions added to the interview schedule in order to develop the element of 'Meaning and Purpose' of the Suicide109

Table 4.4: Sub-themes and additional questions added to the interview schedule in order to develop the element of 'Changing Nature of Relationships' (others)115

Table 4.5: Sub-themes and additional questions added to the interview schedule in order to develop the element of 'Changing Nature of Relationships' (deceased).....117

Table 4.6: Sub-themes and additional questions added to the interview schedule in order to develop the element of Developing theoretical sensitivity for the 'New Normal'.....118

Table 5.1: Information on participants and the deceased127

Table 5.2: Focus group participants.....128

List of Figures

Figure 4.1: Example of a memo from first joint interview.....101
Figure 4.2: Early visualisation of 'Putting Pieces of the Puzzle Together'.....106

List of Diagrams

Diagram 4.1: Tentative conceptual model after 13 interviews120
Diagram 4.2: Tentative conceptual model shared at the focus group.....121
Diagram 4.3: Conceptual model on understanding the impact of suicide..... 124
Diagram 5.1: Understanding the impact of suicide by someone in receipt of mental health services on their family members.....131

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Disseminated Findings

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Oral Presentations

1. Ali, F. (June, 2016). Understanding the impact of suicide by people who were in receipt of mental health services on their family. Suicide and Self-harm Early Career Researchers' Forum, University of Glasgow.
2. Ali, F. (May, 2016). Impact of suicide on the families of people who were in receipt of mental health services. Bradford SOBS – Manchester conference.
3. Ali, F. (May, 2015). *Understanding the impact of suicide on the families of the deceased – taking a positive from the tragedy of a suicide*. An honourable death - A conference for doctoral candidates and early career researchers, Birkbeck College, University of London.
4. Ali, F. (April, 2015). *Understanding the impact of suicide on the families of the deceased*. Postgraduate Research Festival, University of Huddersfield.
5. Ali, F. (December, 2014). *Understanding the impact of suicide on the families of the deceased*. 2nd Congress on Clinical and Counselling Psychology (CPSYC), Antalya, Turkey.

Poster Presentations

1. Ali, F. (November, 2016). Understanding the impact of suicide on the families. Postgraduate Research Conference, University of Huddersfield.
2. Ali, F. (October, 2015). *Understanding the impact of suicide on the families*. Postgraduate Research Conference, University of Huddersfield.

List of abbreviations

CGT	Constructivist Grounded Theory
CQC	Care Quality Commission
DH	Department of Health
NCI	National Confidential Inquiry
NCISH	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
NICE	National Institute for Health and Care Excellence
PST	Patient Safety Team
REC	Research Ethics Committee
SOBS	Survivors of Bereavement by Suicide
SWYFPT	South West Yorkshire Partnership Foundation Trust

Glossary and Key Terms

Cross-disciplinary approaches to studies in suicide research have resulted in a multiplicity of viewpoints, which has caused confusion in the use of key terms. Consequently, for this research and thesis, key terms in suicide and bereavement literature will be defined here in the context of this research and thesis.

Bereavement – The definition of bereavement used in this thesis is by Attig (2004, p.343), who suggests it is “the state of having lost someone we care about or love through death. It is a state of deprivation, not a reaction or response”.

Decedent/deceased – both terms are used interchangeably in this thesis as they are commonly used in popular bereavement literature to describe a person who has died.

Grief – The definition of grief used in this thesis is defined by Butler & Northcut (2013, p.310) as, “a normal reaction to the loss of a significant other, usually with an initial period of intense psychological pain that subsides over time as the individual seeks to construct new meanings in life without the deceased.” Grief is also most often defined in literature as, “the emotional, cognitive, functional and behavioural responses to death” (Zisook & Shear, 2009, p.67).

Loss - Loss is described as the absence of something that held great importance for an individual (Butler & Northcut, 2013).

Loved one – The term ‘loved one’ is used in Chapter 4: Data Analysis as a label I chose to describe the person who died by suicide. This term was used frequently by the participants to refer to the deceased regardless of the type of relationship they had prior to the suicide.

Mourning - Klein and Alexander (2003, p.261) define mourning as the “way in which grief is expressed and is largely done in accordance with socially and culturally prescribed rituals and practices.”

Postvention - The support or interventions implemented for suicide survivors by health services to reduce the risk of negative health consequences (Parrish & Tunkle, 2005).

Self-harm - Causing injury to oneself, including self-poisoning with medication or cutting, irrespective of the motivation behind the act (NICE, 2013).

Suicide -The DH (2012a) provides a widely accepted definition of suicide as a death caused by a self-inflicted and intentional act.

Suicide survivor – For the purposes of this thesis, ‘suicide survivor’ will be used to define the multiplicity of people affected by suicide. ‘Suicide survivor’ is a term that originated from

the title of a book written by Cain (1972) and has been reconceptualised by Andriessen (2009, p.43) as a “*person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of that loss.*” This definition will be used to describe suicide survivors in this thesis, but a key discussion in suicidology is the lack of consensus on defining individuals who have lost someone to suicide and this continues to be a source of contention among researchers (Berman, 2011; Cutcliffe & Santos, 2012; Peters, Murphy & Jackson, 2013). The common usage of ‘suicide survivor’ in international suicide literature is strongly evident (cited in Cerel, McIntosh, Neimeyer, Maple & Marshall, 2014), although it can be misconstrued as someone who has survived a suicide attempt (Andriessen, 2009; Grad, 2011; Honeycutt & Praetorius, 2016).

Describing a suicide - Historical context in England

In setting the background to this research area, it is important to understand the historical context of suicide in England. Suicide was referred to as self-murder or self-killing under common law in the 13th century. The Church of England influenced religious governance and perpetuated the belief that suicide was a sin and punishment for the deceased resulted in their burial in non-consecrated soil (Beattie & Devitt, 2015). A suicide resulted in seizure of the deceased’s property and goods, which had ramifications for the family as they were ostracised by their community and wider society (Seabourne & Seabourne, 2001).

Eventually, legislative changes to the Suicide Act in 1961 in England and Wales decriminalised suicide and England was one of the last European countries to do so. However, suicide has never been a criminal act in Scotland. The term ‘committing suicide’ has become embedded in everyday discourse (Stepakoff, 2009) and reflects the view of suicide as a criminal offence. More recently, organisations such as the Samaritans (2013) have been actively involved in dispelling the stigma of suicide by publicising language that is deemed more appropriate. Avoiding the terminology ‘commit’ suicide is, therefore, strongly advocated, and reflected in this thesis.

Thesis Overview

This section provides a brief overview of the thesis that consists of seven chapters and chapter summaries are provided below.

Chapter One sets the background and my reflections on motivations for this research. This sets the context to better understand how suicide impacts on families, especially as the current suicide statistics in England establish suicide is a serious public health and preventable. Considering the mental health context of the study, this chapter offers an outline of the difficulties families or carers may encounter in caring for or supporting a relative or significant other with a mental illness and the involvement of mental health services in treating the care-recipient.

Chapter Two presents and discusses the literature review, based on the issues relating to the research area. This chapter draws attention to the competing debates on the broader context of understanding 'normal' grief, the impact of suicide on families and the mental health context of the study. Subsequently, this chapter identifies current gaps in knowledge and contributes to strengthening the rationale for the study and culminates with the main research aim and objectives of the present study.

Chapter Three presents the chosen methodology and methods in detail. It begins with the study design overview and then debates why taking a qualitative approach and applying a social constructivist approach was appropriate to understand the impact of suicide on family members. Considering the sensitivity of the research and this population, I discuss the study population, sampling process and participant recruitment strategy. To meet the aim and objectives of the study, I outline the justification for taking a pluralistic approach to data collection; semi-structured interviews and a focus group. I also discuss why Charmaz's (2014) constructivist grounded theory was the most appropriate method to guide the concurrent process of data collection and analysis. The ethical considerations of this research are discussed, including issues raised by the ethics committees and how I addressed them to receive ethical approval. Finally, I highlight key points that capture my reflexivity during the research process, because it is an essential process in constructivist grounded theory.

Chapter Four provides a detailed account of the practical and theoretical process of the chosen methodology and methods. Charmaz (2014) offers a clear and flexible framework to develop an explanation or theory of the phenomena under study. Therefore, this chapter includes sections on memo writing, coding the data, and the sampling of participants, which demonstrate the process of developing the conceptual model on understanding the impact of suicide.

Chapter Five shares the findings of the study, beginning with information on the participants and decedents in the study. Furthermore, the final conceptual model is revealed and the chapter is structured according to its key components. This chapter offers an insight into participants' experiences and their quotes are embedded in the chapter to illuminate key points.

Chapter Six is the discussion of the key findings and the contribution to knowledge, in light of what is currently known in the literature regarding the impact of suicide on family members. Also included is a section on the challenges of ethical issues for researchers conducting future studies with suicide survivors. Clearly there are recommendations and implications for policy-makers, service providers and researchers from the study and these are provided. The chapter ends with the limitations and strengths of the study.

Chapter Seven is the conclusion of the study and summarises the key findings from the research study.

Chapter One: Introduction

My interest in undertaking a PhD originated after my role as a Community Health Development Worker in the NHS ended with the abolition of the Primary Care Trusts (PCTs). My work with marginalised communities in tackling health inequalities covered a spectrum of public health issues, including mental health. In addition, my interest in mental health has always been a subject of personal importance as my mother was diagnosed with depression. I have been involved in her care and support for most of my life and this has been influential in the development of my personal and professional experience. Subsequently, this has motivated me to pursue opportunities where I can engage with people from diverse backgrounds through research and practice. As a keen researcher I always had a desire to complete a PhD. Fortunately, I was successful in finding a PhD opportunity at the University of Huddersfield, which drew together my professional background and personal interest in the area.

The South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) contributed to funding for the PhD and they provide services for mental health learning disability and a range of other community services in their catchment area. The Trust identified their interest in a study researching the impact of suicide by a patient in receipt of mental health services on their families. Nevertheless, I still had flexibility to develop the study and discussed potential research areas with staff members from SWYPFT. During this time, I also conducted a preliminary literature search in suicide bereavement and found relatively few studies on family members, which took account of the mental illness of the deceased or their involvement with mental health services prior to the suicide. Therefore, I decided to explore this area further. This introductory chapter establishes the need for the research and sets out the background for the study by providing: key statistics; information on support for families affected by suicide, and an overview of the legal and policy context in which the research was conducted.

1.1 UK wide recording of suicides

The Department of Health (DH) releases annual figures of suicide rates within the UK, using statistics collected from the Office for National Statistics (ONS) for England and Wales, the National Records of Scotland and the Northern Ireland Statistics and Research Agency (Samaritans, 2016). In the UK, there are differences in methods for the registering and reporting of suicides. England, Wales and Northern Ireland follow a coronial system where a coroner conducts an inquest into the cause of a death within their jurisdiction and certifies a death. Most often, suicide is recorded as a death caused by 'intentional self-harm', 'events of

undetermined intent', suicide or an open verdict (DH, 2014a). A verdict of suicide or equivocal suicide is recorded if there is robust evidence that the deceased intended to end their life. However, if evidence is inadequate in establishing 'beyond doubt' that the death was suicide, then it is recorded as an open or accidental verdict (DH, 2014a).

In Scotland, deaths are recorded by the Procurator Fiscal and include sudden or unexplained deaths. Deaths are generally registered within eight days, but since all the facts regarding the death may not be established at this point, there are variations in the recording of death. In view of the disparities in the recording and under-reporting of suicides in the UK, suicide statistics should be treated with caution as the reliability of data is questionable and may not be accurate (DH, 2012a; Samaritans, 2016).

1.2 Suicide statistics in England

In England, the most recent suicide statistics for the general population have been released up to 2013 (DH, 2015a; 2015b). The statistics show a slight increase in suicide rates, with suicide by males three times higher than females. Notably, suicide rates in males aged 25–29 years are five times higher compared with suicide in females of the same age. In terms of female suicides, there was a 14% increase between 2013 and 2014, however, rates have generally decreased over the past 30 years (Samaritans, 2016). The highest suicide rates for females are those aged between 45–49 (DH, 2015b). In terms of methods of suicide, hanging is the most common in both genders, but disproportionately higher in males. Medication overdose is the second most common method of suicide and is higher in females compared with males (Samaritans, 2016).

The National Confidential Inquiry (NCI) collates statistics on individuals who died by suicide or committed homicide within 12 months of accessing mental health services. This information is reported by The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) and their data on suicide statistics is recorded differently compared with the DH. As a result, there are slight variations in figures, but the NCISH reporting of suicide trends and rates provides valuable information. A recent publication by the NCISH included a 20-year review on suicides in the UK (NCISH, 2016). During 2004–2014, 28% of suicides in the UK general population were by patients in receipt of mental health services and over that time, the suicide rate of mental health in-patients decreased by approximately 60%. The suicide rates are three times higher in patients discharged from hospital into the care of the crisis resolution/home treatment teams (CRHT), especially within the three months immediately after discharge. Higher suicide rates have been recorded in males over 45 years,

and those under 25 years. There has been a decrease in female patient suicides in those aged 25-34 years old but an increase in females aged 55–64 years old (NCISH, 2016).

Suicides have historically increased in times of austerity and financial adversity and due to the current economic climate, suicide rates are expected to increase, especially in males (DH, 2014a). As a result, a larger number of suicide survivors will be affected and they will require effective support. Therefore, understanding how they are affected by suicide is an important public health concern.

1.3 The number of people affected by a suicide

Estimating the number of people affected by a suicide continues to be a source of confusion in academic literature, due to the lack of agreement among researchers (Berman, 2011; Peters et al, 2013). Cerel, Padgett, Conwell and Reed (2009) find the numbers vary greatly, but the most commonly quoted number is that six people are affected per suicide (Shneidman, 1973). Critically, many researchers contend that this figure is likely to be an under-estimation and Cerel and Campbell (2008) propose that between five to 100 people are affected by one suicide.

According to Berman (2011, p.116), estimating the number of suicide survivors is difficult due to the diversity in the "*type of relationship to decedent, age of decedent and frequency of contact with decedent*". Certainly, many researchers propose these factors need to be taken into account in order to better understand who and how many people are affected by suicide (Begley & Quayle, 2007; McIntosh, 1993; Shahtahmasebi & Aupouri-Mclean, 2011). Clear evidence suggests that the ramifications of a suicide extend more widely than the family unit and include the community, social support networks, work colleagues and health professionals (DH, 2015a). However, families or individuals who have a closer relationship with the person who died by suicide are at an increased risk of physical and mental health problems (Barrett & Scott, 1990; Begley & Quayle, 2007; Runeson & Åsberg, 2003; Shahtahmasebi & Aupouri-Mclean, 2011). As a result of considering these issues, I decided to focus this study on the family members (or equivalent, for example partners, extended family members or significant others) of people who died by suicide (see Chapter Three, Section 3.4).

1.4 Support for families affected by suicide

Strong evidence-based research has established that suicide survivors experience poorer mental health such as anxiety, depression, and post-traumatic stress disorder (Young et al.,

2012). Moreover, suicide survivors are disproportionately at an increased risk of suicidal ideation and suicide (Andriessen & Krysinaka, 2011; Dyregrov & Dyregrov, 2005), as well as complicated grief that is persistent, traumatic or prolonged (Young et al., 2012). Therefore, suicide survivors may access postvention or different types of support as discussed in Chapter Two (see Section 2.4), although not all suicide survivors will require health service support or be adversely affected by the death (Jordan, 2008).

To minimise negative outcomes for suicide survivors, service providers need to offer them with information on ways of accessing emotional and practical support immediately after a suicide (DH, 2012a). The Government's suicide prevention policy proposes that interventions for suicide survivors should be timely and appropriate in order to minimise negative health outcomes (DH, 2012a). Critically, the Care Quality Commission found that after the suicide, many families were not provided with information on postvention support by Trusts (CQC, 2016) and this does not meet the Government's recommendations. In fact, according to Public Health England (PHE), two-thirds of suicide survivors did not receive support from health services, including mental health services, the voluntary and community sector (VCS) or from their employers (PHE, 2016). Another concern raised by the Department of Health (DH, 2017) has been the inconsistency and poor quality of suicide bereavement services nationally and the lack of support and help as reported by suicide survivors. Moreover, Pitman, Hunt, McDonnell, Appleby & Kapur (2016a) suggest that limited studies have examined the level of support offered to suicide survivors whose decedent was in receipt of psychiatric services, which is concerning since they may be at greater risk of negative health outcomes. Thus, the authors propose that implementing a qualitative approach to a study is one way in which an in-depth exploration can be undertaken on the quality of support received by suicide survivors.

There are clearly challenges establishing effective and responsive postvention for suicide survivors (Beck & Konnert, 2007; Breen & O'Connor, 2007). This may be partly due to the use of comparison studies to investigate differences between suicide and non-suicide bereavement. This has resulted in ambiguous findings (Cvinar, 2005; McIntosh, 1993) and a limited understanding of the impact of suicide which has contributed to the implementation of inappropriate support for the bereaved, which can negatively affect them (Bonanno & Boerner, 2007; Cerel et al., 2009). McMenemy, Jordan and Mitchell (2008, p.385) argue that a "*one size fits all*" approach to postvention for suicide survivors is ineffective. Therefore, research needs to recognise the individuality of suicide survivors and their personal ways of coping and also acknowledge that their support requirements are different (McKinnon & Chonody, 2014).

A major criticism of studies on postvention for suicide survivors is that the findings disregard the heterogeneity of suicide survivors and fail to understand how they cope with the suicide and what types of interventions they require (Barrett & Scott, 1990; Berman, 2011; Gaffney & Hannigan, 2010; Jordan, 2008; Sugrue, McGiloway & Keegan, 2014). Clearly there is a need for further empirical research to identify the gaps between the needs of suicide survivors and services. This is important in order to provide evidence for strengthening the development of interventions, policies and practice (Hardiman, 2004; Maple, Cerel, Jordan & McKay, 2014; Shahtahmasebi & Aupouri-Mclean, 2011; Wilson & Marshall, 2010). A key way of initiating a deeper investigation of the quality and appropriateness of primary care and VCS support received by suicide survivors is through the implementation of qualitative, empirical studies (Pitman, et al., 2016a). Moreover, qualitative in-depth interviews are able to identify subtle differences in experiences of suicide bereavement that quantitative studies may miss (Clement et al., 2015; Spillane, Larkin, Corcoran, Matvienko-Sikar, Riordan & Arensman, 2017). It is, therefore, justifiable to design this study within a qualitative methodology, especially considering the sensitivity of the research topic (see Chapter Three).

1.5 The mental health context for the research

Having argued for more qualitative research on the experiences of suicide survivors, I will now explore the importance of mental health context, when the deceased had been in receipt of mental health services. Grad (2011) suggests that it is important for some suicide survivors to understand if the death was a deliberate act, personal or caused by specific problems, for example a mental illness or life stressors. This adds to strong evidence that suggests that the suicide of an individual with a mental illness certainly complicates the way in which suicide survivors make sense of the death, especially if they have been involved in the care and support of the relative (Cormac & Tihanyi, 2006; Crowe & Lyness, 2014; Maple, Plummer, Edward & Minichiello, 2007; Shah, Wadoo & Latoo 2010) (see Chapter Two: Section 2.3). Moreover, limited empirical studies examine how suicide survivors' experiences of postvention may be affected by their knowledge of the deceased's engagement with health services (Ward-Ciesielski, Wielgus & Jones, 2014). For example, Spillane et al. (2017) found that family members had a great deal of blame and anger toward the decedent's treating clinician, because they failed to prevent the suicide. Many studies do not consider the mental health context of the deceased, thus doing so would add to our understanding of the heterogeneity of suicide survivors' experiences (Maple et al., 2014).

As suggested in the previous section, suicide survivors are often researched as a homogenous group (Cerel, McIntosh, Neimeyer, Maple & Marshall, 2014; Pitman et al., 2016a) and many

studies fail to consider their personal and social factors (Breen & O'Connor, 2007). To address this disparity in research, one approach that has gained popularity in understanding grief has emerged from a postmodern social constructionist and constructivist paradigm, by acknowledging that the social context of the individual is influential in their grief (Carverhill, 2002; Murray, 2003; Shields, Kavanagh & Russo, 2017). As research in this area has been limited up to now, utilising a social constructivist approach to this study will enable a deeper exploration of this group of suicide survivors (Neimeyer, Baldwin & Gillies, 2006), which is discussed in more detail in Chapter Three.

Another important aspect related to the mental health context is the previous involvement of relatives in the support and care for the deceased person. Many suicides are by individuals who live alone or who are socially isolated (DH, 2012a; DH, 2017). Nevertheless, even family members or significant others such as close friends who do not live with the care recipient are often involved in their care (Cole-King & Platt, 2017; Owens et al., 2011; Shah et al., 2010). Therefore, contextualising life of the family members before the suicide is necessary, and will include personal and situational factors such as their age, gender, kinship, and closeness of relationship with the deceased. Consideration of these factors is likely to add to the in-depth understanding of the impact of suicide (Hall, 2014; Stroebe & Schut, 2000).

1.5.1 Caring for and supporting a relative with a mental illness

According to the Department of Health (2012b), families, carers and friends play an important role in suicide prevention by supporting an individual with a mental illness. The official advice is that families or carers should be appropriately included in care planning and should be provided with the contact information of health services if necessary (DH, 2012b). Families may have experienced the changeability in the care recipient's behaviour, have an awareness of suicide attempts, non-adherence to medication and suicidal intent or have found evidence of planning a suicide (Castelli Dransart & Guerry, 2017; Maple et al., 2014; Shah et al., 2010; Sveen & Walby, 2008). Consequently, family members can inform health professionals with their concerns regarding their relative who may be at risk of suicide (Cole-King & Platt, 2017; DH, 2017).

There are a number of criticisms of health services raised in the CQC report (2016), and made by families/carers who expressed frustration with NHS Trusts regarding the care of their relative prior to the suicide. It highlighted how health services failed to involve families in supporting the care-recipient, and family members also encountered difficulties in seeking help for the care-recipient from health services. Moreover, families felt their concerns regarding the patient's care were not respected as much as those of clinical staff. The CQC

(2016) also identified the reluctance by health professionals to share information with families regarding their relative due to patient confidentiality. As a result, many families were disappointed by the lack of shared involvement and support provided by the Trusts and blamed the mental health services for failing to prevent the suicides (CQC, 2016; DH, 2012a). The National Suicide Prevention Alliance (Public Health England, 2016) also recommends that policy-makers, clinicians and commissioners involve family members in suicide prevention work, because they can highlight gaps in knowledge and contribute to strengthening policy and practice in order to prevent future suicides.

Broady and Stone (2015) suggest that the experiences of carers/families of people with a mental illness are different from those whose care-recipient has a disability or infirmity for example. Carers/families may take on additional responsibilities to ensure their relatives are prevented from harming themselves or others and manage their medication. To some extent, this explains why a growing body of evidence find families caring for or supporting relatives with different types of mental illnesses can experience intense conflict and increased emotional, physical and psychological distress (Castelli Dransart & Guerry, 2017; Cormac & Tihanyi, 2006; Crowe & Lyness, 2014; Peters et al., 2013; Shah et al., 2010).

A qualitative study by Ahlström, Skärsäter and Danielson (2009) offers insights into the experiences of families living with a relative with major depression. The analysis revealed five themes: 'being forced to relinquish control of everyday life'; 'uncertainty and instability are affecting life'; 'living on the edge of the community'; 'everyday life becomes hard', and 'despite everything a way out can be found'. Family members had to prioritise their life around the care recipient, which led to exhaustion, disturbed sleeping patterns and loss of energy. Moreover, the individual with depression shared how the unpredictability of their illness, symptoms and behaviour caused instability in the family unit. As a result, they isolated themselves or were avoided by family members, which added to feelings of conflict, anxiety and stress. This study shows how qualitative research can draw attention to deeper insights into family members or carers' experiences with the care-recipients. This strengthens the rationale for using a qualitative approach to this thesis, because exploring families/carers' past experiences can raise in-depth insights in understanding how the suicide impacts on them.

According to Carers UK (2017), carers and/or families of a relative with severe mental illness, such as depression are often unaware of what support is available to help them cope with the caring responsibilities (DH, 2012b). Therefore, to minimise negative health outcomes, it has been suggested that health professionals should inform family members regarding sources of support (Ahlström et al., 2009). It is argued that the needs of families/carers of suicidal relatives are often not identified in research because care-recipients receive more attention

in such empirical studies (McLaughlin, McGowan, Kernohan, & O'Neill, 2016). Moreover, Frey and Cerel (2015) suggest that research tends to focus on the individual factors of someone at risk of suicide and disregard their family context, which is problematic as family members often play an important role and can contribute to the development of suicide prevention strategies. Therefore, the findings from this thesis will add to a growing body of knowledge to investigate and identify areas of improvement in the support for carers and care-recipients. This knowledge will contribute the implementation of effective mental health service provision for the care-recipient and prevent future suicides (CQC, 2016; DH, 2012a).

1.5.2 Investigations by NHS Trusts into patient suicides

The suicide of a patient in receipt of mental health services has to be investigated by the NHS Trust providing treatment in order to review and learn from the death and where necessary, implement good practice. According to a report by the CQC (2016), families and carers can encounter further distress, because of the negative experiences of the investigation process. Families raised concerns that the NHS Trusts who treated the patient failed to keep them informed of the progression of the investigations leading to them feeling ignored. Adding to families' and carers' distress was the Trust's lack of respect, honesty and sensitivity towards them, which contradicted the Trusts' policies. Importantly, families and carers were not informed of their rights after the suicide of their relative. Critically, families were also not given information regarding advocacy and support during the investigation process if they required help. As a result, the CQC report (2016) posits that failings by the Trusts do contribute to negative experiences endured by families, thereby adding to their distress especially after the suicide. This further points to a need for better understanding of how Trusts should support families after a suicide, as well informing them of services in order to minimise any further distress.

1.6 Summary

This introduction sets the context for the thesis. It outlines the current suicide statistics in the population of England, as well as those decedents who were in receipt of mental health services before their suicide. The difficulty of establishing the number of people affected by a suicide was also debated, but also the lack of support and information on postvention for suicide survivors. This chapter also highlights the importance of the mental health context when the deceased was in receipt of mental health services, including the role of relatives/carers supporting the deceased, involvement with mental health services and their

experience of the investigation process. Finally, this chapter highlights the limitations in current research and the need for a more in depth understanding of the experiences of suicide survivors, taking into account the social and situational context.

Chapter Two: Review of the Literature

This chapter will critically examine literature relating to understanding the impact of suicide on families where the deceased was in receipt of mental health services. In order to understand this literature, it is necessary to contextualise it by understanding ideas of 'normal' grief, expected stages in the grieving process and the medicalising of grief. These ideas and assumptions influence how the bereaved are expected to react over time, regardless of the type of death, so that the diversity of the grief experiences and personal circumstances can be overlooked. I will then review the literature on commonalities and differences in how suicide and other types of death affect the bereaved. Drawing on current empirical studies, a number of factors distinctive to suicide survivors are identified that are also influenced by their life before the suicide. Therefore, to gain a deeper understanding of the mental health context of this study, literature focusing on family members' experiences of caring for or supporting the care-recipient who was in receipt of mental health services will be examined. I will then review studies of different types of support and postvention services for suicide survivors. Finally, I will identify gaps in the literature and knowledge which contributed to developing the rationale for study and setting the aims and objectives.

2.1 Understanding 'normal' grief

A plethora of western grief theories constructed from varying paradigms attempt to explain 'normal' grief. Consequently, providing an overview of all these grief theories is beyond the scope of this thesis. Therefore, this section will discuss dominant theories and key texts, which have been or are still influential in grief and bereavement literature.

From a western perspective, conceptualising 'normal' grief continues to be a source of interest from multiple philosophical paradigms. Undoubtedly, the universal experience of death results in commonalities in the experiences of loss, grief and bereavement in individuals irrespective of their backgrounds. Nonetheless, conceptualising 'normal' grief remains debatable in research and poses difficulties due to the variability in grief experiences (Breen & O'Connor, 2007; Bonanno & Kaltman, 2001; Stroebe & Schut, 2000).

Essentially, grief theories attempt to explain the assumed pattern of grief for the bereaved (Attig, 2004) and provide explanations for the social, emotional and psychological effects of grief on individuals (Buglass, 2010). The emergence of grief theories historically evolved within the behavioural sciences (Howarth, 2007) and influenced the development of stage based, phasic, task orientated and process models. As a result, Bradbury (1999) contends

that the field of psychology and psychiatry have been instrumental in medicalising grief within a positivist paradigm. From this perspective, the focus is on the individual's internal grief, and disregards the context of their social world (Bradbury, 1999).

Setting the foundations of psychoanalytical grief work was Sigmund Freud who was influential in the development of grief theories in psychology. Freud's seminal writings included *Mourning and Melancholia* written in 1917. His grief work developed from observations during clinical work with people experiencing depression and he noted distinct differences between grief and depression. Freud believed that the bereaved had to break bonds with the deceased in order to adjust to their loss and effectively resolve grief. Therefore, maintaining an emotional attachment to the deceased was seen as a pathological response that required clinical treatment. Lindemann (1944) also shared a similar view to Freud by also proposing the bereaved had to emotionally detach from the deceased. In this view, detachment enabled the bereaved to overcome their loss by adapting to a life without the deceased and developing new relationships (Rothaupt & Becker, 2007).

Offering a psychosocial perspective to dying, Kübler-Ross (1969), a psychiatrist, carried out research with over 200 terminally ill patients in palliative care. She developed a theoretical model capturing patients' psychological and emotional responses to dying. The original model reflected the patients' experiences of anticipatory grief by identifying the stages of denial, anger, bargaining, depression and acceptance. Essentially, for Kübler-Ross (1969), denial in patients resulted from the shock of being diagnosed with a terminal illness and elicited feelings of anger. Bargaining captured ways in which patients negotiated ways in which to prolong their life, for example bargaining with God for more time to live. However, depression set in once patients realised their illness was incurable and a natural reaction to the anticipated death, resulting in sadness. The final stage of acceptance reflected how the patient had little interest in life and became withdrawn and isolated. Some patients may feel anxiety as they consider their imminent death or when faced with the uncertainty of the unknown. Importantly, Kübler-Ross later acknowledged that individuals would not experience all the stages and not in any particular order.

Kübler-Ross's model has been adapted as a grief theory and acquired recognition in health care to support the bereaved in clinical practice (Copp, 1998). The model offers health professionals a structured, descriptive and theoretical model to understand grief. The model has also been adapted to understand other types of loss such as chronic illness and divorce (Murray, 2003). However, there are criticisms of the model (see Section 2.1.1). Parkes (2013) carried out a candid reappraisal in 'Death and Dying' (Kübler-Ross, 1969) and reported that the grief model stemmed from original research by James Robertson and John Bowlby in 1952 on mothers separated from their children. According to Parkes (2013), this was not

acknowledged by Kübler-Ross who utilised some of these concepts in her model. Subsequently, the model was adapted by Bowlby and Parkes (1970), based on their studies on the experiences of bereavement by adults.

Bowlby's attachment theory (Bowlby, 1982) has also been prominent in understanding grief from a psychoanalytic perspective (Nesse, 2005). Bowlby's theory comprises of five phases of numbing, yearning, searching, disorganisation and re-organisation. Numbing affects the bereaved person for a relatively short period from hours to weeks as the reality of death is not fully accepted. The numbing phase also includes self-directed anger or anger towards others, which can also be experienced in the next phase of yearning. This phase extends for a longer period of time and includes the intense desire of searching for comfort, which has been lost because of the death. In order to deal with the separation from the deceased, the bereaved seek to replace their loss by creating new relationships. The next phases of disorganisation and re-organisation reflect that the reality of the death has been accepted and enables the bereaved to form new attachments and move away from previous behaviour patterns.

Bowlby and Parkes (1970) further adapted the attachment model to include a 'Phases of Grief' model. They recognised that the personal and circumstantial factors of the bereaved were significant in their adaptation to grief. The model reflected four phases that included: shock and numbness; yearning and searching; disorientation and disorganisation; and finally, reorganisation and resolution. The bereaved were expected to progress through these phases to revert to a level of functioning that was similar to how they were prior to the death.

Worden (2003) describes a wide range of common grief reactions that include sadness, anger, guilt, anxiety, loneliness and fatigue. Moreover, the bereaved experience feelings of helplessness, shock, yearning, emancipation, relief and numbness. Cognitive grief reactions include confusion, disbelief and preoccupation with the deceased. Additionally, there are also physical symptoms of grief such as breathlessness and weakness in the muscles. Finally, Worden cites a number of common behavioural reactions to grief. These include sleep disturbances, loss of appetite, social isolation, crying, forgetfulness and avoiding or keeping reminders of the deceased. Critically, grief may be more complex, as found by Bonanno and Kaltman (2001) who conducted a systematic review on the varieties of grief experiences. Their results identified that normal grief consisted of moderate disturbances to the bereaved, which affected their physical, emotional, cognitive and interpersonal functioning. Grief reactions were more intense in the first few months after the death, but reverted to normal by the end of the first year (Bonanno & Kaltman, 2001). Klein and Alexander (2003) found that the first six months after a death required the most adjustment by the bereaved and after 18 months an acceptable adjustment to the death is achieved.

Over time, traditional grief theories have been adapted by other researchers, for example, Shuchter and Zisook (1999) adapted Kübler-Ross's (1969) model by incorporating the subjectivity of an individual's grief into their own model. These suggest that the intensity and variability of cognitive, emotional, social and behavioural grief reactions influence how the bereaved adapt to their loss. Distinctive to each bereaved person is shock, disbelief, denial, acute mourning, emotional discomfort and social withdrawal, which leads to emotional distress. At times, the bereaved experience symptomatic pain, which is the physical manifestation of psychological pain. Finally, restitution is the point at which individuals still feel their loss, but are able to interact with the world around them and successfully adapt to their grief.

Recently, grief theories have shifted away from traditional prescriptive models, because there is relatively little robust empirical evidence to support their reliability and efficacy for the bereaved (Begley & Quayle, 2007; Buglass, 2010; Corr, 1992; Maciejewski, Zhang, Block & Prigerson, 2007; Sands & Tennant, 2010). Moreover, although Kübler-Ross's model continues to be influential in grief work, it has been heavily critiqued as it assumes that the bereaved pass through each stage in the grieving process (Hall, 2011; Maciejewski et al., 2007). The distortion and oversimplification of grief fails to capture the multifaceted complex processes and emotions of grief, which sets unrealistic expectations of grieving for the bereaved that can have negative consequences (Stroebe, Schut & Boerner, 2017). Concerns are also raised regarding the use of traditional grief theories in clinical practice, because they have been rigorously applied to develop postvention and measure the 'progress' of the bereaved (Breen & O'Connor, 2007; Stroebe et al., 2017). Moreover, grief theories offer little guidance on the identification of factors that increase the risk of complications in grief and can lead to inappropriate or ineffective support (Bonanno & Boerner, 2007; Stroebe et al., 2017).

Importantly, grief theories are constructed in western cultural paradigms and disregard the diversity and individuality of non-western cultural and religious responses to grief (Buglass, 2010; Grad, 2011; Hall, 2011; Larson, 2013; Rothaupt & Becker, 2007; Valentine, 2006). Expecting individuals to conform to an assumptive western norm of grief can lead to difficulties for the bereaved to rationalise their grief (Moules, Simonson, Prins, Angus & Bell, 2004; Shuchter & Zisook, 1999; Watts, 2009). Therefore, Hall (2014, p.12) argues that a "one-size-fits-all" model of grief fails to capture the individualism of grief experiences. As a result, a mounting body of evidence substantiates that grief is a multifaceted response to loss; resulting in individuality and variability in grief experiences (Murray, 2001; Valentine, 2006). Rando (2000) also makes a salient point that grief theories can endeavour to indicate potential responses by a bereaved person, however, relatively little research has been conducted on individual grief patterns and the best way of supporting them. Subsequently,

moving away from stage or task-based grief theories is necessary to reconceptualise how over time, a death changes the bereaved (Beyers, Rallison & West, 2017).

2.1.1 The problem with medicalising grief

A consequence of identifying the expected parameters of the 'normal' adaptive grief process is that people can be identified as having 'abnormal' grief reactions, which have been associated with mental disorders. The dominance of the medical discourse in literature remains persuasive, and as a result, pathologising grief has led to the bereaved being diagnosed with a mental disorder as classified in various diagnostic manuals.

Two of the most utilised diagnostic manuals are; the Diagnostic Statistical Manual of Mental Disorders (DSM), produced by the American Psychiatric Association (APA), and the International Classification of Diseases (ICD) published by the World Health Organisation. These manuals have been highly instrumental in categorising psychiatric disorders, including the medicalisation of grief. Some of these highlighted terms have emerged in various revisions of diagnostic manuals, including the DSM. Currently, the ICD-10 does not cite pathological grief (cited in Iglewicz, Seay, Zetumer & Zisook, 2013). However, the most recent DSM-5 (APA, 2013) now contains persistent complex bereavement related disorder that acknowledges the distinctiveness of grief. A recent amendment to the DSM-5 has been the removal of references to bereavement from the classification of major depressive disorder (MDD). This exclusion has prompted clinicians to recognise that grief is a natural reaction and that it should not be pathologised. Critically, clinicians may struggle to differentiate between grief symptomology and depression, leading to the possibility of over-diagnosing the bereaved with MDD (Iglewicz et al., 2013).

It is argued that categorising these disorders can be advantageous for clinicians by offering them diagnostic tools to assess the bereaved and to implement effective interventions where appropriate (Copp, 1998; Stroebe & Schut, 2000). As a result, people who are bereaved and diagnosed appropriately with a mental disorder can provide evidence of the efficacy of interventions for clinicians and researchers (Klein & Alexander, 2003). On the other hand, a strong body of opposition argues against the medicalisation of grief, because it is a universal human experience (Bryant, 2012; Klein & Alexander, 2003). Stroebe et al. (2000) questions the robustness of evidence to support the medicalising of grief and labelling the bereaved with a mental disorder. This can have negative consequences for the bereaved resulting in stigma, shame, and being marginalised in society, thereby, detrimentally impacting their health (Clement et al., 2015; Shear et al., 2011). The bereaved may also be inadvertently

misdiagnosed and treated for a mental illness such as depression, because its symptoms share similarities with grief reactions (Beyers et al., 2017).

According to Bryant (2012), the DSM or ICD implement a generic diagnostic tool and rigid criteria to grief which is problematic. This neglects the diversity in grief experiences, which are multi-cultural and may be informed by religious practices (Bryant, 2012). Watts (2009) also points out that not all individuals want their grief experience to be labelled, medicalised and classified because it is a normal reaction to a death. Additionally, grief literature predominately focuses on symptoms, possible outcomes and risk factors that are often researched in isolation (Breen & O'Connor, 2007).

Substantial and persuasive evidence supports the need to understand the distinctiveness of grief experiences (Klein & Alexander, 2003; Larson, 2013; Valentine, 2006; Zisook & Shear, 2009). Iglewicz et al. (2013) adds that homogenising the bereaved disregards the social, physical and psychological repercussions on them. Therefore, recognising the individual's context of bereavement, such as the social, cultural and political factors can provide clarity in understanding how these factors are instrumental in their grief experience (Iglewicz et al., 2013). Breen and O'Connor (2007) further identify important considerations for the bereaved which include family, social support and health services. Consequently, clinicians with an awareness of wider socio-economic factors for a bereaved individual will provide a more accurate assessment of whether the grief is normal or pathological (Shear et al., 2011). From this perspective, clinicians and other health professionals will be more likely to effectively support the individual, rather than implementing a generic response (Iglewicz et al., 2013).

2.1.2 Understanding grief from an individual perspective

The discussions in this chapter so far have provided an overview of the difficulties of conceptualising 'normal' grief and problems with medicalising grief, which can fail to consider the diversity of the bereaved and their experiences. As a result, a growing interest in understanding grief has emerged from a postmodern social constructionist paradigm. This approach has gained popularity by acknowledging that the social context of the individual is influential in their grief (Murray, 2003; Shields, Kavanagh & Russo, 2017). Therefore, this section explores key grief theories developed from a social constructivist framework that may be helpful in understanding suicide survivors' experiences.

Recent developments in grief theories draw attention to the importance of the personal and situational context of the bereaved as reflected in the Dual Process Model (DPM) of coping with bereavement by Stroebe and Schut (2000). Factors such as the individual's gender, age, culture and the circumstances of the deceased's death influence how they cope with grief.

The DPM is illustrated in a diagram, which shows two distinct strands relating to how the individual copes with a bereavement. One strand relates to loss-orientated factors and the other refers to restoration-oriented factors, and the *"oscillation between these two components provides a framework for a systematic probing of assumptive worlds, meaning systems and life narratives"* (Stroebe & Schut, 2000, p.69). The DPM offers a deeper insight into how the loss-orientated strand focuses on an individual's stressors and behaviours that emerge from the direct impact of the death. This includes denial, breaking bonds or ties with the deceased or avoidance of restoration changes. The restoration-orientation strand captures the secondary stressors experienced by the individual, such as making changes to their lifestyle, distracting themselves from the grief or establishing new identities, roles and relationships.

Worden's task-based model of mourning (2003) also contests stage-based models of grief and is focused on the bereaved's re-negotiation of their 'new world' without the deceased. Worden proposed his model was dynamic rather than prescriptive or linear, although he suggested there is a natural order to mourning. The first task for the bereaved is accepting the loss of the deceased. Following on is *"to work through the pain of grief"* (Worden, 2003, p.31) and this may include a myriad of emotions such as guilt, relief, despair, loneliness and sadness. The third task is *"to adjust to an environment in which the deceased is missing"* (Worden, 2003, p.32). This reflects the role and relationship the deceased had in the bereaved's life and how, over time, the bereaved re-adjust their life without the deceased. The final task for the bereaved is *"to find an enduring connection with the deceased while embarking on a new life"*. If the bereaved person is still distressed after a few years, Worden (2003) proposes that they have a pathological condition, such as unresolved grief, which requires clinical intervention.

A model of meaning reconstruction in response to the loss of a significant other was also developed by Gillies and Neimeyer (2006). They propose that the bereaved adapt to their loss through meaning reconstruction. In simple terms, the bereaved reconstruct a new reality that has irreversibly changed following their loss. Gillies and Neimeyer (2016) posit that before their loss, the bereaved have meaning structures based on their perceptions of self, faith, spirituality, relationships and a view of the world and future. After a death, the bereaved reconstruct new meaning structures, leading to a changed outlook on life and their future. Meaning structures reflect a new sense of self, re-examining priorities and continuing bonds with the deceased. Moreover, the distress of the bereaved is influential in how they reconstruct new meanings post-loss. For example, an individual's pre-loss meaning structures may be incongruent with the death, resulting in increased distress and a search for meaning. In this process, the bereaved may undertake identity change, sense making and find benefit

from the death. Reconstructing the self, therefore, reflects how the bereaved may develop new identities and relationships. This notion of the bereaved acquiring new roles in their life is also proposed by Stroebe and Schut (2000) in the DPM.

According to Gillies and Neimeyer (2016), sense making essentially captures the need for the bereaved to understand why the death happened. This is important to establish the causality of death and to find answers as a way of dealing with their pain. Benefit finding is taking positivity from the experience of loss, which links in with post-traumatic growth (see Section 2.4.2). Critically, grief does not necessarily result in only negative emotions, but the bereaved may experience positive emotions such as peace and relief (Bonanno & Kaltman, 2001; Zisook & Shear, 2009) (see also Section 2.2.4).

From a constructivist approach, continuing a bond with the deceased is important for the bereaved as a way of coping (Murray, 2003; Root & Exline, 2014). The bereaved may draw on several ways of continuing bonds with the deceased, most often by visiting the deceased's final resting place, speaking with the deceased, keeping their belongings and participating in rituals (Hall, 2014). Arguably, continuing a bond with the deceased can be transformative for the bereaved as they adapt their self, identity and finding positive change in their outlook on life (Berzoff, 2011). However, Field, Nichols, Holen and Horowitz (1999) add that the failure by the bereaved to emotionally detach themselves from the deceased's belongings after six months, can indicate maladaptive coping for the bereaved.

In summary, stage, phasic or task-based grief theories have been influential in understanding individuals' experiences of death, and in some cases, proved popular for clinicians to support the bereaved. Nonetheless, the assumption of a linear response to grief is problematic considering the diversity of individuals and their grief experiences. Alternative models which focus on meaning reconstruction provide a framework for understanding grief as a more complex and individual experience by taking into account their personal and situational context. Consequently, this knowledge can help health professionals gain a deeper insight into the bereaved's experiences and understand how to better support them.

2.2 The impact of suicide on family members

As stated earlier, suicide survivors experience an increased risk of poorer health outcomes compared with individuals bereaved by other types of death (Neimeyer, Prigerson & Davies, 2002; Parkes, 2002; Stroebe, Folkman, Hansson & Schut, 2006; Zisook & Shear, 2009). Arguably, a suicide is a distinctive type of death and the following sections will discuss the debates in this area in more detail.

Family members' perceptions of the suicide of their relative also influence how they make sense of the death. Arguably, deaths that contravene an expected natural order such as suicide, are comparatively different, especially if the death is perceived as premature, such as the death of a child (Hall, 2014; Neimeyer et al., 2002). Suicide can be perceived as an uncommon death, unexpected, traumatic and potentially violent (Grad, 2011; Parrish & Tunkle, 2005). In some cases, a suicide may be perceived as impulsive or opportunistic, which adds further confusion for family members (Hunt et al., 2010). Subsequently, many suicide survivors try to make sense of a death, leading to a stronger need to search for an explanation and answers to understand why the death occurred (Gillies & Neimeyer, 2016; Lindqvist, Johansson & Karlsson 2008). Therefore, this section will highlight key debates relating to suicide survivors in general in the wider context of literature. A number of factors also influence the suicide survivor's grief experience, such as their age, gender, kinship, and notably, the nature of their relationship with the deceased. The relationship encompasses a number of factors, such as the frequency of contact and closeness of relationship (Barrett & Scott, 1990; Berman, 2011; McIntosh, 1993). Finally, compared with other types of deaths, a suicide is a stigmatising death, thus family members may experience negative consequences on individual and societal levels and some of these issues will be deliberated.

2.2.1 Making sense of the suicide

The most pressing question for suicide survivors is why the deceased ended their life, and this adds to the complex nature of their grief (CQC, 2016; Lindqvist et al., 2008; Maple et al., 2014; Parrish & Tunkle, 2005). To make sense of the death, suicide survivors search for clues, ruminate on the events leading up to the suicide or recall the deceased's behaviour to identify missed warning signs that could have prevented it (Grad, 2011; Mitchell, Sakraida, Kim, Bullian, & Chiappetta, 2009). In some cases, suicide survivors may fail to find answers to understand why the death occurred or there is an absence of an explanation that contributes to a more complicated grief process (Hall, 2014; Lindqvist et al., 2008; Young et al., 2012).

One way in which suicide survivors may seek answers is by reading suicide notes left by the deceased that may offer them an insight into why it occurred (McClelland, Reicher & Booth, 2000). According to Callanan and Davis (2009), notes are often left by decedents who lived alone to communicate their reasons for the act, which is especially apparent where they had no prior suicide attempts. In addition, these notes can be instructions for family members to put the deceased's affairs in order or to document their final thoughts (Callanan & Davis, 2009). However, in their qualitative study with parent suicide survivors, Lindqvist et al. (2008)

found that suicide notes left by six teenagers did not provide any comfort or offer any clarification to explain why the suicide occurred.

2.2.2 Personal characteristics of suicide survivors and the deceased

Factors found to be influencing suicide survivors have been explored in many studies to understand how they are affected by a suicide. Clearly, the personal and contextual factors of the bereaved contribute to the diversity in their grief experiences as proposed in recent grief theories (Gillies & Neimeyer, 2006; Murray, 2003; Shields et al., 2017; Stroebe & Schut, 2000). These include a suicide survivor's relationship and kinship with the deceased, as well as their age and gender (Bradbury, 1999; Breen & O'Connor, 2007) and these factors will be discussed in the context of current literature and empirical studies.

Studies can overlook subtle nuances that are personal to any one individual, which may or positively or negatively impact on their experiences (Bailey, Kral & Dunham, 1999; Pitman, Osborn & King, 2013). Many researchers argue that the generalisability of some empirical studies is problematic, because the heterogeneity of suicide survivors is not understood and acknowledged (Maple et al., 2014; Smith, Joseph & Das Nair, 2011). Therefore, to gain a deeper understanding of mitigating factors affecting a suicide survivor, implementing a qualitative approach to a study is advantageous to draw out individual responses (Begley & Quayle, 2007; Jordan, 2001).

The gender of the bereaved person has been considered an influential factor in their grief experiences and is discussed further in the context of the differences in kinship relationships with the deceased. To some extent, the literature identifies gender stereotypical responses to grief, behaviour, identity, expectations, attitudes and perceptions (Pettersen et al., 2015). Versalle and McDowell (2005) argue that gender is socially constructed and 'feminine' grief describes the sharing of emotions with others, seeking support and openly expressing feelings. On the other hand, 'masculine' grief reflects the perception that males prefer not to share their feelings with others or seek support for their grief. Additionally, instrumental grief is often associated with males, where the response to grief is problem solving, showing little emotion and finding cognitive ways of coping with loss (Versalle & McDowell, 2005). One mitigating factor attributed to greater numbers of male suicides is the difficulty of conforming to constructs of masculinity, including not seeking help or sharing their feelings (DH, 2015b; Samaritans, 2016). The literature also offers evidence that after a death, males are less likely to access support. For example, Rando (2000) finds self-help bereavement support groups tend to be dominated by females, because males are less likely to receive or accept support from others.

McIntosh (1993) proposes that the nature of the relationship between the bereaved and the deceased is also an important factor in understanding the impact of a death. Callahan (2000) also argues that the closeness of the relationship between the suicide survivor and the deceased requires serious consideration in understanding the impact of suicide, rather than solely focusing on the kinship relationship. Mitchell et al. (2009) found people closely related to the deceased are more deeply affected by suicide. This finding emerged from their quantitative investigation on comparing the quality of life between suicide survivors who were closely or distantly related to the deceased. Closely related suicide survivors experienced higher rates of distress and psychiatric problems compared with those who were distantly related. Mitchell et al. (2009) concluded that the closely related group had a more intimate relationship with the deceased who were often the person they would turn to for emotional and social support. On the contrary, Feigelman, Jordan and Gorman (2009a) found that parent suicide survivors experienced greater difficulties in their grief if they had an estranged relationship with their child or they had made repeated suicide attempts prior to their death, compared with parents who had a positive relationship with their child. Therefore, examining the closeness of the relationship is an important factor in understanding the differences in suicide survivors' experiences.

There are relatively few empirical studies researching the different kinship relationships of mothers, fathers or step-parents who lost a child (Murphy, Johnson, Wu, Fan & Lohan, 2003a). Most studies with suicide survivors are with parents whose child died by suicide (Maple et al., 2014), and this is reflective of the disproportionate statistics of suicide in younger people (see Section 1.2). Some studies have compared how parents are affected by their child's death to suicide with other types of death. For example, a comparison study by Bolton et al. (2013) investigated parents who lost a child to suicide, motor vehicle accidents and a controlled group of death by other causes. Compared with the other two groups, suicide survivors experienced increased breakdown in marital relationships. The difficulties of observing and coping with their child's deteriorating health contributed to conflict in the family unit. Suicide survivors also reported increased mental and physical disorders, including longer-term depression and anxiety in the two years following the death, although they were actively engaged with health services to seek postvention.

Focusing on mothers whose child died by suicide, a qualitative study by Sugrue et al. (2014) identified how participants' notions of motherhood and identity were affected by the death. Mothers believed they had failed in their role to prevent the suicide, and outliving their child led to feelings of guilt and blame. Moreover, mothers experienced poorer mental health and hid their grief to protect others, especially their remaining children. In a few cases, mothers expressed suicidal thoughts, because they wanted to be reunited with their child in the

afterlife. The suicide profoundly affected mothers by challenging their expectations of life and changing how they viewed the world. Consequently, some mothers reported misusing alcohol and medication to cope with the death.

Siblings who experience the suicide of their sibling are described as the 'forgotten bereaved' by Dyregrov and Dyregrov (2005), because there are few studies examining their experiences. The authors conducted a mixed method study of questionnaires and in-depth interviews to examine how the suicide survivors' age and living circumstances affected the impact of the suicide on them. Seventy siblings were divided into two groups: those living with parents and decedent at the time of the suicide, and those who were not. The results showed siblings who lived with the decedent scored higher on posttraumatic psychological distress. They also reported loneliness in their grief, because it was difficult to draw emotional support from their parents who struggled to cope with the suicide. Contributing to feelings of guilt, blame and rejection for some participants was their knowledge of the deceased's suicide attempt(s) or suicidal ideation, especially if these facts were concealed from their parents. Participants living away from their parents coped better with the suicide, as they avoided their parent's grief. The age of the deceased also identified differences in participants' experiences, because those who lost older siblings recounted anger towards the deceased, followed by feelings of guilt. Older siblings were often perceived as protectors of younger siblings, however, losing a younger sibling meant participants took responsibility for supporting their family and the remaining siblings. Dyregrov and Dyregrov (2005) argue that parent suicide survivors are given more attention by health professionals, researchers, families and social networks. Subsequently, little support is available for sibling suicide survivors, children and young adults who experience prolonged and intense negative grief reactions.

Relatively few studies examine the psychosocial outcomes of parent suicide on children and adolescents. However, Kuramoto, Brent and Wilcox (2009), systematically reviewed nine empirical studies in this area. Participants, who were children at the time the suicide occurred, experienced more adverse psychosocial health risks and conflict with their peers and their family. Additionally, participants who found out about their parent's suicide when they were older, experienced intense grief. Discussing the limitations of their review, Kuramoto et al. (2009) recognise that the small number of studies reviewed limits the scope for generalising findings to child suicide survivors. Moreover, it was difficult to determine if the suicide of a mother or father impacted differently on their offspring, although it was tentatively suggested that children were more adversely affected by their mother's suicide. This is supported in a study by Guldin et al. (2015) who established that children who were young, male, and first-born when their mothers died by suicide, were at a disproportionately increased risk of suicide.

In summary, a number of factors have been found to affect the intensity of the grief experiences of suicide survivors, including age, gender, kinship and the closeness of their relationship with the deceased. However, gaps remain in empirical knowledge in understanding how these factors affect individual suicide survivors. Therefore, taking a qualitative approach to exploring can enable a deeper exploration of the impact of suicide on family members.

2.2.3 The distinctiveness of suicide

As stated earlier, a large body of evidence suggests suicide survivors are disproportionately at an increased risk of suicidal ideation and suicide (Andriessen & Krynska, 2011; DH, 2012a; Dyregrov & Dyregrov, 2005; Samaritans, 2016). Young et al. (2012) write about suicide bereavement and complicated grief and suggest suicide survivors experience poorer mental health such as anxiety, depression and post-traumatic stress disorder. Additionally, suicide survivors can experience feelings of rejection, anger, perceived abandonment and self-blame in failing to prevent the suicide. This can result in complicated grief - that is a persistent, traumatic or prolonged reaction, which is markedly more prevalent in suicide survivors. Furthermore,

An advantage of using a qualitative approach to studies with suicide survivors is that some of the many subtle themes in their experiences can be drawn out that are not identified in quantitative studies (Feigelman, Gorman & Jordan, 2009b; McIntosh, 1993). One of the few qualitative studies identified from the literature review was by Hoffmann, Myburgh and Poggenpoel, (2010). They investigated the lived experiences of five adolescent female suicide survivors who lost a 'significant other' and were interviewed within six months of the death. Participants narrated symptoms of depression, suicidal ideation and suicide attempts that emerged from feelings of hopelessness, failure and loneliness. To cope with the suicide, some respondents adopted risky coping behaviours, such as alcohol and drug misuse. It was found that the suicide elicited strong feelings of guilt and anger, but also blame others, God and themselves for failing to prevent the suicide. Participants felt a sense of loss and/or a void left by the deceased, resulting in the loss of their identity or 'self', and disenchantment in life. Although, Hoffmann et al.'s (2010) study was exploratory, the findings draw attention to subtle insights in suicide survivors' experiences and strengthen the argument of using a qualitative approach in this study.

Contributing to the uniqueness of a suicide is the perception by suicide survivors of the death as either sudden or anticipated which results in important differences in their experiences. Most often, a suicide is a sudden death that strongly motivates family members to search for

an explanation as to why the death occurred (Lindqvist et al., 2008). Family members may also consider a suicide as sudden even though, the deceased may have expressed suicidal ideation or made attempts (Grad, 2011). However, a suicide can be anticipated by some family members (Lindqvist et al., 2008), but generally common examples of anticipated deaths in the literature are from a degenerative illness that occur over time (Kelly, 2014). Recently, there has been a growing interest in empirical literature on how an anticipated suicide affects family members. One qualitative study by Maple et al. (2007, p129) investigated how the '*preparedness of a suicide*' affected parents whose child died by suicide. Anticipating the death for some parents related to their difficulties of caring for their child with a severe mental illness who witnessed their child's suicide attempts and expressions of suicidal intent. Parents also encountered barriers in finding effective treatment from health services, which negatively affected their wellbeing and caused conflict within the family unit. Consequently, participants reported feelings of relief after the suicide, because they believed that their child was at peace from living with a severe mental illness, but also felt guilty. This enabled parents to adapt better to their grief, without more severe prolonged or negative grief experiences. Fundamentally, parents tended to not have such a strong need to search for answers as to why the suicide occurred.

An empirical study by Wojtkowiak, Wild and Egger (2012) also investigated the expectedness of a suicide. Data was gathered from 22 males and 120 females who completed grief questionnaires and self-report surveys. The results showed that participants who anticipated a suicide better understood why the death occurred, and were subsequently less likely to search for explanations to make sense of it. Participants also scored lower on grief intensity, especially in participants who were 'able to say goodbye' to the deceased. The findings offer a better understanding of the diversity of the experiences of suicide survivors and how anticipated suicides affect their grief reactions. However, Wojtkowiak et al. (2012) acknowledged the limitations of their study, including the sample composition of mainly female participants who were recruited via bereavement organisations. Moreover, it was difficult to identify how and in which ways the participants anticipated a suicide. Thus, the authors recommend further qualitative studies to investigate this area in-depth to address the gaps in knowledge.

According to Chapple, Ziebland & Hawton (2015), one way in which researchers investigate how individuals are affected by a suicide is by comparing them with people bereaved by other types of sudden or traumatic deaths. Sudden deaths include homicide, road traffic accidents or unexpected deaths caused by health-related problems, for example, heart attacks. Moreover, sudden and accidental deaths, including suicide, can be compared with anticipated deaths to identify commonalities or differences in the bereaved as exemplified by Bailey et

al. (1999). Their qualitative study found that participants who did not anticipate the death, including suicide, had a stronger need to understand the circumstances of the death than those who anticipated a death. The authors concluded that sudden deaths increased the trauma of coping and negatively impacted on participants. Several empirical studies have also found that the bereaved who lose a significant other to a suicide or sudden unnatural death score higher on stigma, shame, rejection, guilt and responsibility for the death, compared with those who experience sudden natural deaths (Feigelman et al., 2009b; Harwood, Hawton, Hope & Jacoby, 2002; Pitman, Osborn, Rantell & King, 2016b).

Although comparison studies on how individuals are affected by suicide and other types of death are insightful, McIntosh (1993) contends that the findings from these types of studies are questionable. He reviewed 14 quantitative and control studies on grief reactions of individual who lost a significant other to suicide and other types of deaths. The review highlighted methodological weaknesses in the studies, such as small sample sizes, recruitment methods and the participants' inclusion criteria. Moreover, he argued there were disparities in the findings from the reviewed studies that resulted from implementing non-standardised data collection instruments on a selective sample of participants which limited the generalisability of the findings. Several authors argue that these limitations further add to the confusion and ambiguity in this area (see Gaffney & Hannigan; 2010; Jobes, 2000). If methodologically weak comparison studies result in speculative conclusions, this has far-reaching implications for suicide survivors in terms of research, policy, service provision and wider support (Feigelman et al., 2009a; McIntosh, 1993).

This section considers suicide is unique and affects suicide survivors in different ways compared with people bereaved by other types of death. A suicide is often considered a sudden death that results in a more complex grief experience as suicide survivors search for answers or try to make sense of it. In contrast, some suicides are anticipated, leading to differences in the experiences of those affected by the death. Clearly, suicide survivors are individuals and rather than treating them as a homogenous group, the diversity in this population requires further exploration. As discussed in Chapter One, one way of identifying deeper insights relating to suicide survivors and their experiences is by conducting further qualitative empirical studies to address the gaps in knowledge.

2.2.3.1 Suicide as a rational or irrational act

The prevailing view from a Western medical paradigm is that suicide results from an acute psychiatric illness that increases the risk of suicide (Clarke, 1999; DH, 2012b). To an extent,

this type of evidence has perpetuated the dominant societal attitude that suicide is symptomatic of a mental illness (Hewitt, 2013), and is caused by poor mental capacity (Callaghan, Ryan & Kerridge, 2013). Therefore, the perceptions of a suicide by someone with a mental illness in society is often considered an irrational act (Beattie & Devitt, 2015; Bhavsar, 2013; Clarke, 1999). This leads to divisive philosophical debates on determining the rationality or irrationality of a suicide by someone with a mental illness (Clarke, 1999; Hewitt, 2013).

Regardless of a mental illness, it is argued that suicide may be rational as discussed by Mayo (1986, p.144):

In general, when people speak of rational suicide they are using "rational" in the ordinary way: to claim a suicide was rational is to claim that the agent had good reasons for ending his life, that doing so made good sense under the circumstances.

Within this framework, Mayo (1986) concedes that suicide by an individual is an option if they perceive that there is no recourse of recovery from a mental or physical illness and living is impossible. Indisputably, the concept of a rational suicide still evokes immense controversy, but researchers such, as Schramme (2013), support the right for an individual to die by suicide if they cannot find a meaning to their life. It has been suggested that a suicide by an individual with an 'incurable illness', such as a severe mental illness, can be more acceptable in society (McAndrew & Garrison, 2007; Singh, Williams & Ryther, 1986).

Clearly, the mental health context of suicide highlights different perceptions of a suicide, but another factor strengthening the argument that suicide is distinctive is the negative perception of a suicide and ensuing stigma compared with other types of death. This will be discussed further in the next section.

2.2.3.2 The stigma of a suicide

As discussed in the Glossary and Key Terms, suicide was only decriminalised in England in 1961, and is heavily tainted with negative connotations that emerged within the historical context of Christianity. Although many decades have passed, the stigma of suicide continues to be influential in shaping negative beliefs and attitudes to suicide survivors, but also the deceased who may be described by others as selfish or a coward (Cvinar, 2005; Powell & Matthys, 2013). Arguably, deaths that are negatively perceived in society, or considered taboo, may be stigmatising for the bereaved and elicit similar reactions experienced by suicide

survivors. Other types of stigmatised deaths include homicide and acquired immunodeficiency syndrome (AIDS) for example (Feigelman et al., 2009b; Murray, Toth & Clinkinbeard, 2005; Pitman et al., 2016b). These deaths can result in the bereaved hiding the causality of death and experiencing self-blame and social isolation (Murray et al., 2005).

Qualitative studies are particularly beneficial in drawing out subtle nuances in the perceived stigma experienced by the bereaved from deaths which are considered taboo. One study by Chapple et al. (2015) conducted interviews with 80 participants who lost a significant other to suicide or other types of traumatic deaths, such as homicide, road traffic accidents and bomb explosions. Interpretive thematic analysis of the data highlighted how suicide survivors encountered stigma from others, leading to feelings of shame and blame which deterred them openly grieving in public. As a consequence, participants shared how they had to meet societal expectations of grief or 'acceptable grieving' which could be expressed for a short time and then hidden. The traumatic nature of the deaths made it difficult to conform to normative assumptions of grief.

Empirical studies on suicide survivors have reported that they experience the stigma of a suicide (Chapple et al., 2015; Harwood et al., 2002; Sveen & Walby, 2008). Stereotypical societal perceptions of suicide survivors assume they are responsible for the death, dysfunctional, untrustworthy and to be feared (Corrigan et al., 2016). The perceived stigma can leave suicide survivors feeling judged according to Peters, Cunningham, Murphy and Jackson (2016). Their qualitative study with 10 participants also highlighted how rejection and isolation by their friends and community resulted in their detachment from social and family relationships. The authors concluded that the suicide led many participants to internalise the stigma, which negatively affected them. Studies have found that most family members experience some social isolation or withdrawal by others, because of the stigma of a suicide (Harwood et al., 2002; Pitman et al., 2016b; Young et al., 2012). However, a study by Feigelman et al. (2009b), with 462 parents whose children died by suicide, found half of the parents reported developing closer relationships with significant others in their social support, because of the shared sense of loss.

In summary, there is a strong argument that suicide is a distinctive type of bereavement, and both qualitatively and quantitatively distinctive to non-suicide bereavement. Many factors support the argument that suicide is a unique type of death that impacts on family members or significant others in different ways. Stigma experienced by suicide survivors is clearly evidenced in empirical literature, and is a serious concern because it may prevent them from accessing postvention or different types of support (Feigelman et al., 2009a; Peters et al., 2016). Moreover, the perception of a sudden or anticipated suicide impacts suicide survivors differently, and reflects the diversity in this group, however, this area is relatively under-

researched (McIntosh, 1993). Suicide survivors are expected to follow 'normal' grief reactions, but, this can be problematic when one considers the complexity and diversity of their individual experiences. More research is needed to understand how the suicide by someone in receipt of mental health services impacts on their families, because they may express grief reactions, such as relief that may be misunderstood by others who have no awareness of the mental health context of the deceased (Buus, Caspersen, Hansen, Stenager, & Fleischer 2014; Murphy, Clark Johnson and Lohan, 2003b). As this group of suicide survivors is relatively overlooked in research, it strengthens the rationale for implementing a qualitative approach to this study (see Section 2.5).

2.2.4. Post-traumatic growth in suicide survivors

A considerable number of studies with individuals bereaved by suicide or other types of death focus on the negative consequences on individuals. Although a suicide is a traumatic event, positive psychological changes or post-traumatic growth (PTG) can occur in suicide survivors (Gerrish, Dyck & Marsh, 2009). According to Feigelman and Feigelman (2011, p.180), PTG *"is reflected in social change actions, when survivors act collectively to alter the fabric of society, to prevent suicide, and to diminish the stigma that now surrounds it and other mental health problems."*

Relatively few studies specifically focus on PTG in suicide survivors, but many researchers allude to positive growth in their studies. One study by Clarke and Goldney (1995) investigated grief reactions in a suicide survivors support group. They noted positive growth was part of the participants' grief recovery and was reflected in their reconstruction of a new life and sense of self. In addition, participants who took a positive perspective on the suicide also found meaning from the death, for example, it was felt that the deceased may have had a strong need to end their life, therefore, they had fulfilled their wish. In some cases, the deceased had caused a great deal of distress to the suicide survivor following repeated suicide attempts. Thus, the suicide ended the anxiety of an imminent death, leading to feelings of relief (Clarke & Goldney, 1995).

In a more recent phenomenological study, Smith et al. (2011) explored PTG in six adult suicide survivors. Their findings identified participants' increased awareness of life, mortality and an appreciation of the world. The suicide put the participants' lives into perspective, and they were able to cope better with life stressors, leading to changes in their attitude, behaviour and actions. Furthermore, participants experienced a shift in their relationship with others by becoming less judgemental, helping others and being considerate of others' feelings. The authors acknowledge that there were limitations in their study, including the

small sample size, and the recruitment of participants via Samaritans and a suicide bereavement support group. Therefore, they recommended a need for empirical research with participants not accessing interventions, which may offer a more in-depth insight into the diversity of suicide survivors' experiences.

Suicide survivors' sense of personal growth increases when they channel their individual grief into practical ways of raising awareness with others and wider society (Cerel et al., 2009). Moore, Maple, Mitchell and Cerel. (2013) highlight how suicide survivors become activists to campaign and lobby for suicide prevention initiatives or interventions for those affected by the death. In fact, Feigelman and Feigelman (2011) contend that PTG is higher in suicide survivors who have lived with the death over a longer time period compared with the recently bereaved. Therefore, exploring the positive changes and growth in suicide survivors offers a different insight into their experiences, in contrast to research which focuses predominately on the negative consequences of a suicide.

2.3 The mental health context of the deceased prior to the suicide

Chapter One provided a brief overview of key issues relating to the family members or carers' involvement in mental health services while supporting their relative. Having an awareness of these issues is important, because to make sense of a suicide, family members often draw on their experiences with the deceased prior to the suicide, or as Wertheimer (2001, p53) terms, 'looking back'. As stated earlier (see Section 1.5), family members recall their knowledge of the care-recipient's mental health context, especially if they have been involved in their care and support (Cormac & Tihanyi, 2006; Crowe & Lyness, 2014; Maple et al., 2007; Shah et al., 2010). For example, Sveen and Walby (2008) identified that suicide survivors may experience different grief reactions which may be misunderstood by others who are unaware of the mental health context of the deceased. This is a significantly different finding compared with people bereaved by other types of death. Sveen and Walby (2008) systematically reviewed 41 empirical studies on mental health and grief reactions of suicide survivors. The review highlighted that some suicide survivors, who cared for their relative with a mental illness, reported feelings of relief after the suicide. In these cases, suicide survivors' difficult experiences in caring for the deceased, included dealing with the unpredictability of the mental illness, suicidal intent and suicide attempts. Therefore, this section will focus on the mental health context of the deceased prior to the suicide, when they were known to have a mental illness and/or receive support from mental health services.

2.3.1 Life before the suicide: prior involvement with mental health services

Although this study focuses on the suicide of those in receipt of mental health services, not all those with a mental illness receive support and treatment from services. In fact, a large number of the deceased may have had an undiagnosed mental illness. Many psychological autopsies have identified undetected mental disorders as a risk factor in suicides (Cavanagh, Carson, Sharpe & Lawrie, 2003; Houston, Hawton & Shepperd, 2001). Psychological autopsies analyse data gathered from documentation held by different agencies, such as the NHS, Coroner's Office and local authorities. People closest to the deceased are also interviewed as they have a greater insight into the deceased's life prior to the suicide, including their poor mental health, suicidal behaviour or expressions of suicidal intent (Wertheimer, 2001). Furthermore, the perceived stigma of a mental illness can result in an individual hiding the symptoms, preventing them from honestly disclosing their mental illness to their families or stopping them from seeking help on their behalf (Clement et al., 2015; Samaritans, 2016). Therefore, some families will have limited knowledge or awareness of the deceased's mental illness or engagement with mental health services.

It is widely accepted that mental health services heavily rely on families and carers to provide substantial support to a relative with a mental illness (Copeland & Heilemann, 2011; Klevan, Davidson, Ruud, Karlsson, 2016). However, there is an increasing demand for closer working collaborative partnerships between the patient, carer and mental healthcare professionals. This can lead to an exchange of information to provide more effective support to the care-recipient and prevent future suicides (Clearly, Walsh & Dowling, 2014; McLaughlin, McGowan, Kernohan & O'Neill, 2016). Often, families or carers have in-depth insight into the care-recipient's mental health, which enables them to seek early intervention for them if they note worrying changes (Klevan et al., 2016). On the contrary, mental healthcare professionals usually have greater knowledge of the care-recipient's mental disorder and treatment, which can be shared with families or carers to help them in supporting a suicidal relative (Grant, Ballard & Olson-Madden, 2015; Jeon, Brodaty & Chesterson, 2005).

It has been argued that mental health services should be more supportive of the carers or families of patients (CQC, 2016; Copeland & Heilemann, 2011; Shah et al., 2010). According to Cleary et al. (2014), families caring for relatives with a severe mental illness lacked understanding and knowledge of the mental health problems and treatment when the care-recipient was diagnosed. As a result, families felt uninformed of what to expect, especially when health professionals provided inadequate explanations or information on their relative's treatment or care. Another criticism was of healthcare professionals heavily medicating the patient, rather than implementing more holistic treatment options. Similar findings emerged

from a qualitative study by Lindgren, Åström & Graneheim (2010) with parents of self-harming adult children. They had largely negative experiences of the Swedish healthcare system and consequently, parents felt lost, confused, lacked confidence in health providers and felt trapped without any recourse to help for their child. Champlin (2009) adds that carers experience anxiety regarding the health and safety of their relative in mental health services, especially as in-patients. Family members felt their relative was at risk of harming themselves or being harmed by others, including clinicians. Wertheimer (2001) suggests that another area of confusion for families is when the care-recipient is diagnosed with different mental illnesses or a long time is taken before a diagnosis is given. Moreover, Peterson, Luoma and Dunne (2002) add that health professionals have been criticised by family members for prescribing the wrong medication or dosage to the care-recipient or failing to consider the serious possibility of a suicide.

Parents of children who self-harm can also encounter negative experiences with health professionals if clinicians lack the necessary training and skills to effectively support them according to Raphael, Clarke and Kumar (2006). Their qualitative study identified that the negative attitude of health professionals affected the level of engagement and compliance by children in their treatment. Similar findings emerged in Lindgren et al.'s study (2010, p5) which described parents 'being broken' from their negative experiences with health professionals when seeking help for their adult children who self-harmed. Moreover, differences in opinions between healthcare staff and carers can also be problematic as suggested by McNeil (2013). Families may have a greater understanding of their relatives' needs, and therefore may disagree with the healthcare professionals on the best treatment options. In some cases, families will strongly advocate on behalf of their relative to ensure their treatment choices are respected, but these decisions may be contested by health professionals. However, Champlin (2009) adds that families may be constrained from requesting support for their relative, because they do not want to be perceived as overbearing by healthcare staff.

Families or carers have also raised the issue of the lack of continuity of care by health professionals treating their relatives (Champlin, 2009). McLaughlin et al. (2016) highlighted similar findings and added that healthcare staff worked independently rather than as a team to effectively treat the patient. This can be challenging and frustrating for the patient and carers, because of the difficulties in developing relationships with treating clinicians, resulting in a lack of trust and understanding. In addition, family members can receive contradictory information from different mental health clinicians regarding the treatment for the care-recipient that adds to their frustration (McNeil, 2013).

Families or carers of patients accessing mental health services may also encounter problems with patient confidentiality, especially when the care-recipients are 18 years or over (Lindgren et al., 2010). Patient confidentiality can prevent family caregivers being informed by health professionals if their relative is suicidal, has made suicidal attempts or deliberately self-harmed (McLaughlin et al., 2016; Raphael et al., 2006). In their study, Lindgren et al. (2010) found health professionals failed to involve parents in meetings about their adult child, even though in some cases the patient had consented. As a consequence, parents felt invisible and ignored by healthcare staff. According to Copeland and Heilemann (2011), some caregivers, especially mothers who are primary caregivers, may want to take legal guardianship of their child's care. This was especially apparent if mothers had concerns about their child's lack of mental capacity or their child's refusal of treatment that could benefit them. However, mothers encountered barriers from mental health services who opposed this action or failed to support them. This was problematic, as mothers recognised their child needed long-term medical support to stabilise and treat the mental disorder. As a result, they felt disempowered, voiceless and helpless when seeking effective treatment or communicating their fears with mental health providers.

In summary, empirical research suggests that in general, the support health services provide family members while caring for their relative is inadequate. Essentially, mental health professionals should respect and value the contribution and commitment of family members or carers supporting a relative at risk of suicide. This is necessary because clinicians may have opportunities to effectively engage with or treat a care-recipient at risk of suicide and prevent future suicides. As stated earlier, patient confidentiality can be problematic for carers or families if their relative has poor mental capacity or the care-recipient is under the age of 18. Although health professionals and families/carers have to respect confidentiality, it is important to find a balance (DH, 2014b). Family members in a study by McNeil (2013) suggest they require sufficient information on the care-recipient to be able to offer their support and also to allay their fears, especially after suicide attempts or crises.

2.3.2 Life before the suicide: the personal experiences of families caring for and supporting people with a mental illness

According to Broady and Stone (2015), carers of relatives with a mental illness face different challenges compared with carers of those who are elderly, have a disability, or a terminal illness. For example, carers of relative with a mental illness are more likely to encounter the sporadic and unpredictable nature of their illness that causes greater emotional burden. Moreover, health services may fail to recognise the burden on this group of carers and since

research is lacking in this area, further studies are necessary to explore how the caring responsibilities impacts on their health to better determine their needs. A few studies have found that suicide survivors who have been subjected to the deceased's difficult behaviour, self-harm and expressions of suicidal intent, draw on these events to make sense of the suicide (Grad, 2011; Peters et al., 2013). Therefore, this section focuses on the existing literature in the area to gain an insight into families or carer's experiences.

Some studies with families/carers include suicide survivors, as exemplified in a study by McLaughlin et al. (2014), who explored the burden of caring for or living with a suicidal family member. Eighteen family members were interviewed, including seven suicide survivors. One theme of family burden encapsulated the participant's constant anxiety, stress, fear and worry for the suicidal person affected their relationship, and others in the wider family unit. Consequently, participants and other family members expressed poorer psychological and physical well-being. Another theme, relating to secrecy and shame, captured how family members were coerced by the suicidal relative to conceal their suicidal behaviour from others. Participants also reported feelings of shame from the perceived negativity of others regarding the suicidal relative, participants or their wider family. Due to the secrecy imposed by the suicidal person, participants found it difficult to seek support or share their experiences with others. The theme of coercion by the care-recipient is further supported in a qualitative study by Weimand, Hall-Lord, Sällström and Hedelin (2013) who reported that carers felt pressured to conceal their relatives' mental illness or symptoms from others. On the other hand, family members may also coerce the care-recipient to take medication or engage with mental health services.

The responsibility of care on primary caregivers supporting a relative with a severe mental illness highlights the competing tensions they experience in balancing daily life, work, family responsibilities and social activities (McLaughlin et al., 2014). Copeland and Heilemann (2011) state that mothers caring for their children with a mental illness left them unable to work, pursue their desires, or fulfil their needs, and led to financial difficulties and limited social and family support. Additionally, family members can feel burdened with more responsibility of care if people in their social support network distance themselves because of their relative's mental illness (Champlin, 2009). Consequently, family members or carers may feel lonely, helpless, isolated, frustrated, exhausted, powerless and trapped (Klevan et al., 2016; Lindgren et al., 2010; McLaughlin et al., 2014; Trondsen, 2012). Weimand et al. (2013) suggest that some carers contemplate suicide themselves, because of the intense and prolonged challenges of caring for a relative with a severe mental illness. Adding to carers' difficulties is feeling a sense of powerlessness, because of their negative experiences with health services when seeking help for the care-recipient.

Mothers are often primary caregivers and can suffer violence from their adult child with a severe mental illness according to Copeland and Heilemann (2011). Their qualitative study highlighted competing tensions experienced by mothers; keeping their child at home and being a victim of future violence against protecting their child from risk of harm if they lived outside the home. Witnessing their child suffering with a severe mental disorder, and in some cases a deteriorating illness, left mothers feeling sadness, pain and grief for their child. Mothers also questioned their ability to care for their child and feared for the future once they were unable to support them.

Family members or carers can feel a sense of loss for the care-recipient they had known before their illness, as identified by Champlin (2009). This was a challenging process for family members and comparable to grief after a death. Trondsen (2012) also captured the theme of a sense of loss and sorrow from their qualitative study with children aged between 15 to 18 years whose parents had a severe mental illness. Children felt grief from the loss of the parent as they were before the mental illness and yearned for a 'normal' family life that their parents were unable to provide. Cleary et al. (2014) also add that family members or carers can also experience a sense of loss for the life they had with the care-recipient before they had a mental illness.

Certainly, witnessing suicide attempts or suicidal ideation can have a detrimental impact on families (Maple et al., 2014; Shah et al., 2010; Sveen & Walby, 2008). For example, carers can be in a constant state of fear of suicide attempts according to Trondsen (2012) who investigated adolescents' experiences of caring for a parent with a mental illness. Participants were on 'emergency alert mode' and modified their behaviour to prevent future suicide attempts.

Buus et al. (2014) proposed that suicide attempts can be either anticipated or unexpected, which results in differences in care-givers' experiences. Parents of children who made suicide attempts participated in focus groups and the findings identified how anticipated suicide attempts left parents in a constant state of fear and anxiety. However, parents felt relief after a suicide attempt if they had been expecting one over a long time. In contrast, an unexpected suicide attempt left parents feeling shocked and guilty because they failed to protect their child. Repeated suicide attempts left some parents feeling hopeless, shame, but also anger, blame and hate towards the child. In a few cases, participants also disclosed feeling suicidal due to the trauma of dealing with suicide attempts.

Caring for a relative who self-harms or has a mental illness can also have repercussions on the family unit as shown in a phenomenological study by Raphael et al. (2006). Parents were fearful of admonishing their child to avoid future episodes of self-harm, resulting in the child holding power in the family unit. Moreover, Ferrey et al. (2016), highlighted how parent's

attention to a self-harming child resulted in other siblings feeling resentment, upset, frustration and anger. Some siblings hid their brother's or sister's self-harm from their school age friends to prevent bullying, because of the secrecy and stigma. In some cases, siblings left the family home when relationships in the family become too strained and difficult. Canvin, Rugkåsa, Sinclair and Burns (2014) added that female siblings are more susceptible to the effects of their sibling's suicide attempts, resulting in a poorer quality of life.

Despite the challenges of caring for a relative with a severe mental illness, McCann, Bamberg and McCann (2015) proposed that there are a number of things that support family members to continue in their caring role. Carers hear expressions of appreciation or witness the care-recipient's contentment, which gives them satisfaction and purpose. Moreover, carers draw on their social support network or family unit for respite which is an effective way of coping. Carers can receive emotional and practical support from others that can decrease some of the burden of care and contribute to a better quality of life. In addition, carer's coping strategies include participating in social and physical activities, accessing community-based support groups and organisations, and health services, such as General Practitioners (GPs), counsellors and psychiatrists.

Jeon et al. (2005) suggested that respite care is another source of support for carers of relatives with a severe mental illness, but found there are gaps in knowledge on the efficacy of respite care for caregivers of relatives with a severe mental illness. Their systematic review found that most studies on respite care focused on family members of people with dementia. but, from the limited studies available, Jeon et al. (2005) found these carers had unmet needs. Due to the unpredictability of the mental illness, planning respite care in advance was difficult, leaving them unsupported and struggling to cope. Mothers in Copeland and Heilemann's (2011) study also required respite from their child when they felt overburdened with the responsibility of care, but were unable to find support.

Broady and Stone (2015) propose that carers of people with severe mental illness have greater needs for support or access to health services themselves than carers in general. Their Australian study gathered survey data from 1,916 carers, including 354 carers of people in receipt of mental health services. The results showed that mental health carers expressed a greater need because their emotional and psychological mental wellbeing was adversely affected from their caring role. Although mental health carers were more likely to seek health service support, the unpredictability of their relative's mental illness meant they encountered barriers because services were not flexible enough to meet their needs. Therefore, the authors recommended that individualised and flexible services are required to meet the needs of mental health carers in order to minimise negative health outcomes. Many studies have also advocated that mental health care professionals have to understand carers' personal history,

experiences, context and involvement with mental health services. Disregarding this contextual knowledge can result in health professionals missing important information and knowledge in order to assess the level and type of support for carers (Bolton et al., 2013; Buus et al., 2014). Another way to support families/carers is for health professionals to share information with them on appropriate services to prevent negative health outcomes, leading to the implementation of a tailored approach to support not only care givers, but also the care-recipient (McLaughlin, et al., 2014).

In summary, to make sense of the suicide, family members will draw on their past experiences with the deceased, especially leading up to the suicide, which in turn influences their grief experiences. Bearing in mind the mental health context of this study, family members draw on their knowledge of the deceased's mental illness and/or engagement with mental health services to make sense of the death. Therefore, examining the life before the suicide for family members is important to find deeper insights into how the suicide impacts on them.

2.4 Types of support and postvention for suicide survivors

This section will discuss different types of support and postvention for suicide survivors, although it should be acknowledged that their needs will vary between individuals and over time. This means that some individuals might prefer not to access professional interventions or share their death experience with others at particular times (Jordan, 2008; Smith et al., 2011). The bereaved generally develop their own personal way of dealing with a death, including risky health behaviours, for example, self-medicating, overworking, alcohol or substance misuse (Grad, 2005; Hoffmann et al., 2010; Sugrue et al., 2014).

Coping strategies may also include drawing on religion or spirituality by finding comfort from co-religionists in their networks (Burke & Neimeyer, 2014; Klein & Alexander, 2003; Matthews & Marwit, 2006). Essentially, Byock (2002) describes spirituality and religion as broad constructs shaped by a set of values, belief, rituals, practice, customs and knowledge. These constructs connect the individual with a higher existence (Byock, 2002). Certainly, religious or spiritualist values influence how the bereaved perceive death and, often, beliefs about the afterlife play an important factor in their response to death (Holloway, Adamson, Argyrou, Draper & Mariau, 2010; Murphy et al., 2003b). Critically, further studies are required to explore how the bereaved use religion or spirituality to deal with their grief, as it is overlooked in research (Matthews & Marwit, 2006).

Many researchers have identified family and social support networks as beneficial to help suicide survivors cope with the death (Jordan, 2008; Maple et al., 2014; McMenamy et al., 2008; Peters et al., 2016; Young et al., 2012). Social support networks generally encompass

families, friends, neighbours and colleagues who can also provide the suicide survivors with emotional and practical support immediately after the event, especially if they struggle with their grief (Aho, Tarkka, Åstedt-Kurki, & Kaunonen, 2009; Kalischuk & Hayes, 2004; Trimble, Hannigan & Gaffney, 2012). Relationships with family and friends can become closer for suicide survivors, because of the shared sense of loss (Feigelman et al., 2009a; Rosenblatt, 1988). As previously highlighted (see Section 2.4), females are more likely than males to access their social support networks and receive effective emotional support (Beattie & Devitt, 2015; Terhorst & Mitchell, 2012).

The literature review has identified a number of studies with suicide survivors who recruited participants from bereavement support groups (Smith et al., 2011; Wojtkowiak et al., 2012). While these studies may be criticised for their selection bias, support groups can be beneficial for suicide survivors (Groos & Shakespearer-Finch, 2013; Jordan & McMenemy, 2004; McMenemy, et al., 2008), and it is important to understand the ways in which they are effective. According to Begley and Quayle (2007), the distressing nature of suicide may deter those affected from discussing the death with people in their wider social support network. Additionally, suicide survivors may have difficult relationships with others, fear burdening their social support with their grief or have experienced stigma from others (Begley & Quayle, 2007; Harwood et al., 2002; Peters et al., 2016). Therefore, if social support networks are not meeting their needs, they may prefer to access bereavement support groups (Feigelman et al., 2009a).

Exploring how peer support groups are helpful for suicide survivors continues to be a source of interest. The majority of suicide survivors engaging with support groups are relatives or immediate family members of the deceased (Cerel et al., 2014). Examining why these groups are effective, Pietilä (2010) reported that suicide survivors found groups therapeutic and cathartic. The group is a forum for them to seek affirmation that their feelings are normal compared with others in the group. Bereavement support groups can also provide a relatively safe environment for members to honestly express their feelings and enable a greater understanding of their experiences (Pietilä, 2010; Toller, 2011).

Feigelman and Feigelman (2011) investigated the effectiveness of peer support groups for suicide survivors through participant observation and highlighted how the shared experience of losing a significant other was beneficial for the participants. Attending a group enabled them to find positive role models and inspirational figures. Moreover, they also developed friendships with other members and this was advantageous if they were unable to find support from their own networks. Recently, on-line support for suicide survivors, including virtual peer support networks, have become accessible for many people affected by suicide (Clark, 2001;

Rawlinson, Schiff & Barlow, 2009). McMenamy et al. (2008) add that other coping strategies used by the suicide survivors include reading books and accessing websites on grief.

Health services also provide a valuable service in terms of formal postvention for the bereaved. Most often the bereaved access their GP first, who prescribes medication or refers individuals to other health services (An Fhailí, Flynn and Dowling, 2016; Hawton & Simkin, 2003). Although an argument has been made that prescribing medication to some suicide survivors can hinder their grieving process (Klein & Alexander, 2003), pharmacotherapy is thought to be useful to help them cope with the grieving process, especially when their grief experiences are too difficult to cope with (Klein & Alexander, 2003). Other services include individual counselling (Raphael, Middleton, Martinek & Misso, 1993), group therapy (Hawton & Simkin, 2003), psychotherapy (Pietilä, 2010) and other specialist and psychological postvention treatments, such as cognitive behavioural therapy (Young et al., 2012). These services have been shown to provide some relief to those who are experiencing intense or complicated grief (Klein & Alexander, 2003; Raphael et al., 1993).

2.4.1 Criticisms of postvention and support

While many studies support the effectiveness of postvention and support for suicide survivors, there are criticisms. Most studies on postvention are conducted within a western culture and ignore non-western cultures which may have different types of postvention (Andriessen, 2009; Rosenblatt, 1988). Difficulties may also arise for suicide survivors when interventions created and led by clinicians involve obstacles to access (Feigelman & Feigelman, 2011). It has been strongly highlighted that health professionals lack understanding of suicide bereavement and often implement inappropriate services that fail to address their needs (Andriessen & Kryszynska, 2011; Jordan, Feigelman, McMenamy & Mitchell, 2011; Peters, et al., 2013). Consequently, health professionals and service providers lack the knowledge to recognise the individuality of grief experiences, which can lead to harm or distress for suicide survivors (Bonanno & Boerner, 2007; Cerel et al., 2009; Hall, 2014).

It is important to recognise that suicide survivors who cared for or supported someone who was in receipt of mental health services, may have had negative experiences of services that affect their access to postvention. Pettersen et al. (2015) reported that family members significantly lacked trust in the Swedish health care system after the suicide of their relative who was in receipt of health services, compared with non-bereaved individuals. In addition, Ward-Ciesielski et al. (2014) found family members had exceedingly negative attitudes towards specific therapists treating the deceased prior to the suicide. Subsequently, participants blamed these clinicians for failing to prevent the death, but these negative

experiences did not affect their future engagement with health providers. However, the authors tentatively suggested that negative views of therapists could hinder the effectiveness of suicide survivor's treatment, but acknowledge that this finding is not generalisable to the wider population of suicide survivors.

From their phenomenological study, McKinnon and Chonody (2014) highlighted criticisms of postvention from interviewing 14 suicide survivors. Many encountered barriers which prevented them from utilising support, such as the health professionals' limited experiences in grief and bereavement, their lack of compassion, and the inconsistency and discontinuity of care. Participants experienced distress when retelling their stories to numerous professionals, which deterred them from accessing additional services. The authors concluded that suicide survivors felt their individual needs were not met because of the difficulty of finding appropriate services and the poor availability of local services.

As discussed in Section 2.2.3.2, the perceived stigma for suicide survivors can prevent them from utilising postvention and seeking support from health professionals (Peters et al., 2016; Pitman et al., 2016b; Trimble et al., 2012). GPs are generally the first point of contact for them to access postvention, but this can raise challenges as found by An Fhailí et al., (2016). They recruited 15 suicide survivors from suicide bereavement support groups in Ireland who participated in three focus groups. Participants in the sample included those who were receiving postvention and those who were not. Three key themes emerged from the analysis; acknowledgement, stigma and the need for proactive support by the GP. The first theme captured the importance of GPs listening to participants, discussing their grief and acknowledging the suicide. The second theme of stigma related to feelings of shame and self-isolation from their community. Stigma deterred many participants from attending the GP surgery, especially at busy times as they wished to avoid people. The final theme reflected the importance of the GP proactively and psychologically supporting suicide survivors by listening and talking with them, rather than prescribing medication.

To some extent, the perceived stigma of the suicide can lead to negative changes in relationships and access to social support networks, and may therefore adversely impact on the mental wellbeing of suicide survivors (see Section 2.2) (Chapple et al., 2015; Feigelman et al., 2009b; Peters et al., 2016; Pitman et al., 2016a). Social support can be problematic if they feel others avoid or withdraw from them, which may add to feelings of isolation (An Fhailí et al., 2016). Suicide survivors can also feel frustration and anger towards others if the death is trivialised or others make judgements about their grief reactions (Trimble et al., 2012).

As stated in the previous section, suicide bereavement support groups can be beneficial for many suicide survivors, but these can also be ineffective. Pietilä (2010) questions whether support groups are a psychological or social device that influence suicide survivors to

construct their grief in ways that are socially acceptable and considered normal. Support groups may also affect a suicide survivor's expectation of how they should grieve to conform to traditional stage or linear based grief models (Pietilä, 2010) (see Section 2.1.1). However, this can be problematic considering the diversity in grief experiences of individuals (Buglass, 2010; Grad, 2011; Hall, 2011; Larson, 2013; Rothaupt & Becker, 2007; Valentine, 2006). McKinnon and Chonody (2014) found that peer bereavement support groups can be traumatic for suicide survivors when sharing their stories or hearing others' experiences. This was also found in a qualitative study by Dyregrov, Dyregrov and Johnsen (2013) with people who accessed general bereavement support groups. They also found the needs or expectations of the bereaved were not met, but also the lack of strong leadership and structure in the group. Moreover, general bereavement support groups can be criticised for overlooking the heterogeneity of the bereaved, for example, the different kinship relationships between the bereaved and deceased, and their experiences of different types of death, such as suicide (see also Section 2.1). Subsequently, support groups can elicit immense distress and cause negative health outcomes in suicide survivors (Barlow et al., 2010).

The aforementioned studies identify that existing postvention and support for suicide survivors can be problematic and inappropriate, which can to some degree detrimentally impact on them (Bonanno & Boerner, 2007; Cerel et al., 2009). McMenamy et al. (2008, p.385) argue that a "*one size fits all*" approach to postvention is ineffective to support suicide survivors. Therefore, there is a strong need for research, especially long-term studies with suicide survivors, to determine the effectiveness of postvention services (Andriessen & Kryszynska, 2011). (Wittouck, van Autreve, Portzky & van Heeringen, 2014). McDaid, Trowman, Golder, Hawton and Sowden (2008) recommend future studies on suicide survivors should gather their views to ascertain what aspects of interventions are effective and identify what support would be beneficial, such as social support networks or support groups. This can result in opportunities to gather knowledge from the bereaved themselves to inform the identification, design and implementation of preventative interventions for those at risk of health-related issues (Breen & O'Connor, 2007; Cerel et al., 2009; Dyregrov, 2002).

In summary, postvention can be effective for the bereaved, including suicide survivors, but the distinctiveness of a suicide can result in a need for different types of interventions. Suicide survivors require a tailor-made approach to address their needs, which explains why suicide bereavement peer support and individual coping strategies are preferred. However, as shown in this chapter, further research is necessary, especially by health services in order to gain a greater understanding of how clinicians and service providers can better support suicide survivors.

2.5 Summary, rationale and context of the study

This chapter highlights how suicide survivors' experiences are distinctive compared with other types of death, although there are some commonalities, and that quantitative and comparative studies do not provide a deep understanding of the impact of a suicide. The literature review also highlighted how many empirical studies with suicide survivors overlook the mental health context of the deceased, perhaps because the majority of suicides are by individuals who were not in receipt of mental health services (NCISH, 2016; Pitman et al., 2016a). In some cases, the care-recipient may have hidden their mental illness or engagement with health services from suicide survivors (Clement et al., 2015; Samaritans, 2016; Wertheimer, 2001), in other cases the family members knew of their involvement and were actively involved in supporting them. The impact of suicide on suicide survivors may be different depending on whether or not they were actively caring for or supporting someone in receipt of mental health services. Critically, this area is relatively neglected, leading to gaps in knowledge.

The literature review highlights a number of issues pertinent to understanding how families/carers are affected by the suicide of individuals who were in receipt of services. Societal attitudes to grief are stereotypical and people who are unaware of the mental health context of the deceased may misconstrue suicide survivors' different grief reactions, such as relief and peace (Buus et al., 2014; Gillies & Neimeyer, 2016; Iglewicz et al., 2013; Sveen & Walby, 2008). Moreover, suicide survivors may consider the suicide as a rational act, because the deceased had been detrimentally affected by a chronic, life-long illness mental illness that is difficult to treat, resulting in a poor quality of life (Mayo, 1986; Schramme, 2013).

Research to date has tended to focus on the suddenness of a suicide, which has a different impact on suicide survivors' grief reactions (Bailey et al., 1999; Chapple, et al., 2015; Feigelman et al., 2009b; Harwood, et al., 2002; Pitman et al., 2016b). However, suicide survivors who are supporting or caring for someone in receipt of mental health services may anticipate a suicide, or at least it is not so unexpected and this brings a different perspective to their grief reactions that may not meet societal expectations (Lindqvist et al., 2008). What is not so clear in the previous research is how and why suicide survivors anticipate a suicide and a deeper understanding of the impact on them. Implementing a qualitative approach supports a subtler investigation that will enable further investigation into the impact of suicide on family members and how they make sense of the death (Bailey et al., 1999; Clarke & Goldney, 1995; Feigelman & Feigelman, 2011; Moore et al., 2013; Smith et al., 2011; Wojtkowiak et al., 2012).

Investigating the mental health context of the deceased is also important because negative experiences of health services and health professionals treating the deceased can be a barrier for suicide survivors who seek or wish to receive effective postvention (Pettersen et al., 2015; Ward-Ciesielski et al., 2014). This is a serious public health concern as suicide survivors are at greater risk of poor physical and mental health outcomes, including suicide (Andriessen & Krysinaka, 2011; DH, 2012; Dyregrov & Dyregrov, 2005; Samaritans, 2016). Clearly, many studies have raised criticisms of generic responses by health services that fail to meet suicide survivors' needs, which can be ineffective or adversely affect them (Bonanno & Boerner, 2007; Cerel et al., 2009; McMenemy et al., 2008). This indicates a requirement to identify the needs of suicide survivors, because limited empirical evidence is currently available (Clarke & Goldney, 1995; Dyregrov, 2002; McMenemy et al., 2008). Furthermore, exploring the effectiveness of postvention for suicide survivors is also necessary, because this area is relatively under-researched (Andriessen & Krysinaka, 2011; Wittouck, et al., 2014).

Whether or not most suicide survivors are engaged in postvention, and most are not, it is important to identify the various ways they cope or deal with the suicide. Rando (2000) contends that much uncertainty exists in grief literature which fails to examine individual grief patterns, individual ways of coping and does not identify effective ways of supporting the bereaved. Consequently, a qualitative exploratory study with suicide survivors, will lead to a better understanding of their perspectives which can support health services to identify, design and implement preventative interventions to minimise negative health outcomes (Breen & O'Connor, 2007). This is consistent with a co-production approach to research and service design (Breen & O'Connor, 2007).

The review also established that little research has been conducted on male suicide survivors who have lost female decedents and studies with a diversity of kinship relationships with the deceased (Maple et al., 2007; Wojtkowiak et al., 2012). Moreover, suicide survivors are often recruited from bereavement support groups and overlook the majority of suicide survivors who are not engaged in interventions. Subsequently, further research is necessary that reflects the diversity of suicide survivors to gain a deeper insight into their experiences (Maple et al., 2014; Smith et al., 2011).

A suicide is a type of death that compels suicide survivors to reconstruct their social world (Gillies & Neimeyer, 2016). They draw on their past experiences of caring for or supporting the care-recipient, including their involvement in mental health services, to make sense of a suicide (Begley & Quayle, 2007; Cormac & Tihanyi, 2006; Crowe & Lyness, 2014; Shah et al., 2010; Wertheimer, 2001). Therefore, contextualising the life of the suicide survivors before the suicide is necessary, including personal and situational factors such as their age, gender, kinship and closeness of relationship with the deceased (Hall, 2014; Neimeyer, Baldwin, &

Gillies, 2006; Stroebe & Schut, 2000). This is consistent with a social constructivist approach which will offer a way of capturing the individuality of suicide survivors' experiences and diverse perspectives to understand the impact of suicide and how they make sense of the death (Feigelman & Feigelman, 2011; Gillies & Neimeyer, 2016; Moore et al., 2013; Murray, 2003; Shields et al., 2017; Smith et al., 2011; Stroebe & Schut, 2000; Worden, 2003). Taking a qualitative approach to a study on suicide survivors can draw attention to capture the nuances of their unique stories, experiences and perspectives that quantitative studies are unable to identify (McIntosh, 1993; McKay & Tighe, 2014). Moreover, the distinctive group of suicide survivors where the decedent was in contact with mental health services has been little researched and hence an exploratory method is required. Therefore, qualitative methods were used as these tend to be flexible enabling the pursuit of different lines of inquiry and the drawing of original insights. This enables the researcher to thoroughly investigate the processes and experiences of suicide survivors (Dyregov et al., 2011). As a result, this adds to the justification of using a qualitative approach to this empirical study (see Chapter Three). Taking into account the rationale and context for this study, the next section will explicitly state the study aim and objectives.

2.6 The aim and objectives of the study

In the development of this study, careful consideration was given to the criticisms of quantitative studies and the limited number of qualitative studies that capture the voices of suicide survivors. The review also identified the gaps in knowledge on suicide survivors that take into account the mental health context of the deceased. Furthermore, SWYPFT had recognised the need for further research in this broad area which had implications for supporting families bereaved by suicide. These considerations informed the research aim and objectives of the study:

Aim: To understand the impact of suicide on families of people who were in receipt of mental health services.

The aim of this research and thesis will be achieved by addressing the following objectives for this study:

- To investigate suicide survivors' perceptions of the health service support, which they and the deceased received before the suicide.
- To identify the individual needs and experiences of suicide survivors.
- To generate recommendations for improving health services for suicide survivors.

The next chapter will discuss how the study design was developed in a qualitative framework to address the aim and objectives of this thesis.

Chapter Three: Methodology and Methods

This chapter provides an account of the philosophical and theoretical framework that has shaped the methodology and design of this study. The chapter begins with a brief overview of the study design and the sections that follow will elaborate in detail on each element of the research design, including decisions I made that guided the research process. Chapter Four will provide in-depth details of the analysis process.

3.1 The study design overview

A qualitative approach to the study was taken, which sits within a social constructivist framework. A clear sampling and recruitment process was developed for family members whose relative died by suicide whilst in receipt of mental health services. Before conducting the study, ethics approval was received from the University and the NHS and management approval by SWYPFT. Participants were recruited via the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Patient Safety Team (PST) and Survivors of Bereavement by Suicide (SOBS) who were convenience or purposively sampled. Charmaz's (2014) constructivist grounded theory (CGT) directed the concurrent process of data collection and analysis. This method is advantageous to develop new theories in a topic area that lacks theories (Urquhart, 2013).

Two qualitative methods were used to gather data; semi structured interviews followed by a focus group. Different lists of questions were used to collect data during the interviews and the focus group. In total, 17 participants were interviewed; two participants recruited via the SWYPFT PST and 15 participants from SOBS (including two SOBS helpline workers). During the continual analysis of the interview data, various tentative conceptual models and diagrams were developed that captured the impact of suicide by someone in receipt of mental health services on family members (see Chapter Four: Data Analysis). After analysing the interview data, a tentative conceptual model was then shared with seven SOBS participants in a focus group.

The focus group data was comparatively analysed with the interviews and led to further changes to the model (see Chapter Four: Section 4.1.6). In CGT, the researcher's reflexivity is essential in the research process, including their interpretation of the data. Therefore, key points drawn from my reflexivity regarding the research process are discussed at the end of this chapter (see Section 3.7).

3.1.1 A qualitative research approach

The study focuses on understanding the impact of suicide on families and I define 'impact' as the effect of the suicide on family members. Impact captures behaviour, actions, thoughts, strategies, feelings and communication. To address the aim and objectives of the study, I considered a variety of methodologies from quantitative to qualitative approaches.

Quantitative studies are rooted within a positivist paradigm and utilise data collection methods such as surveys or questionnaires (Bruce, 2007). Often, data is collected from a large sample to test hypotheses, measure variables and analyse numerical data (Bruce, 2007; Madill, Jordan & Shirley, 2000). As discussed in Chapter Two, numerous quantitative studies with suicide survivors or the bereaved have contributed to knowledge. Nonetheless, there have been criticisms of these types of studies on suicide survivors, including bias in the sample, methodologically weak designs and lack of depth into understanding their experiences.

Chapter Two also established that limited studies examine the deceased's mental health context prior to the suicide and how this impacted on family members. Considering there are gaps in existing knowledge, utilising a quantitative approach to this study was problematic. Difficulties included designing a questionnaire to gather participants' data from the limited literature available. Moreover, devising a sampling frame was challenging based on the population of the study. Therefore, an exploratory study was undertaken to address the aim and objectives of this research and to investigate participants' experiences in-depth. Flexibility was also required to define the sampling criteria used for selecting family members participating in the study. Taking into account the shortcomings of applying a quantitative approach to this study, I considered a qualitative methodology. What becomes clear from qualitative research literature is that the research process is not linear, but dynamic and fluid (Birks & Mills, 2015). Qualitative research consists of a myriad of diverse research methods and approaches, underpinned by different philosophical assumptions (Denzin & Lincoln, 2005). Carverhill (2002) makes an important point that in qualitative studies, the researcher continually defines and describes their research process so there is no 'correct' way of interpreting an event or the participants under investigation.

I position myself in an interpretivist theoretical framework, as individuals have multiple perspectives of realities (Urquhart, 2013). Participants play a critical role in studies conducted within an interpretivist framework position. Hence, the researcher focuses on understanding meanings attached to participants' voices, actions and experiences (Fossey, Harvey, McDermott & Davidson, 2002). Therefore, knowledge is gathered on how participants' social realities are constructed in the broader context of an individual's race, gender, cultural, political and social framework (Corbin & Strauss, 2008).

One philosophical framework that is congruent with this position is symbolic interactionism, originally developed by George Mead and Herbert Blumer. They believed an individual's behaviour, attitudes, language, actions, processes, thoughts and meanings are shaped by their social interactions (McCrae & Purssell, 2016). Therefore, 'impact' on suicide survivors can be understood via their interpretation of symbolic elements that make up their social world (Crotty, 2012). Consequently, implementing a qualitative approach to this study was justified, which led to deliberations on choosing methods that revealed such meaningful elements and interpretations.

Symbolic interactionism underpins grounded theory methods which focus on human interaction (Denscombe, 2014). Therefore, they are compatible according to Bryant and Charmaz (2007), because both the method and the theory study specific realities, interactional processes and develop theory from the empirical data. Grounded theory, originally developed by Glaser and Strauss (1967), is an inductive method for data collection and analysis, aimed at developing a theoretical explanation of the topic under investigation. An advantage of theory building approaches to qualitative studies is that the results can address areas where there are gaps in knowledge, limited knowledge or confusion because of inconclusive results (Alvesson & Kärreman, 2011; McGhee, Marland & Atkinson, 2007).

Tweed and Charmaz (2012, p134) suggest studies most suited to the use of grounded theory focus on the context of the participants and, "*investigate how social structures, situations and relationships influence patterns of behaviour, interactions and interpretations.*" For these reasons, the approach was particularly suited to my research aim and objectives. Over time, several different versions of grounded theory have emerged from the Glaser and Strauss (1967) original post positivist/pragmatist epistemology and now include post-modern constructivism (Tweed & Charmaz, 2012). Nonetheless, the core principles of Glaser and Strauss' (1967) methods are, to an extent, found in all the forms of grounded theory. These features include coding, categorising and comparatively analysing data. From this process, the researcher develops theoretical understandings of the data and uses theoretical sampling to refine emerging insights. Eventually, the researcher reaches theoretical saturation, leading to a theory of the context and major social processes of the studied phenomenon (Charmaz, 2014).

Considering there are different versions of grounded theory, the researcher's ontology and epistemology is influential in choosing the most appropriate one to their study design (Jeon et al., 2005). Keeping this in mind, I initially referred to grounded theory by Glaser and Strauss (1967). They proposed that the researcher has to remain objective and without any assumptions on the topic under investigation. Therefore, to avoid bias, the researcher is expected to write the literature review after the completion of the analysis. This approach

would prevent the researcher from being influenced by existing literature that would direct the topic under investigation during the analysis (Glaser & Strauss, 1967). Critically, delaying the literature review to avoid such influences may not be effective, as researchers inevitably bring their own assumptions and knowledge into the research (Thornberg, 2012). Moreover, a research proposal had to be submitted to the University at the start of the PhD, which included a preliminary literature review. As a result, I considered methods that encouraged my subjectivity and interaction with participants in the research process. Flexible methods were also required to pursue areas of inquiry during the research due to the exploratory nature of the study.

One version of grounded theory that recognises the researcher's subjectivity in the interpretation and co-construction of the participants' data is CGT by Charmaz, which is '*ontologically relativist and epistemologically subjective*' (Mills, Bonner & Francis, 2006: p9). Essentially, the researcher's values, beliefs, experiences and reflexivity are integral in the research process (Charmaz, 2014). CGT was congruent with my interpretivist position and the methods support exploratory studies by offering flexibility, yet structure to analyse and collect data (see Section 3.1.4). As a result, CGT methods were adopted in the study design.

3.1.2 Constructivist grounded theory

CGT is situated within an interpretive framework and draws on social constructivism, which focuses attention on how an individual internally and actively constructs meaning through social relationships (Young & Collin, 2004). According to Charmaz (2014: p14), 'constructivist' in CGT captures the researcher's subjectivity in the interpretation and co-construction of the participants' data. As discussed in Chapter Two, recent developments on understanding the complex area of suicide and grief have emerged from a social constructivist perspective (see Section 2.1.2). Evidence suggests that a multiplicity of personal and situational circumstance factors greatly influence suicide survivors and how they make sense of a suicide (Neimeyer et al., 2006).

Suicide can challenge the assumptive world of the bereaved, causing difficulties in making sense of their loss and rebuilding their social world (Hall, 2014). Hence, 'normal' grief can only be understood in the social context of the bereaved (Parkes, 2010). Therefore, applying a social constructivist theoretical framework to this study is beneficial to investigate the personal and situational conditions of family members before and after the suicide. As a result, a deeper understanding of the impact of suicide and how family members reconstructed their social worlds would develop.

There are several other advantages of taking Charmaz's (2014) approach to a study. CGT is an iterative, inductive, deductive, abductive, open-ended, yet structured method of analysis and data collection (Charmaz, 2014; Urquhart, 2013). CGT explores the meaning and understanding of participants' experiences in the context of their lives (O'Connor, Netting & Thomas, 2008). The data collection and analysis processes are concurrent, enabling the researcher to explore new insights as they emerge during the research to develop the theory. According to Charmaz (2014), theory is an explanation of the psychological or social processes that are grounded in the data. These advantages certainly strengthened my rationale for using CGT.

In summary, understanding the impact on family members within the mental health context of the deceased is under-researched. Therefore, this exploratory study required flexible iterative and systematic methods to engage with participants as I co-constructed data with the participants. As a result, I developed a theoretical understanding of the participants' social processes, meanings, actions and language in constructing their social realities.

3.1.3 Process of analysis in constructivist grounded theory

Many aspects of CGT are derived from classical grounded theory, however, there are differences. Charmaz (2014) argues that the coding process should be fluid, rather than rigid and prescriptive as devised by Glaser and Strauss (1967). Accordingly, CGT begins with open coding, that essentially means labelling pieces of text from the transcripts, for example line by line. To avoid descriptive coding, gerunds are used to promote analytic coding and, where possible, '*in vivo*' codes (Charmaz, 2014, p.134). These codes are participants' words that capture their views, meanings or actions. Charmaz (2014) also suggests that the researcher begins identifying sensitising concepts early in the analysis, to generate areas of inquiry, ideas and questions.

After open coding, Charmaz (2014) guides the researcher to synthesise open codes into categories at an analytic level and examine the relationships between the categories. Another requirement of CGT is constant comparison of the data during the analysis (Charmaz, 2014). Glaser and Strauss (1967) originally established the use of constant comparison and outlined four steps in this process. Firstly, to compare incidents which relate to each category; secondly, to merge categories and their properties; thirdly, to demarcate the theory and finally to write the theory.

During the cyclical process of data collection and analysis, Charmaz (2014) suggests new insights emerge. The analysis process continues until theoretical saturation when no new insights develop and leads to the researcher developing a theoretical explanation of the phenomena under study (Glaser & Strauss, 1967).

3.1.4 A pluralistic approach to data collection

To address the research aim and objectives, I used two data collection methods; firstly, semi-structured interviews and secondly, a focus group. There were several reasons for this. Investigating the impact of suicide on family members is sensitive research, so I considered methods that gave me face to face interaction with participants. This meant I could manage participant's distress and deal with issues while gathering data. Secondly, the topic of my investigation was under-researched and thus required flexibility to be able to pursue new insights to explore participants' experiences in-depth.

In qualitative research, pluralism describes drawing on multiple methodologies, sources of information and methods (Cho & Trent, 2006; Frost et al., 2010). There are several reasons why implementing a pluralistic approach in qualitative research is advantageous. Using multiple methods helps to gain a holistic understanding of participants' views (Barbour, 2005; Frost et al., 2010) and capture multiple perspectives on the area of research (Fossey et al., 2002). Another advantage is that data gathered from two methods can be comparatively analysed for commonalities and differences (Charmaz, 2014). Arguably, implementing different qualitative methods highlights transparency on the data analysis, effectiveness of the research design and evidences the quality of the findings (Frost et al., 2010; Shenton, 2004).

The most commonly used combination of data collection methods in a single study and grounded theory studies, are interviews and focus groups (Lambert & Loiselle, 2008). Kitzinger (1995, pp.299-300) clearly states the benefits of implementing a pluralistic approach of interviews and focus groups:

Gaining access to such variety of communication is useful because people's knowledge and attitudes are not entirely encapsulated in reasoned responses to direct questions. Everyday forms of communication may tell us as much, if not more, about what people know or experience. In this sense focus groups reach the parts that other methods cannot reach, revealing dimensions of understanding that often remain untapped by more conventional data collection methods.

Kitzinger (1995) proposes there are advantages to a methodological pluralistic approach in a study that includes a focus group and interviews. A focus group can address limitations within interviews, such as, if individuals feel uncomfortable with one-to-one interviews with the researcher. Additionally, the formality of individual interviews may deter people participating in studies or some participants may believe they have little to contribute. In these cases, participating in a focus group may be better suited as it provides a stimulating forum for discussion with other participants in eliciting their views on the topic area (Kitzinger, 1995). On the other hand, a focus group may deter people from participating or they may withhold personal information when discussing a sensitive issue (Morgan, 1996; Rabiee, 2004). This is an important point, as gathering data from families bereaved by suicide requires thoughtful deliberation in ascertaining the suitability of a focus group.

The study design required thought regarding the order of the interviews and focus group. It was decided that conducting interviews first would set the foundation of an in-depth exploration of the research area. As stated earlier, CGT aims to develop a theory or an explanation of the research topic that is grounded in the data (Charmaz, 2014). Sharing the tentative theory derived from the analysed interviews with focus group participants would then aid in developing theoretical sensitivity. Using a focus group after the interviews would also enable a deeper exploration of how the theory related to other participants' experiences. The focus group data would also capture participants' interactions and multiple perspectives on the emergent conceptual model. In addition, comparatively analysing interviews and focus group data would also add to the quality, clarity and transparency of the findings.

3.1.5 Ensuring quality in qualitative research

There are extensive debates about the different ways quantitative and qualitative methodologies may demonstrate the quality of their findings. Arguably, a strength of quantitative research is that findings can be easily scrutinised for their credibility, reliability and rigour (Guba & Lincoln, 1994). Rigour in quantitative terms comprises of objectivity, reliability, measurability and validity that enable studies to be standardised and replicated (Davies & Dodd, 2002). On the other hand, qualitative studies are most often inductive, abductive and utilise a smaller sample size to gather a wealth of descriptive data (Bruce, 2007; Charmaz, 2014). Generally, the concept of validity encapsulates internal and external validity. Internal validity refers to how trustworthy the findings are in accurately reflecting reality, whereas external validity relates to the generalisability of findings with a wider population (Anfara, Brown & Mangione, 2002). However, the notion of an independent reality with which results can be compared, is nonsensical in constructivist studies and moreover,

typically in the absence of a sampling frame, it is impossible to judge the representativeness of samples in qualitative research. In addition, Carverhill (2002) proposes that terms taken from the positivist paradigm such as generalisability or external validity are not appropriate for qualitative research. As a result, this study adopts a different criteria for ensuring the quality of this study as suggested by Shenton (2004). Rather than validity, Shenton argues the need for dependability, which can enable the emulation of qualitative studies by other researchers rather than expecting them to duplicate others' findings. Shenton (2004) also proposes confirmability rather than objectivity in qualitative research and this is demonstrated by the researcher by stating the research design, limitations of the study and showing transparency of the research process (Davies & Dodd, 2002; Shenton, 2004).

3.1.5.1 Quality in constructivist grounded theory studies

As discussed in Section 3.1.3, Charmaz (2014) encourages the researcher to be honest during the research process and provides methods to aid them. Memo writing and reflexivity are essential components of ensuring the quality of CGT, in which the researcher documents their thoughts, decision making and experiences. This results in an audit trail of the research during the fieldwork and the analysis process, as the researcher develops theoretical sensitivity, arrives at theoretical saturation and eventually generates the theory of the phenomena under investigation. The idea of reflexivity is not exclusive to CGT and for these reasons, is an essential requirement in most qualitative research studies (Creswell & Miller, 2000). Another way a researcher can record their subjectivity and interpretation of the data, is in reflexive journals (Cho & Trent, 2006). Chapter Four gives details of the procedures I adopted to ensure the quality of my analysis.

The quality of emergent findings can be strengthened further by sharing them with respondents who originally participated in the study (Creswell & Miller, 2000). On the other hand, findings can be shared with different participants from the sample population to gather their feedback (Cho & Trent, 2006). This was one of the key reasons why I conducted a focus group with mostly new respondents. I used this to explore the acceptability of the model I had developed from the data analysis. This was one of the key reasons why I conducted a focus group with mostly new respondents. I used this to explore the acceptability of the model I had developed from the data analysis.

3.2 Study population

In order to address the aim of the study, I focused on the population of family members whose relative died by suicide whilst in receipt of mental health services 12 months prior to their death. Since SWYPFT funded the PhD, I focused on the population of suicide survivors within the specific geographical area covered by the Trust. Recruitment was initially via the PST, but then the majority of participants were recruited via SOBS. Details of the recruitment and sampling strategy are described in the next sections.

3.3 Recruitment

The recruitment strategy for participants in the study required careful thought for the interviews via the PST, SOBS and focus group participants. These three approaches to recruiting participants are given in the following sections that explain the inclusion and exclusion criteria for participants.

3.3.1 Recruitment of participants via the Patient Safety Team (PST)

Since the study was supported by SWYPFT, early consultations with the Medical Director led to the identification of the PST in the Trust who investigate cases of sudden death, including 'apparent suicides' by patients. The PST follow a clear investigation process, which involves lead investigators liaising with families of the deceased. The investigation attempts to establish the deceased's care in the NHS, and where there may have been missed opportunities or lessons to be learned by NHS services. Once the investigation process is completed, a PST lead investigator conducts a shared reading of the report with the families.

My negotiations with the PST led to a thorough and methodical deliberation about the recruitment of participants. As a result, a carefully designed recruitment and consent process was developed (see Appendix 8). Following discussions with them, PST Lead Investigators were confident that it was appropriate for them to share the study leaflet with families upon receipt of the investigation report (see Appendix 2).

3.3.1.1 PST sample inclusion and exclusion criteria

Clear sample inclusion and exclusion criteria were developed in-line with guidance from the PST. This comprised:

- Adults aged 18 years or over.
- Adults who had lost a family member (or equivalent, such as extended family member) through suicide (or apparent suicide).
- Where the family member who had died was in receipt of mental health services at some point in the last 12 months prior to their death.
- Where the family member had received an investigation report from the SWYPFT PST within in the last 12 months.

Respondents were excluded if there was any uncertainty about the cause of death of their family member or where families had not received the investigation report. Moreover, if families were experiencing any level of distress, the PST lead investigators were able to use their discretion to share the study information. Finally, the PST would only put cases forward where there were no known risks to the researcher by potential participants.

To broaden the sample and explore diversity in time since the suicide, the PST agreed to contact families from historical cases. This sample included families who had received an investigation report up to three years prior to the start of the study (1 October 2009 onwards). The same inclusion and exclusion criteria applied for historical cases. Invitation letters were sent to these families via the PST (see Appendix 14) with a contact details form (see Appendix 4). Family members completed and returned reply slips directly to me to register their interest in the study. Once I received completed reply slips, I contacted potential participants to discuss the study and answer any questions they had. Participants were offered one week to consider participating in the study or to contact me to discuss any concerns. Subsequently, I contacted family members for their decision and once verbal consent was received, I arranged a mutually convenient date and time for the interview.

Most participants gave their verbal consent at the first point of contact and I emailed or posted participants with the information sheet (see Appendix 3a) and a consent form (see Appendix 5a) to read before the interview. Prior to conducting the interview, I re-iterated the participant's rights in the study, offered an opportunity to ask questions and gave them a list of support organisations (see Appendix 7). Written consent was obtained once participants completed and signed the consent forms.

One of the original objectives of the study had been to investigate health professionals' (HPs) perspectives on how suicide survivors deal with suicide. It was anticipated that interviewing HPs would allow an in-depth understanding of their perceptions of the needs of suicide survivors, how the families dealt with suicide and the support HPs offered them. The process of recruiting HPs would begin after family participants who had been interviewed were asked to nominate, if possible, a HP who had been involved in the care of the deceased and the family.

To ensure ethical research, family participants were asked for their written consent to confirm their nominated HP (see Appendix 9). An invitation letter with a reply slip would be posted by me inviting the HP to take part in the study (see Appendix 6b). If the HP agreed to participate, I would contact them to discuss the research, answers any questions, and arrange a mutually convenient date and time for the interview. However, after a protracted period and much effort, only two participants were recruited via the PST and neither was able to nominate a HP. Due to the lack of participants via PST, it became difficult to identify HPs who could participate in the study, therefore, a decision was made not to include HPs in the study. However, the two relatives recruited via the PST were retained in the sample.

3.3.2 Recruitment of participants via SOBS

The lack of participants recruited via the PST required adopting a different recruitment strategy. I had been aware of Survivors of Bereavement by Suicide (SOBS) while compiling a list of support organisations for participants (see Appendix 7). SOBS is a national organisation that offers suicide bereavement peer support through a helpline and locality-based groups. I contacted a local SOBS group leader to discuss my study and I was invited to attend their local monthly support group on 17 September 2014.

Initially I was reluctant to recruit participants from SOBS, as the literature review had identified criticisms about a bias in empirical studies which recruited participants already engaged in postvention, especially from bereavement support groups (Groos & Shakespearer-Finch, 2013; Jordan & McMenemy, 2004; McMenemy, et al., 2008). Nevertheless, there was still limited knowledge in understanding why suicide survivors accessed bereavement peer support groups (Neimeyer & Cerel, 2015) and recruiting participants from SOBS was still consistent with my research aims and objectives. Hence, recruitment via SOBS was a valuable opportunity to meet suicide survivors, hear their suicide experiences and access the group.

3.3.2.1 SOBS sample inclusion and exclusion criteria

An amended version of the inclusion criteria was introduced for SOBS participants who were not recruited via the PST. To avoid confusion for SOBS participants, references to SWYPFT were removed. The sample inclusion criteria comprised:

- Adult aged 18 years or over.
- Adult who had lost a family member (or equivalent, such as extended family member) through suicide (or apparent suicide)

- Where the family member who had died was in receipt of mental health services at some point in the last 12 months prior to their death.

During the analysis of the interview data, I identified participants who required support from professionals or suicide survivors who were also support workers. Consistent with CGT, I wanted to explore this area of peer suicide bereavement support by taking a purposive approach to identifying participants who could contribute knowledge. SOBS offered a volunteer run peer support helpline staffed by suicide survivors, therefore, these staff were included in the sample.

Before recruitment of SOBS helpline workers, a telephone discussion with the helpline support co-ordinator took place. A recommendation was made that only helpline workers who had a minimum of two years' experience on the helpline should be recruited. This was important, as helpline workers would have received the necessary training and experience in supporting people using the service. The remaining inclusion and exclusion criteria for helpline workers was the same as shown above for SOBS interviewees.

University SREP ethics approval was gained and a revised version of the participant information sheet (see Appendix 16) was sent to the SOBS national office. The details of the study were disseminated electronically to all SOBS helpline workers. The same process of gaining verbal and written consent was followed, as stated earlier, for interviewed participants (see Section 3.4.2).

A total of 17 SOBS participants were interviewed, including two helpline workers.

3.3.3 Recruitment of focus group participants

The recruitment process for focus group participants began during the interview process with the SOBS participants. The aim of the focus group was to share the emergent conceptual model during the analysis of the interview data. Therefore, the focus group participants were convenience sampled (see Section 3.3).

In planning the timing of the focus group, I reached theoretical saturation (see Section 4.1.4) after interviewing 17 participants on 29 October 2015. Consequently, I arranged for the focus group to take place on 26 January 2016. As I regularly attended the SOBS monthly group meetings to recruit participants for interviews, I shared the focus group leaflet at the same time (see Appendix 20) and a participant information sheet (see Appendix 21). Once details of the venue, date and time of the focus group had been finalised, I posted or emailed participants who registered their interest with this information. This included a covering letter (see Appendix 22), a participant information sheet and a consent form (see Appendix 23). I asked participants to complete the consent form in advance if possible, or upon arriving at

the focus group so that the forms could be counter-signed by me before the start of the discussion.

3.3.3.1 Focus group sample inclusion and exclusion criteria

The inclusion and exclusion criteria for focus group participants was the same as participants recruited via SOBS for the interviews:

- Adult aged 18 years or over.
- Adults who had lost a family member (or equivalent, such as extended family member) through suicide (or apparent suicide)
- Where the family member who had died was in receipt of mental health services at some point in the last 12 months prior to their death.

In total, seven focus group participants were recruited via SOBS. In grounded theory studies, it is difficult to anticipate the number of participants in the sample, as data collection ceases when data saturation has occurred (see Section 3.1.4). After interviewing 17 participants, conducting the focus group and reaching theoretical saturation in the analysis, no further data was collected.

3.4 Sampling

Considering the sensitivity of the study, developing a sampling process for participants was a lengthy and deliberated process. A detailed account of the sampling process during the fieldwork is provided in the next chapter on Data Analysis (see Section 4.1.3). Three approaches were implemented, based on addressing the aim and objectives of the study.

Firstly, participants were recruited for interviews via the PST and clear inclusion and exclusion criteria for participants were developed (see Section 3.4.1). At the beginning of a grounded theory study, participants are sequentially or convenience sampled to explore the broader context of the phenomena under study (Draucker, Martsof, Ross & Rusk, 2007; Tweed & Charmaz, 2012) and that was done with participants from the PST.

The second sampling strategy for interviewees was via SOBS (see Section 3.3.2). Participants were purposively sampled to investigate areas of inquiry I identified from the analysis who could generate knowledge in these emergent areas. Participants were also convenience sampled if they requested to be interviewed.

Thirdly, the focus group participants were convenience sampled from SOBS, because I wanted to develop theoretical sensitivity of the tentative conceptual model. The model was developed

from the analysis of the interviewed participants, but I wanted to comparatively analyse the interview data with the focus group data.

3.5 Data collection methods

3.5.1 Developing questions for the interviews and focus group

Discussing suicide with the next of kin respondents required me to carefully compose the list of questions that met ethical standards (see Section 3.7). One way of minimising harm by the researcher is to ensure participants understand what is being asked of them (Williams, Woodby, Bailey & Burgio, 2008). Another way is to minimise hierarchical relationships between the researcher and participants by keeping interview schedules open rather than structured (Mills et al., 2006). This allows participants to guide the discussion and raise issues that are important to them.

For the interview schedules, I used uncomplicated language and devised open questions to avoid 'yes' or 'no' answers. This approach enabled participants to share fully their experiences (Silverman, 2013). Further considerations when developing questions are wording and ensuring participants fully understand the questions (Fontana & Frey, 1994). The researcher also needs to clarify their understanding of points raised by participants, answer their questions and where appropriate, share their own personal experiences (Mills et al., 2006). Consequently, I carefully phrased questions in simple and clear terms to remove any ambiguity for participants in what was being asked of them. Prompts in the schedule enabled me to clarify and further explore answers given by participants.

In this study, three interview schedules were designed:

The first interview schedule was used with participants recruited via both the PST and SOBS (see Appendix 1a). Core questions included: how family members felt about the care the deceased had received by health services prior to the suicide; their perceptions of the suicide, how the suicide impacted on them, how they coped with the suicide and their needs in dealing with the suicide.

The second interview schedule for SOBS helpline workers (see Appendix 19) was developed after analysing the PST and SOBS interview data. My analysis identified that participants reported their need for peer suicide bereavement support. Subsequently, I wanted to investigate this area of inquiry further to develop theoretical sensitivity by purposively sampling SOBS helpline workers. Questions included: why people rang the helpline; what

support people requested; what motivated them to become a helpline worker and what they gained by talking about their loss.

The third interview schedule (Appendix 24) for the focus group aimed to explore an emergent conceptual model I developed after analysing 17 interviews. The focus group used a different list of questions which focused on how the tentative model related to participants' experiences. In addition, amendments needed to be made regarding how the conceptual model would be useful for other families bereaved by suicide.

3.5.2 Semi-structured interviews

Different types of interviews range from open, semi-structured to structured interviews (Potter & Hepburn, 2005). Semi-structured interviews are commonly used in grounded theory studies (Tweed & Charmaz, 2012). CGT requires flexibility to explore new insights arising from the analysis, therefore, I decided semi-structured interviews to be appropriate. This enables the researcher to ask additional questions during the interview (Fontana & Frey, 1994; Potter & Hepburn, 2005). Adapting the interview schedule was important for me to develop theoretical sensitivity and generate the theory.

Myers and Newman (2007) list several dangers in the research interview. A key one is the "*artificiality of the interview*". The interview is seen as a contrived arrangement by the researcher to interview a stranger regarding a specific phenomenon. As a result, participants may lack trust with the researcher, leading them to be selective with what they share. Additionally, participants may feel uncomfortable sharing personal information or their inner thoughts and emotions.

To address these issues and to develop rapport and trust with potential participants, I regularly attended monthly SOBS meeting over a year. I became a familiar face to many people who participated in the study and they often approached me to discuss the study. I also offered participants the choice of home interviews so they were comfortable in their own environment. Participants only consented to participate when they felt comfortable and wanted to share their experiences (see Section 3.7: Reflexivity).

Another critique of qualitative research is that the researcher can misconstrue the participants' language or words as they apply their own interpretation (Myers & Newman, 2007). However, CGT provides a framework and strategies for the researcher to be honest in the research process, through memo writing and documenting their reflexivity (Charmaz, 2014). Including a focus group in this study was one way of sharing the emergent findings from the interviews and checking the appropriateness of my findings (Cho & Trent, 2006).

In total, I conducted interviews with 17 participants that included three joint interviews and one telephone interview. I interviewed eight participants (including two of the joint interviews and the telephone interview) at the University and nine participants were interviewed at home. Interviews at the University required me to book a private, quiet room where we would not be disturbed. In anticipating distress, I provided participants with refreshments and informed them of the facilities in the building such as the restrooms. A detailed account of my reflexivity in dealing with distress is given in Section 3.7.2.

Interviews at participants' homes posed different challenges as three of the interviews were interrupted by other members of the family or by distractions in the house, such as telephone calls. I anticipated this and when interruptions occurred, I paused the interview and the recorder. When the participant was ready to continue and we had privacy, the interview was resumed.

Nearly all the interviewed participants experienced distress and upset at which point I asked participants if they wished to stop or pause the interview. All of these participants felt comfortable enough to continue with the interview and in sharing their emotions with me. To an extent, I had established a degree of trust over this time and many people attending the group became familiar with me. As a result, participants did not feel embarrassed when sharing their distress and were comfortable in disclosing their private thoughts.

3.5.2.1 Joint interviews

I introduced joint interviews to accommodate participants who preferred being interviewed together rather than individually. I conducted three joint interviews; two interviews with a husband and wife and one with a mother and daughter (see Table 5.1).

Taylor and de Vocht (2011) suggest combining individual and joint interviews in a study can produce multiple perspectives from participants. Importantly, individual and shared meaning of the research topic can also be explored (Taylor & de Vocht, 2011). Certainly, I found the joint interviews were advantageous in generating diverse perspectives and adding richness to the data.

Notably, the first joint interviewees described their interview as cathartic, although the interview was not a counselling session. Perhaps the length of time since the suicide occurred (over two years ago) enabled the participants to feel comfortable in talking about their experiences together with a stranger. Corbin and Morse (2003) suggest participants in studies have something to gain from the process, including sharing their experiences to help others or disclosing their story if they have no one to hear it.

During the joint interviews, I wrote notes of new insights but also the interactions and dynamics of the participants (see reflexivity Section 3.7). I was aware of the dynamics and interactions between participants in the joint interviews and made notes of non-verbal communication. Observing the participant's behaviour, I was alert to silence, laughter and pauses. A strength of joint interviews was that participants were able to comfort each other when they were distressed and gave mutual moral support when discussing sensitive topics. Moreover, I used these notes as prompts when I wrote my reflexive journal immediately after each interview, but also when thoughts came to mind. The journal was helpful as I referred to it in writing memos (see Section 4.1.1) and as I analysed the data. It helped me to become self-reflexive in the process of coding and to develop theoretical sensitivity.

Joint interviews revealed insights for all the participants as they recounted their suicide experiences in the presence of the other participants. Participants shared feelings or events that the other interviewee had been unaware of or had blocked out immediately after the suicide. Certainly, for participants, an advantage of using joint interviews in this study was being able to clarify, and facts, recollect memories or events that helped them 'fill in the blanks'. I further noted how each participant disclosed feelings and thoughts they had hidden from the other to protect them from distress after the suicide, but now felt comfortable sharing.

There are limitations of joint interviews. Taylor and de Vocht (2011) suggest that a researcher needs to identify individual experiences from both participants. To address this point, I prompted individual participants if I needed more information. In addition, Myers and Newman (2007) contend that the influence of participants on each other's responses can be problematic if a participant feels uncomfortable sharing sensitive information in the presence of the other. However, none of these issues seemed to be problematic in any of the joint interviews I conducted. Rather to the contrary, they seemed to share more information with each other than they had done before.

3.5.2.2 Telephone interview

SOBS offered a national telephone helpline service staffed by suicide survivors who voluntarily provided peer support. Recruiting helpline workers would enable me to investigate why they provided support on the helpline and why suicide survivors required peer support. The University SREP approved an amendment to the study, including the second interview schedule (see Appendix 19). Since most helpline workers work from home and are based across various geographical areas in the country, I introduced the option of telephone interviews.

I conducted the only telephone interview with a helpline worker because the geographical distance was problematic. This made it difficult to conduct a face-to-face interview, supporting the advantage of telephone interviews in terms of practicalities for the researcher (Novick, 2008). Irvine (2011) suggests the researcher should have a preliminary introductory telephone call with each participant to establish a level of rapport. Before the telephone interview, I therefore called the participant to share details of the study and answer any questions. This was helpful for establishing an understanding and familiarity of each other before the actual interview. Prior to the telephone interview, I emailed the participant with an information sheet (see Appendix 17), consent form (see Appendix 18) and a list of support organisations (see Appendix 7).

I faced several challenges in terms of practicalities for the telephone interview. I had to ensure the interview was in a quiet, private space where I would be alone to avoid interruptions or breach confidentiality. In order to record the interview, I had to place the call on loudspeaker and place the audio recorder next to the speaker. An additional issue was gaining consent from the participant prior to the telephone interview. Due to the lack of time, the participant did not sign the consent form, but verbal consent was given and audio-recorded with the participant's permission.

A key criticism of telephone interviews is the lack of non-verbal cues, but there are ways in which researchers can gauge the reactions of participants by noting auditory cues such as sarcasm, distress and anger (Novick, 2008). Moreover, sighs, hurried responses or hesitation in participants can also alert the researcher to identify areas that may require further exploration (Sturges & Hanrahan, 2004). In my telephone interview, I was able to hear these cues, but there were times when the participant was silent or paused in answering questions. I understood these to be points where the participant found sharing their responses was difficult, distressing or when she was thinking about her response.

One of my concerns during the telephone interview was around providing comfort to the participant if they became distressed during the interview. Certainly, not having face-to-face contact with participants makes it difficult for researchers to anticipate distress (Sturges & Hanrahan, 2004). However, I still noted the participant's distress from her voice and auditory cues, so I gave her time to answer questions.

Another critique of telephone interviews is that they tend to be shorter in duration compared with face-to-face interviews (Novick, 2008). Comparing the length of times between the two methods, Irvine (2011) found the researcher spoke more in telephone interviews than the participant. It can also be problematic for the researcher to assess the depth and breadth of the quality of the data if participants share less detail or do not elaborate. My telephone interview lasted almost two hours, which was comparable to the length of time with the face-to-face interviews. The participant was an advocate for suicide survivors and a long-time helpline worker. As a result, she was comfortable in answering questions and disclosing personal information. In terms of the quality of data, the participant dominated the interview and offered details of her experiences without many prompts. Indeed, an advantage of telephone interviews for participants is privacy and anonymity, which enables participants to easily share sensitive information (Novick, 2008).

Offering the choice of telephone interviews to helpline workers was beneficial in this study. The telephone interview generated in-depth data and contributed to understanding why participants required support from other suicide survivors.

3.5.3 The focus group

Generally, the focus group is an informal, but focused discussion to gather data with multiple participants at the same time, using an unstructured interview schedule (Morgan, 1996). There are several reasons why a focus group was justified in this study. A focus group facilitates a thorough exploration of participant's beliefs, cultures, attitudes and behaviour on a focal point of investigation (Krueger & Casey, 2009). It is also beneficial for the researcher

to examine the group interaction between participants on the topic of investigation, which is distinctive to individual interviews (Fossey et al., 2002). Participants' interaction in a group stimulates an exchange of information, experiences and ideas on the research area (Kaplowitz & Hoehn, 2001). Arguably, focus groups also allow participants to check the appropriateness of the interpretation of the data and challenge any findings they deem to be inaccurate (Cho & Trent, 2006; Creswell & Miller, 2000).

I decided a focus group was appropriate for the study (see Section 3.1.4) to gather participants' multiple perspectives and interactions on the emergent conceptual model. Additionally, applying a CGT approach to the study required developing theoretical saturation of the data. Therefore, gathering focus group data and comparatively analysing it with the interview data contributed towards developing the emergent theory. I also had to decide whether participants would be recruited from a pre-existing or newly formed group.

Recruiting participants from a pre-existing group has advantages and disadvantages. Critically, recruiting participants from a pre-existing group may deter some members from expressing their views if they contradict the majority of other members' opinions (Krueger & Casey, 2006). However, recruiting from a pre-existing group removes some of the practical challenges to facilitate a focus group (King & Horrocks, 2010; Munday, 2006), participants need little time in getting to know each other and feel confident and comfortable in expressing their views (King & Horrocks, 2010; Munday, 2006). To a degree, a pre-existing group has acquired a level of trust so participants may comfortably agree or disagree with each other (Kitzinger, 1994). Trust is important in focus groups so that participants can honestly share their feelings and private and personal matters with each other (Rabiee, 2004).

Considering the sensitivity of the research, recruiting from SOBS, a pre-existing group, would be beneficial to foster a more supportive forum for eliciting participants' data. In addition, focus group participants would be familiar with the group format of SOBS monthly meetings. One important factor for recruiting via SOBS was that members had a common interest in suicide, which enabled them to talk with others, ask questions, learn, listen and meet others. It was therefore essential that I kept the focus group as supportive, open and informal as possible.

I decided to recruit individuals via SOBS who met the original sample criteria, regardless of whether they had been interviewed already or not (see Section 3.3.3). Having a combination of participants was advantageous to allow interviewed participants to reflect on their contribution and clarify or expand on areas where necessary (Guba & Lincoln, 1994). However, participants who had not been interviewed before would also be able to offer their perspectives on the conceptual model.

During my attendance at SOBS monthly meetings, I also noted that many people were not regular members. Therefore, there would be a possibility of recruiting non-regular SOBS members. Having diversity in the sample was also beneficial in eliciting multiple perspectives on the tentative findings. Thus, I was able to note the interaction between participants, their verbal and non-verbal communication, which further added depth to their responses (Sakellariou, Boniface, & Brown, 2013; Taylor & de Vocht, 2011).

In terms of practicalities, there is a debate amongst researchers about the number of participants needed in a focus group. Rabiee (2004) contends that between six and 10 would be suitable. This would enable the researcher to engage with the participants, manage the group and gather a wealth of data from multiple perspectives. Fundamentally, the number in each group should allow each participant to contribute to the discussion, but not be so large as to result in separate pockets of discussion (Krueger & Casey, 2009). In designing the focus group study information, I decided that up to nine participants would be an appropriate number to allow participants to interact with each other and allow a thorough exploration of their views on the tentative findings.

According to Morgan (1996), the researcher or moderator facilitating a focus group needs to possess certain skills and traits. Issues of power between the researcher and the group participants need to be addressed, including how the researcher manages the group dynamics. The researcher must ensure participants are able to offer their perspectives as there may be instances where some participants may dominate the discussion or some participants may not feel comfortable in offering their views (Morgan, 1996). The researcher plays a pivotal role in a focus group in managing and understanding the dynamics, regardless of whether participants are recruited from a pre-existing group or are strangers (Rabiee, 2004). King and Horrocks (2010) suggest that before the focus group the researcher needs to share explicitly their role in the study and the focus of the discussion. This fosters an environment of trust and enables participants to make an informed choice and give consent. At each SOBS meeting, I clearly stated the rationale for the study, why I wanted to conduct a focus group and shared the focus group leaflet (see Appendix 20) and participant information sheet (Appendix 21).

Maintaining confidentiality in a focus group requires a different approach, as many participants are sharing information and potentially, deeply personal information. A concern during this research was how participants would maintain confidentiality outside the focus group. As a researcher, I could not take responsibility for any such disclosure. However, the participant information sheet (see Appendix 21) and consent form (see Appendix 23) stated how I would maintain the confidentiality of participants. This was re-iterated before the start

of the focus group and once participants had made an informed choice and signed the consent forms, they agreed to preserve confidentiality in the group.

Another issue I had to consider was managing the potential distress in focus group participants (see Sections 3.6 and 3.7.3). Understandably, a focus group may elicit a range of emotions in participants, including anger, humour, sadness and distress (Krueger & Casey, 2009). The researcher needs to minimise risk and distress to participants (Munday, 2006) and certainly after interviewing participants, it was clear that the majority experienced distress. Therefore, in order to minimise this, I informed them of their rights in the study, including pausing or stopping the interview. I also provided participants with a list of support organisations (see Appendix 7) before the discussion.

One important issue when collecting data from focus groups, is determining how to analyse the data. As a qualitative approach was used in this study design, the method of analysis had to be congruent with the chosen methodological framework (Rabiee, 2004). Focus groups can be used effectively within a CGT framework as a method of data collection and analysis. I followed the same process used in the interviews and comparatively analysed the data. Documenting my reflexivity involved establishing a trail of evidence, such as making notes and writing memos. These were written before, during and after the focus group. This was significant to capture participant's non-verbal communication, group interactions and dynamics (Rabiee, 2004). Insights into my reflexivity from the focus group are given in Section 3.7 and a detailed account of the analysis on the focus group data is noted in Section 4.1.5.

3.5.3.1 Conducting the focus group

The strength of using a focus group in this study is clearly demonstrated, however, there is much debate about the practicalities of a focus group in research (King & Horrocks, 2010). Addressing the aforementioned theoretical and practical complexities of conducting a focus group (see Section 3.5), required careful deliberation. One concern was planning and recruiting participants for the focus group. I carefully designed a leaflet (see Appendix 20) to disseminate with SOBS members at the meetings regarding the study. I also asked people to consider a time and venue for the focus group, which was important in meeting their needs and preferences.

During the monthly SOBS meeting, I kept a register of people interested in participating and noted feedback on venues, dates and times. Many of the SOBS members proposed the focus group should take place at the researcher's university and this was arranged. Seven

participants attended the focus group, who included previously interviewed participants, those who had not been interviewed, regular meeting attenders and irregular attenders. All the participants added to the diversity of the sample in terms of gathering their experiences of suicide, age, gender and their relationship with the deceased (see Chapter Five: Table 5.1). The focus group was audio recorded with consent from each participant and transcribed for analysis purposes. As I was familiar with the majority of participants in the focus group, I was able to identify their voices from the audio recording. This was helpful in accurately typing up the transcript and noting individual responses.

Another consideration was how I would manage the focus group, facilitate the discussion and observe so I could take notes. According to King and Horrocks (2010), a large focus group requires a moderator to facilitate the group and an observer to take notes. For this reason, I decided my supervisor would moderate the focus group with me, which would be beneficial in terms of practicalities. While recruiting participants for the focus group, I informed them that my supervisor would be present so individuals could make an informed decision about participating. My supervisor works for both the University and SWYPFT and therefore, was aware of maintaining confidentiality and anonymity of participants.

At the beginning of the focus group I was responsible for re-iterating the aim of the focus group with participants, sharing the format of the group and ensuring they had read the focus group information. This approach ensured participants had given fully informed consent by signing the consent form. I also outlined ground rules such as speaking one person at a time so everyone could hear others' responses and which would ensure clarity when transcribing the audio recording.

Krueger and Casey (2009) suggest the researcher should avoid jargon so participants can contribute to the discussion. Therefore, I carefully considered sharing Diagram 4.2 with participants in a way they would clearly understand. Rather than overwhelming the group with presenting the whole model, I decided to construct the model beginning with the core of the 'loved one' (the term used by these SOBS members for the decedent) and 'the family member'. After sharing the findings for each element, I then introduced the next element of the model and ended with the 'new normal'. Before sharing the model, participants were informed that they could ask questions if they were unsure about the model.

After presenting the model, my supervisor then asked participants questions from the interview schedule (see Appendix 24), as well as giving prompts to gain insight into new areas which required further exploration. My role was to focus on making notes on points raised, answer any questions raised by participants or ask questions if I wanted clarification on emergent areas. I also made notes of non-verbal cues by participants such as facial expressions, silences, sighs, humour and signs of distress. Observing the group dynamics was

also interesting as all the participants had met each other at SOBS meetings, but not all of them were regular SOBS members. Recruiting from a pre-existing group was beneficial in that it led to an informal, supportive and relaxed discussion. Participants were forthcoming with their responses and each person had an opportunity to speak. This was important because all participants expressed their views and fairly participated without anyone dominating the conversation or interrupting.

Participants were also comfortable with me and challenged points I raised when sharing the conceptual model. The focus group lasted almost four hours, which was longer than the two hours I had anticipated. The focus group gathered multiple perspectives on the tentative conceptual model and how the model related to participants' experiences. This was beneficial in reaching theoretical saturation and developing the emergent theory. My analysis of the focus group data is provided in Chapter Four (see Section 4.1.5) and my reflexivity of the focus group is discussed in Section 3.7.3.

3.6 Ethical considerations for the study

Gaining ethics approval on studies with suicide survivors can be challenging (Gemmill, Williams, Cooke & Grant, 2012; Moore et al., 2013). The ethics of conducting research with suicide survivors raises a number of issues that require deliberation by the researcher, especially in the social sciences. This section will, therefore, discuss the wider debates in ethical research with participants who may be perceived as vulnerable; including suicide survivors. Section 3.6.1 will discuss gaining ethics approval for this study. As the original recruitment strategy of participants was via SWYPFT PST, a favourable opinion was obtained from an NHS Research Ethics Committee (REC) and authorisation was also required from SWYPFT and the university sponsoring the study.

Conducting ethical research is a significant concern for researchers, regardless of whether a human participant is directly or indirectly involved within the research (Guillemin & Gillam, 2004). According to Etherington (2007), ethical studies require researchers to demonstrate fairness, autonomy and the participant's right to privacy during the research. When developing the study design, researchers have an ethical obligation to identify and address any potential risks to participants and themselves. Respecting participants is also crucial, so that participants receive appropriate information to voluntarily take part in studies and give informed consent (King & Horrocks, 2012).

Researchers submitting research proposals to RECs that involve participants who may be considered vulnerable, can be challenging (Beck & Konnert, 2007; Fisher, 2012). Moreover, Gemmill et al. (2012) argue that the scrutiny given to ethically sensitive studies by RECs,

may result in hindrances for researchers in securing ethics approval. Perceptions of the vulnerability of participants by committee members can lead to barriers and possible delays in gaining ethics approval and often, RECs may request the researcher to make rigorous considerations (Fisher, 2012). Appraising previous studies with suicide survivors highlighted difficulties by researchers to gain approval from RECs. Committees can be described as overprotective of suicide survivors (Lakeman & FitzGerald, 2009a, 2009b) and overstate the risks to participants, especially in qualitative studies (van Orden et al., 2010). Researchers may also encounter difficulties in accessing the population of suicide survivors which can to some extent explain why relatively few qualitative studies have been conducted after a family suicide (Begley & Quayle, 2007).

Undoubtedly, stringent ethical considerations are essential in qualitative research, especially in potentially sensitive studies (Corbin & Morse, 2003). Studies considered sensitive are those involving participants who may experience emotional or psychological distress during the research (Gemmill et al., 2012). Subsequently, researchers need to reflect carefully on developing and planning a project which would reduce any possible distress to vulnerable participants. In terms of bereavement research, Stroebe, Schut and Stroebe (2003, p.239) states that the researcher is "*potentially an intruder into the world of the bereaved.*" Considering this, safeguarding the bereaved person's rights is obligatory in order to protect their wellbeing through an ethical framework. The perceived vulnerability of the bereaved may prevent them from participating in sensitive research (Beck & Konnert, 2007; Williams et al., 2008). Moreover, participants disclosing sensitive issues or past trauma may increase their levels of distress and cause themselves harm (Biddle et al., 2013; Corbin & Morse, 2013).

Arguably, there may be reluctance from ethics committees to approve studies with under-represented groups. However, people should be given an opportunity to access and participate in studies (Williams et al., 2008). The literature identifies positive outcomes for suicide survivors who participate in studies that is often overlooked, especially by ethics committees. Dyregrov et al. (2011) investigated the participation of suicide survivors in qualitative studies and found they reported benefits of being interviewed. Here, participants used the interviews as an opportunity to vent feelings and thoughts, ease their stress and disclose experiences, which they had not shared with others. The fear of distressing other members of their family had deterred participants from previously revealing their innermost feelings, thus they were able to talk about the deceased and remember them in positive ways. A strong motivation for participants participating in the study was also to help others who had experienced a suicide and to prevent future suicides. Therefore, participants preferred not to be considered vulnerable, but as people who were actively contributing to meaningful

research. It was concluded that interviews enabled participants to consider the suicide from different perspectives and gain insights into why the suicide occurred.

Other researchers, such as Hutchinson, Wilson and Wilson (1994), have identified the benefits of qualitative interviews for participants. These include a sense of purpose, self-awareness, empowerment, healing and providing a voice for the disenfranchised. In circumstances where participants become distressed, these authors advise the researcher to stop the interview and search for possible solutions for the distress. This indicates that the researcher is aware of the vulnerability of participants and their rights. The moral obligation of researchers is to refer participants to counselling services or, in some cases, requires the researcher to liaise with participants after the interview with a follow-up telephone call or a visit where appropriate.

In this study, self-selection by participants, irrespective of how soon after the death of a significant other, assumes that the participant has willingly made an informed decision. Their consent is based on receiving accurate information and assessing the risks and benefits of participating in research. From this perspective, the researcher has to trust participants will decide themselves, whether they wish to participate in research (Williams et al., 2008).

3.6.1 Gaining approval from Research Ethics Committees (RECs)

As this study examines the impact of suicide on families, a thorough and in-depth consideration was given to gaining approval from various ethics committees. An initial application for approval was submitted to the University School Research Ethics Panel (SREP).

One ethical issue raised by SREP related to how soon after the suicide I would recruit participants. After many discussions with the PST, it was anticipated that the study leaflet and participant's information sheet would be shared with family members after the PST had completed the investigation. This took approximately three months, but more often took up to five months due to complexity. Subsequently, the PST lead investigators offered a shared reading of the investigation report with families and shared the study information (see Section 3.4.1). However, the University SREP suggested 12 weeks after the suicide was too soon to approach family members and asked me to justify my decision. This raised an interesting point and many researchers have experienced the uncertainty of knowing the most appropriate time to recruit participants (Williams et al., 2008).

The literature on determining the most appropriate time to recruit bereaved participants remains ambiguous for researchers (Stroebe et al., 2003). Exploring perceptions of end of life care with families, Williams et al. (2008) asked eight participants how soon after a death people should be interviewed. Participants were recruited who had lost a family member

between three to six months prior to the interviews. The results showed mixed responses, as a small number of respondents (13.5%) felt one month or less from the time of a death was appropriate. Almost 25% of participants thought one to six months was acceptable and over 27% reported six months to one year was suitable. However, the majority of respondents agreed that waiting to approach participants for at least two years after the death was excessive.

In terms of the PST recruitment process, I kept 12 weeks' post-suicide in the inclusion criteria after taking guidance from the PST. However, from my perspective, participants should be able to make an informed choice in consenting to participate, regardless of the time since the suicide occurred. Therefore, I did not stipulate a time since the suicide in the inclusion/exclusion criteria for SOBS participants and left individuals to make their own decision. In strengthening my argument, I was aware of the challenges of suicide survivors receiving appropriate and timely intervention to reduce poorer health outcomes (DH, 2012a). Consequently, one of my objectives in this study was to identify the needs of suicide survivors. Having an opportunity to recruit recently bereaved participants would offer me an opportunity to investigate this area further and compare experiences. SREP agreed with my decision and after approval was given, an application was submitted to the Integrated Research Application System (IRAS). Any NHS based research in the UK requires an IRAS application, and research involving NHS patients requires a favourable opinion from an NHS REC to ensure all ethical considerations regarding participants in their study are addressed.

Several ethical concerns were raised when meeting the local NHS Health Research Authority ethics committee. I originally developed the study with individual semi-structured interviews with family participants. One concern, was how I would address other people being present at the interviews and how I would maintain confidentiality in these circumstances. Considering the sensitivity of the topic, there was a possibility of participants inviting another person to support them during the interview. Moreover, if interviews were conducted in a participant's home, other people might be present who could potentially listen to the interview and therefore breach confidentiality. Addressing these concerns, participants who preferred home interviews were asked if they could choose a time and date when they would be alone and, if possible, find a space where we would not be disturbed. In anticipation of being disturbed while interviewing participants in the home, I would pause the interview until the participant was alone.

A final point raised by the ethics committee regarded how I would handle requests made by participants who would prefer a joint interview with another family member. Sakellariou et al. (2013) suggest that joint interviews should be utilised according to the aims of the research study and the needs of participants. However, a researcher needs to consider the

ethics of joint interviews, especially if tension is experienced between the participants. This can occur between participants if there are differing opinions or a participant discloses information unknown to the other participant (Sakellariou et al., 2013). If areas of conflict emerge between participants in joint interviews, Taylor and de Vocht (2011) advise the researcher to handle the situation sensitively, without leaving any participant in a difficult position. Taking into account the potential distress to participants, I included the option of joint interviews and both participants had to give informed consent before the interview.

Another point made by the NHS REC, was to explicitly state what steps I would implement if a participant disclosed harm to themselves or to others. According to Bell (2013), the researcher needs to consider breaches in confidentiality and consider consequences for both the participant and themselves during the research process. However, the researcher needs to be clear about when they will breach confidentiality (Mishara & Weisstub, 2005). In this study, I had already stated that if there was a disclosure of harm to the participants or others, participant confidentiality would be breached. However, I inserted a more detailed section in the participant's information sheet (see Appendix 3a) that if confidentiality needed to be breached I would speak with the participant first and then I would notify my research supervisor. Potentially, other relevant authorities would be informed in the interest of participant safety. If the participant did not want help and discussed harming themselves or others, the researcher would decide what steps needed to be taken and under which circumstances (Mishara & Weisstub, 2005). In ethically sound research, safeguarding the participants requires the researcher to provide them with details of appropriate support services or organisations. This stance encompasses the principle of caring, but the choice is with the participant if they wish to access these sources of help.

Once a favourable opinion from the NHS REC approval was received, I submitted an application to SWYPFT for local NHS management approval as the study included recruiting family participants via SWYPFT PST. A requirement of seeking ethics approval from the SWYPFT, included attending a meeting with the Trust's service users group, Research Involvement Group (RIG). The RIG suggested minor corrections to the participant's study information but were satisfied that all of their ethical concerns were addressed. These minor corrections were addressed before commencing the research study.

The time taken to apply and gain approval to the original study was almost nine months, from November 2013 to July 2014. During the course of the study, amendments were made to the original study to recruit participants via SOBS, which only required approval from the University SREP. A further amendment was made to the study for recruiting SOBS helpline workers and focus group participants. Consequently, another application for ethics approval was submitted and approved by the University SREP. However, in light of the debates in

conducting research with suicide survivors, the study did not raise any such ethical dilemmas or difficulties during the course of data collection. In fact, many participants found the interviews and focus group beneficial in understanding the suicide. The challenges of ethical issues are further discussed in Section 6.4, in light of the positive experiences of participating taking part in this study. Furthermore, Chapter Six details recommendations for future research with suicide survivors.

3.7 Reflexivity

This section begins with establishing what reflexivity is, why it is important and the following sections consider my reflexivity during this qualitative study. I share my role as an 'insider/outsider' as a researcher (see Section 3.7.1); dealing with distress (Section 3.7.2). and finally, my reflexivity of the focus group (see Section 3.7.3).

According to Carl Rogers (1959, p.185), "*no theory can be adequately understood without some knowledge of the cultural and personal soil from which it springs*". In other words, the foundations of a theory can be better understood in the context of the researcher's position, their subjectivity and their influences in the development of the theory. Essentially, the researcher's self-reflexivity underpins the research process and begins by the researcher clearly positioning themselves in their ontological and epistemological stance in the research. As a social constructivist, I bring my sense of self, beliefs, background, values, attitudes and behaviour into my research (Finlay, 2008; Williams et al., 2008).

Reflexivity is an important factor in qualitative research and is described by Eide and Khan (2008, p.205) as "a brief window into an ever-changing life, where the past is continually transmuted in every recollection and by every present and future circumstance". Reflexivity is an essential aspect of CGT, which clearly positions the researcher's subjectivity and interpretation of the data as fundamental in the research process (Charmaz, 2014). The researcher's reflexivity provides transparency and clarity to demonstrate the appropriateness of their research methodology, (Cho & Trent, 2006; Williams et al., 2008).

As discussed in Section 3.1.2, qualitative research requires the researcher to document an honest and transparent audit trail to support the quality of the findings (Cresswell & Miller, 2010). Finlay (2008) suggests that the researcher should introduce reflexivity as soon as the research idea is formulated and throughout the research process. Tools for evidencing reflexivity include writing memos, which is an essential part of CGT for the researcher, or keeping a reflexivity journal (Charmaz, 2014). Reflexivity helps the researcher to think about challenges or insights during the research process and recognise the limitations in their study (Guillemin & Gillam, 2004).

3.7.1 Insider/outsider perspective as a researcher

Considering the nature of the study, one of my concerns before meeting with SOBS was being asked if I had lost someone close to suicide. Reading the literature on suicide survivors had raised my awareness of many researchers who had experienced the suicide of a significant other, which motivated them to conduct studies in the area. I was aware of the difficulties in recruiting participants, because of the sensitivity of the topic and to a degree, assumed that not experiencing the suicide would be a barrier. Reflecting on my position, I was an 'outsider' because I did not share the characteristics or experiences of the participants (Dwyer & Buckle, 2009).

My role as a researcher also added an aspect of being an outsider, as I was conscious of the power relationship between the participants and myself (Karnieli-Miller, Strier & Pessach, 2009). The hierarchy of power relations is based on the methodology and methods of data collection (Karnieli-Miller et al., 2009). Charmaz (2014) is clear that in CGT, the researcher and participant are both part of the co-construction of the data. Regarding interviews, Corbin and Morse (2003) contend that issues of control between the researcher and participants can arise in interviews. In semi-structured interviews the researcher may hold control during the interview process rather than the participant. The researcher sets the questions for the interview schedule and influences the interaction between themselves and the participants. The authors also add that participants may feel less comfortable in disclosing information if they feel powerless or the researcher may not have asked the right questions to elicit their views. However, as the interview progresses, participants may be more comfortable in sharing information with the researcher.

A preliminary telephone conversation with the SOBS group leaders was important to introduce myself, discuss the study and seek approval to share the study leaflet with their group. The group leaders were very interested in the study and invited me to attend one of their monthly meetings. The group had been well established for many years and had had little involvement with this type of research. I felt this would deter people from participating in the study to share potentially sensitive and painful experiences. Reflecting on how I would approach the group for the first time, I drew upon my learning and experience in Rogerian person-centred counselling many years ago. Although I have not been a counsellor, my learning has instilled me with skills, attitudes and values, which have been influential in my personal and professional experience. Establishing trust and building a rapport with people involves being genuine, honest and transparent. Rogers (1959) also advocates the counsellor positions themselves from the client's perspective in order to establish some empathic understanding of the client.

At the first SOBS meeting, I attended the group early to have refreshments with members. This gave me an opportunity to speak with the group leaders who introduced me to some regular members. Members were then invited to sit in a circle and introduce themselves to share who they had lost to suicide. I was then invited to share the study and I decided I would share personal and professional experiences of mental illness to find common ground with potential participants. Sharing this information established a sense of understanding for members of who I was and my rationale for the study. Group leaders asked members if they consented for me to sit in and listen and I confirmed that if there were any objections I would be happy to leave. The entire group verbally consented for me to listen to their experiences and take notes. This allowed me to reflect and think about the questions I formulated in the original interview schedule.

After the meeting, I felt that sitting in every subsequent group meeting would be inappropriate. The ethos of SOBS was peer suicide bereavement support and having a researcher present at every meeting could deter members from sharing their experiences or attending the group. Consequently, I negotiated with the group leaders that I would attend before the meeting started to have informal talks with the members over refreshments. Once the meeting started and group members introduced themselves, I would then share the study information with the group and leave. This process worked well and as I attended the group, members would informally speak with me.

Over time, I began establishing tentative relationships with regular members and heard families' experiences of suicide by a significant other. Although this was difficult and distressing at times, I gained a deeper understanding of the lives of regular members. In addition, I developed a stronger relationship with many people attending SOBS, built rapport and gained a deeper level of trust.

During the meetings with SOBS, I was conscious of keeping clear parameters as a researcher, but I became less of an 'outsider' with the passing of time (Dwyer & Buckle, 2009). Sharing some of my personal stories as carer of my mother who has a mental illness gave an insight to SOBS members in understanding why the study was important to me. Occasionally, I was invited to participate in SOBS events, which were only open to people accessing SOBS. For example, the last meeting before Christmas, I was invited to a social event where members would bring food, socialise and light candles in remembrance of the people who died by suicide.

Over the duration of my research, my boundaries as a researcher became less rigid as I became an accepted group member. Undoubtedly, spending over a year visiting the group supported the study. Dwyer and Buckle (2009, p.60) suggest that a researcher does not have to position themselves as an insider or outsider but can be within 'the space between'. The

researcher becomes less of an outsider as they increase their knowledge by engaging in the research area, learning about the topic through literature and gathering participants' data (Dwyer & Buckle, 2009).

Having an awareness of the power dynamics between the participants and myself was important as a researcher and in being reflexive. I encouraged participants to take the lead in identifying a suitable date and venue for an interview. Most often, participants asked to be interviewed at the University, away from home, but eight interviews took place at participants' homes. Meeting participants at the main entrance of the University was important in taking them to the room and having a chance to speak informally with them prior to the interview. I ensured participants were provided with refreshments before we started the interviews.

Interviewing participants in their homes was different in the sense that I had less control. It was difficult to account for disturbance or interruptions during the interview process, which became apparent when I interviewed three participants in their homes. During the interview family members came into the room and interrupted. However, I paused the recording and continued the interview when participants were ready. Although one of my concerns was being asked if I had experienced the suicide of a significant other, I was never asked the question during the time I spent with the group. This highlights how researchers often come into a study with their own assumptions, concerns and anxieties, but sometimes these are unfounded.

3.7.2 Dealing with distress

Dealing with distress from participants was expected due to the topic of investigation and led to addressing ways of minimising any distress (see Section 3.6). I ensured participants were given time to think about participation, had the opportunity to ask questions and were given the study information to make an informed decision. I advised participants that the interview may elicit distress, but my role was not as a counsellor. A fundamental part of ethical concerns is the responsibility of the researcher in providing participants with information of where to access support if necessary (Drury, Francis & Chapman, 2007). Therefore, participants were given a list of support organisations before the interview started. I also left time at the end of each interview for a debrief with participants, in which they had an opportunity to share feelings and concerns about the interview process.

As I had expected, some participants were distressed during the interviews. I had made it clear prior to the interview that they could stop, pause or take a break at any time. The majority of participants did experience distress, yet continued with the interviews. Witnessing

the distress of participants was difficult, but showing compassion and sensitivity was important. Corbin and Morse (2003, p343) state:

Although researchers might not have encountered the same loss or have undergone the exact experience, many researchers have also experienced sorrow, loss, anger, and despair. Therefore, during these intense and distressful moments, researchers often connect with participants at a very deep level.

While I had not experienced participants' loss, I could empathise to a degree through my experiences of loss and supporting a someone close with a mental illness. Moreover, my personal and professional experiences had exposed me to other people's distress so I was not overwhelmed. Therefore, when participants became distressed, upset or cried, I listened and waited until the participant said they were ready to continue. Often participants would resume where they stopped, but a few times participants indirectly talked around the point that caused them distress. In these cases, I did not ask the same question again and moved on to a different question.

At the end of the interview, I asked participants how they felt about the interview. A few individuals shared how they felt the interview was cathartic or therapeutic and this has been supported in other empirical studies (Bell, 2013; Buckle, Dwyer & Jackson, 2010; Eide & Kahn, 2008). Despite the distressing nature of the study, nearly all the participants shared that their motivation to participate was to help others by telling their stories.

Dealing with distress felt by the researcher is a key ethical concern of the University and I had to ensure I had recourse to support should I require it. All research requires addressing risks or harm to the researcher and an interview process can expose the researcher to distress (Orb, Eisenhauer, & Wynaden, 2001). My supervisor had explicitly made a point that he would be available after each interview should I need to speak to him if I was distressed or had any concerns. I experienced some distress from the monthly SOBS meetings, which at times I found overwhelming as I witnessed the intense sadness and crying of members in the group. However, I drew on my own ways of coping. Writing in a reflexive journal and discussing the interviews during regular supervision was helpful for me.

The first meeting I had with the group was difficult, as I did not expect such a high level of distress. After the meeting, I wrote extensively in my reflexivity journal about this experience. This was cathartic for me in unburdening my distress, but for days after the meeting, the feelings of sadness and distress still occupied my thoughts. Subsequently, I mentally prepared myself for the next meeting and to an extent, leaving before the group shared their stories was important as I was less exposed to the intensity of their grief.

As a researcher, I also felt one step removed at an emotional level from the participants. While my concern was for the participant's welfare, I was constantly processing their responses. I concentrated on participants' reactions, language, non-verbal cues, expressions and engaged in identifying or exploring new insights by adding prompt questions.

3.7.3 The focus group

In terms of my reflexivity during the focus group, I noted interesting insights by listening to and observing a few participants who had been interviewed. Certainly, a strength of the focus group for the researcher is receiving participant's feedback on the emergent findings (Cho & Trent, 2006). One example that generated a discussion in the focus group was the use of the word 'choice' by a few interviewed participants in the context of the suicide by someone with a mental illness:

But you're as much emotionally upset at that time when you're doing the interview. So sometimes you can say things and think afterwards well I shouldn't have said because that wasn't the right word to say and I think sometimes when you try and you've got so much grief to get over, trying to get all over at once and you can't just rationally say something. (Keith)

(Agreement in the group)

And one word can have lots of different meanings can't it? So it's not just about the word. (Supervisor)

It doesn't necessarily mean that that's word, it's a way of you emotionally thinking of what's the word I can use. Sometimes you use a word, which isn't appropriate. (Keith)

Qualitative studies have been criticised because it is possible to misconstrue participants (Myers & Newman, 2007). Although CGT accepts this is to some degree inevitable, the above extract illustrates a person's subjectivity in their use of words that may have different interpretations. One example in the focus group related to the word 'choice' in the context of the suicide and generated a great deal of discussion. From my interpretation, some interviewed participants believed the suicide resulted from the difficulties of living with a long-term chronic mental illness. As a result, participants perceived the suicide occurred because the deceased had felt a burden on others or they were releasing themselves from the pain of mental illness. A number of participants also found evidence of the planning of the suicide and suicide attempt(s). These factors contributed to their belief that the suicide was a choice, an altruistic act, a rational act, but also for a minority of participants, a selfish act.

Sharing the word 'choice' in the focus group generated a different perspective as many participants believed the suicide by someone with a mental illness was an irrational act, therefore, challenged the notion of suicide as a 'choice'. Compared with the interviews, a strength of the focus group was eliciting diverse perspectives, capturing interactions between participants and gathering multiple participants' responses. I reflected on why participants strongly debated this point and why some participants raised a concern regarding how the readers of the thesis would consider a suicide by their loved one.

If the suicide was perceived as a choice and a rational act, then I realised this portrayed a negative image because of the stigma of suicide as a selfish act. I considered the stigmatisation of suicide and a mental illness had influenced many focus group participant's disapproval of a rational suicide. Here, Rebecca illustrates her understanding of choice in this context:

I still disagree with that because in terms of your PhD whoever reads it reads it as choice and reads as a rational act and the whole point of your PhD in my opinion is for the reader. So I think that I still disagree with that ... I can't speak for other people but I can't imagine that any single one of us would really have meant, understandingly used the word choice. It was something, it was a way to interpret for you what happened but actually, I don't believe any of us think it was choice, that's my opinion.

After the focus group, I questioned how I interpreted and analysed the findings by re-reading my memos, interview transcripts and reflexive journal. Focusing on how I interpreted the word choice I found many references to how some participants used the word and in what context. The strength of my reflexive journal and memos lay in recognising and stating how I co-constructed data with the interviewed participants.

In the focus group, some participants reflected on their interviews and noted at the time, that their feelings and emotions may have influenced their responses. In addition, the time since the suicide and interview seemed to be an important factor in demonstrating the intensity in their emotions, such as Penelope.

I was saying to this gentleman (supervisor) that after speaking to you I was very emotionally involved at that time, now we can look a bit more rationally you know to look at, this more structured looking at it, your contribution's going to be more different but can aid the study.

The emotional intensity was less for Penelope, because there was a longer time between the suicide and the focus group. I also reflected on whether the interviews were more emotionally intensive because the focus was on the participants. Interviews often lasted over one hour

and participants were continually asked personal questions about the suicide, which was demanding. On the other hand, the focus group had a different rationale and participants engaged in a general discussion, rather than being subjected to intense one-to-one questioning. Understanding the motivation of why participants took part in the focus group was also essential. Many participants believed the thesis was an important tool for sharing families' experiences of suicide as widely as possible, thus their contribution was important.

Focus group participants suggested that the findings should be disseminated to health providers, as most participants in the study strongly blamed health services for failing to provide appropriate support to the deceased. Therefore, they felt there were lessons to be learnt to prevent other families experiencing a similar event. Participating in the study also meant finding a positive from the suicide by helping others and by making their story public. In a sense, participants telling their story was a 'symbolic tie with the deceased' and a legacy of the person who died.

I know you're doing it for the health authority that is sponsoring you, but how can you get this through to other health authorities even in Yorkshire never mind in the rest of the country? Because I think some of this is very valuable. (Penelope)

(General agreement from the group)

Because a PhD has to be a bit of new research that nobody else has done hasn't it? (Penelope)

Yeah, so it's out there all the time so it's accessible, so hold on to it. (Rebecca)

A strength of the focus group is the interaction between participants who listen to and learn from each other's experiences. There were a few times in the focus group when knowledge was exchanged, which increased the understanding of participants. One example is given in the following extract when discussion focused on families' rights in the care of the deceased if they had poor mental capacity. Most participants were unaware of their rights.

Because it's not my main area, I've stayed up night after night after night reading legislation about you know what they should be doing and what's good practice you know. And actually they should have explained it to the relatives when I took her in... I could have applied to the courts for a guardianship order. (Sarah)

Oh well I didn't know that for a start! That's something else I've learnt today. (Penelope)

Another insight I noted during the focus group was the use of humour by some participants when discussing particularly distressing issues, which I also noted in some participants I had interviewed. As a result, I became especially interested in exploring this further and referred to the literature. I identified that a significant number of studies had been conducted into the use of humour in coping with life's stressors. However, I found a particularly insightful qualitative study by Åstedt-Kurki, Isola, Tammentie and Kervinen (2001) on the importance of humour in the wellbeing of patients in hospital. Data was collected from individual interviews, a group interview with patients and letters written by the patients about how they used humour while in hospital. These authors established that humour plays a prominent role in patients' coping strategies when faced with challenging situations, such as experiencing severe ill health. Humour was not only important for participants in taking attention away from their illness, but also helped participants to adopt a positive attitude to their illness and was a non-verbal way of participants communicating their feelings without articulating their emotions. Furthermore, humour was utilised as a coping strategy by patients in strengthening their self-confidence, self-care and putting life into perspective.

In bereavement, humour can be an effective coping mechanism for people with anxiety and depression, as found in a quantitative study by Ong, Bergeman and Bisconti (2004). They concluded that positive emotions including humour, reduced depressive symptoms and the stress experienced by widows in the immediate months after their bereavement. Reflecting back to the focus group and interviews, I found a number of participants used humour as a way of expressing their opinions without articulating words (Åstedt-Kurki, Isola, Tammentie & Kervinen, 2001; Ong et al., 2004). However, in the focus group, two participants used humour to diffuse a passionate discussion and lessen the seriousness of the debate. From this perspective, I saw humour was important in shifting the group dynamics, especially since all the participants were familiar with each other. Recruiting participants from a pre-existing group was certainly advantageous, as participants had established trust with each other and felt comfortable in sharing their innermost thoughts and feelings. At times, the participants' perspectives were diverse, yet the group accepted and respected each other's opinions.

Chapter Three has provided a detailed account of the methodology and methods chosen for this study. The analysis of the data resulted in the development of a conceptual model on understanding the impact of suicide. Chapter Four: Data Analysis, will now detail the process of data analysis and how the conceptual model was developed, grounded in the data.

Chapter Four: Data Analysis

This chapter is structured to demonstrate the practical application of taking a CGT approach in the study and will offer a detailed breakdown of the development of the final conceptual model. Therefore, key points during the analysis will focus on memo writing and followed by: coding the data; sampling strategy; developing theoretical sensitivity; analysis of the focus group, and re-conceptualising the final model. References to my subjectivity and reflexivity are also embedded in this chapter to illuminate how I progressed through the research process. Considering semi-structured interviews were used to collect data, questions were adapted or inserted to pursue areas of inquiry in the development of the conceptual models. Examples will be provided on how some elements in earlier tentative conceptual models were constructed using the analytic tools suggested in CGT (Charmaz, 2014). The emerging elements and questions I added to the interview schedules are detailed in Tables 4.1- 4.6 (see Sections 4.1.1, 4.1.2 and 4.1.4). The elements presented in these tables were included in two earlier conceptual models (Diagrams 4.1 and 4.2), which I developed during the analysis. One draft conceptual model (see Diagram 4.2) was shared in a focus group in order to check the acceptability of the tentative findings (see Section 4.1.5). After the analysis of this data, I continued developing theoretical sensitivity, with a greater focus on the mental health context and the theoretical and practical implications of the findings. This led to a deconstruction and reconceptualisation of the elements of the earlier models that resulted in the final conceptual model identifying the impact of suicide on families (see Chapter Five, Section 5.2).

A detailed section on the sampling strategy (see Section 4.1.3) is included to demonstrate how theoretical sensitivity was achieved during the development of the final conceptual model.

4.1 Process of developing the conceptual model

As discussed in Chapter Three (Section 3.1.2) in grounded theory studies, the analysis and data collection occur concurrently, so I transcribed each interview verbatim and coded the data before the next interview. This was important for the next stage of the analysis, memo writing.

4.1.1 Memo writing

As discussed in Section 3.1.3, memos play an essential role in CGT to document areas of inquiry that require further exploration. Writing memos and sorting memos into categories was essential to generate theoretical insights by purposively sampling participants in a way that captured diversity in terms of age, gender and relationship to the deceased (see Section 4.1.3). This was important during the analytic process in gaining a deeper insight in understanding how suicide impacts on families. Following guidance from Charmaz (2014), I dated my memos in chronological order and, where possible, titled memos with the participants' words. This approach was beneficial for me to keep the analysis grounded in the data. From the beginning of the study, I wrote memos in a Word document, but also used a journal to write my thoughts as they occurred while in the field, during the analytic process and away from my computer. I subsequently typed up the handwritten memos in an electronic Word document as soon as possible, as a way of effectively managing the information. Another advantage of writing memos was to document insights I found interesting in my reflexivity during the study, such as following joint interviews, the telephone interview and the focus group (see Section 3.7).

Memos were necessary to demonstrate the sequence of my thoughts in the development of the conceptual models and identifying specific points during the analysis process. I will now discuss one example of how a memo contributed to the analytic process in theory development of one element in an earlier conceptual model. Figure 4.1 is a memo I wrote after the first joint interview that captured 'private and public' grief. This distinction became apparent while comparatively analysing the data as I highlighted the different ways the participants dealt with the suicide. Examining why this was the case, I referred to the literature and my thoughts at the time are discussed after Figure 4.1. Moreover, I added additional questions to the interview schedule during data collection in order to develop theoretical sensitivity during the analysis. Eventually, 'private and public' grief became part of a broader category on the differences in participants' private and public self, and this data was integrated into an element I labelled 'Changing Nature of Relationships' (self). Table 4.1 shown at the end of this section summaries the themes that make up this element and contains the questions I added to the interview schedule during data collection.

Figure 4.1 : Example of a memo from first joint interview

27/10/14 'Private & public grief'

The first joint interview with Connie and her daughter Charlotte who had lost her fiancé to suicide. As Charlotte had answered most of the questions, I tried to tease answers from the mother about how the suicide had impacted her. Connie's response was that she felt she had no right to grieve because it wasn't her partner who had died. I was struck by the nature of the relationship with the deceased and the fact that she was not biologically related to him. Still, I wondered why she could not grieve for him? From the interview, both participants mentioned how their relationship with the deceased had been challenging. This made me think if the nature of the relationship with the deceased influenced both their grief responses. Interviewing Connie, I wondered whether this perception of her right not to grieve had influenced how she dealt with the suicide. She said she had **private grief**, where if she was upset she would cry in private. She also had a copy of the suicide note that she read when she was upset and said it brought her comfort when she read it. She did not want to show distress in front of Charlotte in public in case it upset her, so modified her grief. Charlotte talked about setting up a shrine for the deceased in her bedroom, which only three people had seen. I asked Charlotte what people would think about her shrine and she said they wouldn't understand or would question her mental health. So, what is private grief? I want to ask the next participant whether they have private and public grief and what it means to them. The 'masking' of grief as described by Charlotte, I label as 'public grief', because it was shared with others, such as discussing the suicide with her mother. I haven't really read about private and public grief in the literature yet and could be something interesting so I will check the literature.

I find **symbolism** comes strongly in the analysis especially with tokens or mementos of the deceased. Charlotte talks about a ring she's had made with some of the deceased's ashes and inside the ring are words from a song that meant something to her. She wears his clothes to feel close with him, finds comfort from the suicide note, has a shrine and has kept his things in the house where he'd left them. This was to convince herself to think that he'd be home soon and that he wasn't gone. I remember Robert Neimeyer's work on continuing bonds, which could be a way of people remembering the deceased through these reminders. I'll ask the next participant whether they have reminders of the deceased and what significance it has to them. Are some reminders more other important than others are? Why?

From this memo, I interpreted 'private and public grief' as different ways of grieving. I noted that private grief was a way of coping, maintaining a relationship with the deceased and avoiding distress to others, such as family members. Charlotte admitted that her private grief was hidden because it may not be construed as 'normal'. As I wrote the memos, I interpreted an awareness of socially accepted notions of normal grief. Charlotte referred to 'masking' her grief to meet others' expectations, which I interpreted as public grief. Finding the balance of what they saw as 'normal' grief was problematic and various faces of public grief were shown to others according to where participants were, such as at work, or who they were with, for example friends or with family members. I identified the distinction between private and public grief as a line of inquiry requiring further exploration with subsequent participants. Consequently, I introduced a new question to the interview schedule, "*Can you tell about the ways in which you grieve? Would you describe some ways as public or private?*" As I examined this further in subsequent interviews, I comparatively analysed the participants' data.

During the research process, I highlighted how participants described the suicide as distinctive compared with other types of death they had experienced, which led to difficulties in coping and grieving. Consequently, participants developed personal ways of expressing and dealing with their grief that they found helpful in private away from others. In some cases, private ways of dealing with the suicide were to avoid the perceived judgements of others as found with Charlotte. Many participants also described how they struggled to conform to societal expectations of grief in public by expressing their loss without showing too much emotion or to avoid distressing others. Another reason why participants 'masked' their grief in public was to avoid the perceived stigma of the suicide. Some public ways of grieving with others was comforting for participants, for example marking the deceased's death anniversary with family or close friends.

To explore the differences between private and public grief, I referred to the literature and consulted Goffman's (1971) work titled the 'Presentation of Everyday Self'. He suggests that individuals play different roles and show aspects of themselves during their interactions with others to influence how they are perceived or to gain information from others. Goffman adds that individuals partake in activities in private away from others and hidden because they may be considered deviations from societal norms. This was true to an extent in this study, as I noted participants concealed aspects of themselves or conducted activities in private to avoid being misconstrued by others. For example, Charlotte made a shrine to maintain a bond with the deceased, which enabled her to openly express herself without being witnessed by others and this was important to help her cope. Many participants also disclosed that they developed a need for solitary, individual and personal strategies to deal with the suicide, because they were important to them and they needed time away from others. Activities

included nurturing plants, gardening, reading, walking, praying, listening to music, and speaking to the deceased. Participants chose these activities because they were enjoyable, comforting, therapeutic, relaxing, offered them an opportunity for reflection, and to remember the deceased. On the other hand, the during their interactions with others, participants changed their behaviour and language give the impression that they were coping with the suicide. This led me to the distinction between their public self, which was visible and shared with others, and private self that was more hidden and private. Goffman suggests that an individual may deceive others 'for their own good', so in this study participants described how they dealt with the suicide to prevent distressing others, especially to those they had a closer relationship with. Continued analysis during the data collection contributed to illuminating on some of the ways in which the suicide was dealt with in private and hidden ways, or shared with others in public. I incorporated these conceptual developments into the element 'the changing nature of relationships' and this is summarised in Table 4.1.

Table 4. 1: Sub-themes and additional questions added to the interview schedule in order to develop the element of 'Changing Nature of Relationships' (self)

Sub-themes	Description	Questions added to the original interview schedule
<p>-Differences in participants' private and public self</p> <p>(Private grief & public grief)</p>	<p>To deal with the impact of the suicide, participants constructed diverse ways of expressing themselves in private and public. Private ways were individual, important, personal and hidden from others to prevent participants from being judged or misconstrued. For example, keeping shrines in remembrance of the deceased. However, participants presented themselves differently in public to meet others' expectations or societal norms when dealing with the suicide. Participants took part in collective and shared activities with others, such as attending the funeral.</p> <p>There was a wide diversity in grief experiences, which impacted participants mentally, physically and in a minority of cases, with somatic symptoms. Private grief refers to expressing their own grief, in ways which may not fit 'normal' grief or avoiding distressing others. Public grief referred to a 'masking' of grief and grief adapted according to the social situation.</p>	<p>Can you tell me about the ways you grieve? Are some public or private?</p> <p>What is 'normal' grief?</p> <p>How did you feel at the time? How did the suicide affect you?</p> <p>What is the difference between a suicide and non-suicide death?</p> <p>Are there any things, which are important to you that belonged to the deceased? Why? Have you created any rituals after the suicide?</p>
<p>-Private & public coping</p> <p>-Social support</p>	<p>Private and personalised coping included reading self-help books, taking up new hobbies, taking medication and drawing on religion and spirituality.</p> <p>In public, participants engaged in interventions such as bereavement support groups, SOBS and postvention. The family and social support provided effective support to cope with their shared loss</p>	<p>How did you cope at the time?</p> <p>How are you coping now?</p> <p>What support, if any, was offered to you and by whom? (When was that? How helpful was it?)</p> <p>Is there any other help you could have benefited from at the time?</p>
<p>Relationship with self</p> <p>(Also links in with 'new normal')</p> <p>-Self-identity</p>	<p>Loss of the old self before the suicide and emergence of changed or new identity. The notion of identity is developed by the participant or given by others</p>	<p>How would you describe yourself as someone who has lost someone to suicide?</p> <p>Have you changed in any way because of the suicide?</p>

4.1.2 Coding the data

Charmaz (2014) provides a clear and flexible framework for coding the data and the first step is open coding on the verbatim typed transcripts. I coded every transcript line-by-line, which enabled me to examine smaller extracts of data that perhaps would be overlooked when analysing larger data sets (Charmaz, 2014). Open coding resulted in a large number of codes therefore, allowed me to identify insights I wanted to explore, or gaps in the data, which required further exploration (Tweed & Charmaz, 2012).

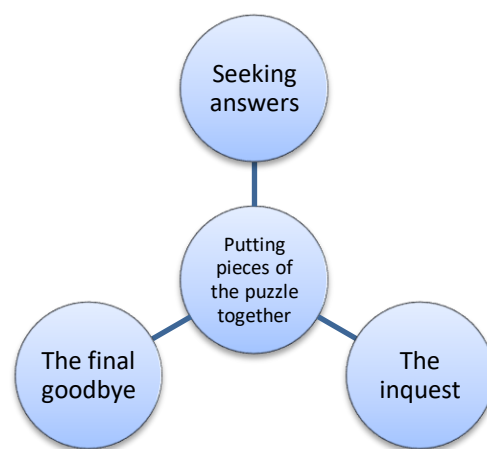
To avoid descriptive coding, Charmaz (2014, p.134) encourages the researcher to use gerunds or the noun form of the verb and where possible, 'in vivo' codes in keeping as close as possible to participants' words. While open coding I used codes that reflected the participants' language and perspectives to ensure the data was grounded. Two examples of this include "piecing the puzzle" and the "new normal", which I used to label two elements in earlier conceptual models (see Diagrams 4.1 and 4.2). During open coding I was interested in capturing processes or actions that allowed me to consider theoretical notions arising from the data. For example, I was interested in how participants coped with the suicide and what strategies they used. Another process I wanted to explore was how participants made sense of the suicide and identified notions of rational, irrational, selfish and selfless suicide.

Open coding laid the foundation for the next stage, focused coding (Charmaz, 2014), which enables the researcher to examine the codes at a more analytical level by conceptualising pieces of data. However, during the coding process I found overlaps with pieces of text in the data, so some pieces of text were coded multiple times. Open coding enabled me to identify patterns in the data and highlight the wide range of frequently repeated codes, which I then synthesised into focused codes. Some focused codes captured frequently recurring open codes that were guided by the responses from the interviews. For example, I synthesised open codes that identified different ways participants coped with the suicide into the focused code of 'coping'. I wanted to emphasise aspects of coping expressed by participants or establish activities they developed that caused changes in their behaviour to help them cope better with their loss and the suicide.

However, some focused codes were labelled from themes I identified from the data, such as 'relationships', 'private and public grief', 'reminders of comfort and discomfort', 'being left out of the loop' and 'concealment and protection'. Comparatively analysing the data, I highlighted new focused codes, re-labelled existing codes and discarded some focused codes. Throughout this process of coding I wrote memos as I identified new lines of inquiry which required further investigation by sampling participants and introducing questions to the interview schedule.

I integrated focused codes into the formation of a smaller number of tentative concepts. One way of how I made sense of the information and helped me to develop theoretical sensitivity was by drawing visual diagrams. Using creative ways to illustrate information has been a strong factor in how I effectively retain information (see Section 4.1.4). An example of such a visualisation is illustrated in Figure 4.2, 'Putting Pieces of the Puzzle Together', which occurred after interviewing Iris.

Figure 4. 2: Early visualisation of 'Putting Pieces of the Puzzle Together'



'Putting pieces of the puzzle together' emerged during the analysis when I recorded memos on how there was a need for participants to find an explanation or answers regarding why the suicide occurred. Examining why this was the case, participants described the suicide as distinctive compared to other deaths they had experienced, because the deceased had ended their life and the death was perceived as sudden. As a result, I became interested in ways in which participants sought answers through their own investigations and from others, and to do this I referred back to the transcripts. I highlighted the ways in which participants searched the deceased's belongings and their house or attended the inquest for answers. This strongly featured in three participants who were interviewed at the beginning of data collection, therefore, I added questions to explore this area further in later interviews. Then, when analysing the data, I developed the categories 'seeking answers', 'the final goodbye' and the 'inquest' to capture participants' activities around the element 'putting pieces of the puzzle together' (see Figure 4.2). As I comparatively analysed the data, I referred back to these categories, wrote focused codes and referred to the literature on suicide bereavement. Studies had also identified how suicide survivors' had a strong need for answers, especially if

the death was sudden. This element was initially included in an earlier conceptual model (see Diagram 4.3: Section 4.1.5), but was re-labelled “piecing the puzzle” as it was an *in vivo* code (Charmaz, 2014, p.134). “Piecing the puzzle” were Hannah’s words and not only did this term capture the different ways participants tried to make sense of the suicide (as illustrated in Figure 4.2) but it also prompted a deeper investigation of the ideas and conceptions that lay behind it. The sub-themes that arose are summarised in Table 4.2, and include the questions I added to the interview schedule to develop theoretical sensitivity.

Table 4.2: Sub-themes and additional questions added to the interview schedule in order to develop the element of “Piecing the Puzzle”

Sub-themes	Description	Questions added to the original interview schedule
Self-investigation – -The final goodbye -Putting affairs in order -Visiting Medium / spiritualists -Health professionals	There are ways in which participants sought answers or clues as to why the suicide occurred through their own investigations. For example, in private, many participants searched the deceased’s belongings, checked their mobile phone and internet search history. In public, participants spoke with the deceased’s friends and a few participants spoke to health professionals regarding the deceased’s mental illness and treatment.	How did you search for clues or answers as to why the suicide happened?
Answers from others -The inquest -SOBS	This refers to finding out facts previously unknown to them about the deceased’s engagement with health services, undisclosed suicide attempts, expressions of suicidal intent, details of the post-mortem and the verdict of the death. Accessing SOBS was a way of finding answers from others’ experiences	How did you find the inquest process and verdict that was given? Why?

During coding I was interested in capturing processes or actions that allowed me to consider theoretical notions arising from the data. One example was exploring how participants made sense of the suicide and their perceptions of the death. The earlier interviews alluded to a selfless suicide, which reflected a perception that the deceased wanted to release themselves from living with a severe, life-long mental illness and avoid being perceived as a burden on their families. This was an interesting insight, because it challenged the societal norms of a

suicide as selfish, so I wanted to explore these unconventional views of the suicide further. In addition, checking the existing literature on suicide bereavement had identified few studies that investigated perceptions of a suicide by a significant other. Consequently, I added questions to explore this area and from the data collection and analysis I identified the notions of rational, irrational, selfish and selfless suicide (see Table 4.3: 'Meaning and Purpose' of the Suicide). Examining why there were differences in participants' views, it became apparent that their level of awareness regarding the mental illness of the deceased and engagement with mental health services were influential factors in shaping how they perceived the suicide and made sense of the death. Most participants perceived the suicide as rational or selfless for the reasons stated earlier, because the majority of these participants had some or even full involvement and/or awareness of the deceased's mental illness. In contrast, very few participants described the suicide as selfish. Examining why there were differences, I found these participants had had an estranged relationship with the deceased and one participant had no knowledge of the mental health context of the deceased. Comparing the differences, I noted that participants who perceived a selfless suicide had a closer relationship with the deceased, which added another dimension to understanding why there was diversity in family members' perceptions.

In coding the data, I realised how there was an underlying need for participants to find meaning and purpose from suicide in order to make sense of the death and understand why the suicide occurred. This need influenced their perceptions of the suicide. In order to develop this emergent area further, I highlighted multiple codes that were inter-related in shaping how participants derived meaning and purpose of the suicide, for example their relationship with the deceased, the 'new normal', and the answers participants gained by "piecing the puzzle". At the time, I integrated this data into the element of 'meaning and purpose' of the suicide, and as I developed theoretical sensitivity (see Section 4.1.4), I included this element into the earlier developed tentative conceptual models that are discussed later in this chapter (see Section 4.1.5: Analysis of the focus group).

Table 4.3: Sub-themes and additional questions added to the interview schedule in order to develop the element of 'Meaning and Purpose' of the Suicide

Sub-themes	Description	Questions added to the original interview schedule
<ul style="list-style-type: none"> -Rational suicide -Irrational suicide -Anticipated suicide -Unexpected suicide -Value of the suicide -Selfless -Selfish 	<p>Participants' perceptions of the suicide influenced the meaning and purpose of the suicide. The severity and length of diagnosis of the mental illness was influential in perceiving the suicide to be a rational or irrational act. A rational act reflected the planning & preparation of the suicide, suicide note, suicide attempt(s) and expressions of suicidal ideation.</p> <p>A suicide perceived as an irrational act alluded to the poor mental capacity of the deceased, where suicide was the only recourse. The meaning of the suicide was a selfless act because it released the deceased from their pain and relieved the burden from the families.</p> <p>In some cases, the suicide was perceived as selfish because it was a choice, planned and rational. On the other hand, the suicide was perceived as unexpected, regardless of suicidal expressions or attempt(s). Suicide attempt(s), expressions of suicidal intent & suicide note(s) alluded to an anticipated suicide</p>	<p>In any way, do you see the suicide itself as a token of comfort? Perhaps because it was what the deceased wanted or it lifting you from strain and burden in caring and possibly worrying about the deceased?</p>

Coding the data also requires the researcher to undertake constant comparison of the data (see Section 3.1.2), which is an important part of grounded theory (Glaser & Strauss, 1967). Writing about constant comparison, Urquhart (2013) describes it as a continual process of comparing specific events, incidents and answers between participants. Comparison between participant's data commenced from the first interviews, where I coded the data with other participants. I identified areas to investigate from responses provided by participants from the questions in the interview schedule or key areas I highlighted that were grounded in the data. This process contributed to developing concepts from the data and was essential in setting the foundation for developing a theory to understand the impact of suicide on participants.

A more in-depth discussion on examples of areas of inquiry I identified from the analytic process is detailed in the next section on sampling strategy.

4.1.3 Sampling strategy

This section provides a detailed account of how participants were sampled in the study, which includes purposive sampling and convenience sampling.

Initially, I used convenience sampling, i.e. I included any respondents who met the inclusion criteria and who volunteered to be interviewed. This type of sampling is often the case at the beginning of CGT (Charmaz, 2014). The first few interviews in this study set the context of understanding how suicide impacted on participants. The coding process generated a multitude of insights into the mental illness, the decedents prior engagement with health services, the suicide and how the participants were coping. Consequently, I identified the need for more diversity in a few areas in order to explore the emerging findings further. As new areas of inquiry become established during the analysis process, I therefore used a purposive approach to include participants in the sample to explore areas of inquiry in terms of the kinship and nature of the relationship with the deceased, age, gender and the length of time since the suicide. One advantage of regularly attending SOBS, was that I had a better understanding of the background and stories of the participants. Subsequently, I invited people to participate in the study who could add to the diversity in these areas and comparatively analyse their data with earlier collected data. Again, this cyclical process of data collection and analysis led me to add questions in subsequent interviews in exploring lines of inquiry.

The first joint interview comprised participants recruited from the PST who had not accessed peer suicide bereavement support. Therefore, recruiting via SOBS allowed me to explore participants' experiences of the group. Additionally, I wanted to examine the diversity of gender, age, kinship and relationship with the deceased, as well as the length of time since the suicide occurred. Charlotte and Connie were non-biologically related to the deceased. They were a fiancée and a potential mother-in-law. As I attended SOBS, I invited Iris for interview, a mother who lost her son to suicide over sixteen years ago, whereas Charlotte and Connie experienced the suicide two years ago. Comparative analysis of the data from the three participants identified similarities and differences in their data, but also generated a wealth of new insights.

Considering the first three participants interviewed were women, I identified gaps in knowledge, such as male suicide survivors' experiences being under-reported in empirical research (Maple et al., 2014). I subsequently invited male members of SOBS to participate in the study to compare their gender experiences. Thomas was the first male participant to be interviewed in the study who had lost a son to suicide, but he requested a joint interview with his wife Victoria, who was stepmother to the deceased. This was advantageous in not

only exploring gender experiences, but also examining the kinship relationship between a stepmother and the deceased.

Writing memos on the analysis I had conducted so far, all the decedents were male and existing literature had ascertained that male suicide rates were disproportionately higher than female suicide rates (Samaritans, 2016). Therefore, female suicide had received more limited attention in empirical studies (Maple et al., 2014). In writing memos, I questioned whether losing a female to suicide led to a different experience for male participants, which I had also noted when developing a rationale for the study. There remained gaps in knowledge relating to experiences of male suicide survivors who had lost a female significant other (Maple et al., 2014). As a result, I purposively sampled Jonathan, who had lost his wife. In addition, I wanted to capture more diversity in the time since the suicide occurred and look at how this may affect coping and grief. Jonathan had been bereaved for over a year, which was recent compared to the previous participants. Furthermore, as I developed theoretical sensitivity, I wanted to interview another male participant who had lost a female to suicide so I invited Harry, who had lost his daughter, to be interviewed. Harry had asked to be jointly interviewed with his wife, Cath. Reflecting on this interview, I again noted differences between the locations of the suicide as, so far, two decedents died outside their home and three died at home. Moreover, I identified multiple suicide attempts by two of the decedents and how these were considered a 'cry for help', rather than a serious suicide attempt. These perceptions of the attempts were an influential factor in contributing to why participants described the suicide as unexpected.

Having interviewed three male participants and five female participants, I still wanted to gather further data on male participants' experiences of losing their partners/wives, because so far only Jonathan, who had lost his wife to suicide, was included. Subsequently, I invited Peter who lost his wife three years previously to be interviewed. In developing theoretical sensitivity, I also wanted to analyse gender and coping, which uncovered stronger similarities than differences in the participant's grief experience. Moreover, I wanted to explore further how suicide impacted on participants who were not closely biologically related to the deceased as I had only interviewed two participants, Charlotte and Connie, who fitted this criterion. Thus, I invited Emma to participate who had lost an extended family member. Comparing the non-biologically related participants' data highlighted that these participants did not have such a close relationship with the deceased compared with most participants who were first-degree relatives.

As most participants were parents who lost children to suicide, I wanted to interview participants who had lost a parent or a sibling to suicide to investigate this area further and made a request at SOBS meetings. As a result, Hannah who lost her father requested to take

part in the study and this interview was particularly insightful. I discovered Hannah had a challenging relationship with her father, which had led to a different impact from the suicide when compared with the majority of participants in this study. Christine, a mother who lost her young adult son to suicide three months ago was then convenience sampled after she requested to be interviewed. Comparing Christine's recent experience of the suicide with earlier collected data was insightful, but I also wanted to explore how the age of the deceased impacted on participants, especially if the deceased had died young. Constant comparison of the participants' experiences of death, dying and loss, had identified the widely accepted natural order of dying, where older people would die first due to natural age, whereas, the death of a young person was unexpected. I noted differences between the suicide and other types of death, for example, most participants had anticipated the death of a relative to a terminal illness or in older age. In a few cases, in this study, a suicide was anticipated because of the deceased's history of mental illness, expressions of suicidal intent and suicide attempts. Acknowledgement of the mental illness led to debates by participants about whether the suicide was a rational or irrational act (see Table 4.3: 'Meaning and Purpose' of the Suicide). At this point I had interviewed 13 participants and an early draft conceptual model (see Diagram 4.1), was developed at that point, and is discussed in Section 4.1.4. It illustrates my interpretation of the data and concepts I identified at that stage in the analytic process.

As the recruitment continued, Gemma contacted me, because she was aware of my request to interview someone who had lost a sibling and revealed a very different suicide experience compared with the majority of participants. The difficult nature of her relationship with the deceased was partly comparable with Hannah who also had an estranged relationship with her father. Both participants also disclosed their lack of grief and inability to cry for the deceased. At this point, I compared the draft conceptual model (see Diagram 4.1) with Gemma's data to strengthen the appropriateness of my findings. The next interview was with Helen who was convenience sampled as she requested to participate in the study and had lost her husband to suicide.

One key area I wanted to investigate further from the analysis, was the participants' need to meet and seek help from others who had experienced a suicide. For example, during the interviews I asked participants how they coped with the suicide and if they had accessed postvention. So far, almost half of the participants revealed that they had used counselling services but most had found it ineffective. However, participants believed health professionals could not truly empathise with them, because they had not experienced the suicide of a significant other. I therefore, wanted to understand how suicide bereavement peer support could be an effective postvention to families bereaved by suicide. As SOBS also provides a national helpline service staffed by volunteers who are suicide survivors, I decided to explore

this insight in-depth. Subsequently, I utilised purposive sampling to recruit helpline workers and adapted the existing interview schedule (see Appendix 19). I included specific questions that would allow me to illuminate suicide bereavement peer support further. The main questions included why people affected by suicide preferred talking to a helpline worker rather than a health professional. I was also interested in what motivated helpline workers to volunteer for the helpline, what they gained from talking to people affected by suicide and whether the helpline work helped with their own grief.

Two interviews with suicide survivors who were also helpline workers took place. The first interview raised some insight into their experiences of being a helpline volunteer. There was some clarity regarding why family members would prefer peer support and what motivated a helpline volunteer to offer peer support. A further interview with Violet, who was convenience sampled as she contacted me revealed very similar data to Elizabeth. It confirmed that suicide survivors needed to speak with someone who also had experienced a suicide. Due to the rarity of suicide, not many people in the suicide survivor's social networks or health professionals were able to offer them the support they required. Moreover, the anonymity of the helpline enabled them to overcome the perceived stigma of the suicide that led many people to ring the helpline, as it was anonymous.

I had compared the draft model I developed after interviewing 13 participants (see Diagram 4.1) and, after interviewing 17 participants, no new insights emerged and I reached theoretical saturation (see Section 4.1.5).

4.1.4 Developing theoretical sensitivity

This section provides an outline of how I developed theoretical sensitivity within a CGT framework. Charmaz (2014) provide guidance for researchers in strengthening theoretical sensitivity and suggest that the researcher pursues the multitude of insights arising from the data by investigating them, developing ideas through theoretical sampling and constant comparative analysis. The researcher's philosophical position is influential in the development of theoretical sensitivity and their knowledge of the research area shapes the emergent theory. Charmaz adds that the analysis process is flexible rather than linear or prescriptive and as the researcher interacts with the data, they develop the conceptual content of the study. Corbin and Strauss (2008, p.109) also state that developing theoretical sensitivity comprises: "*(a) reviewing the scheme for internal consistency and for gaps in logic, (b) filling in poorly developed categories and trimming excess, and (c) validating the scheme*". Following this process was essential in the evolution of the theory to explain the impact of suicide on family members.

As a constructivist grounded theorist, the analysis was to a certain extent influenced by how I interpreted participants' data. Areas I wanted to explore further were pursued through a continual process of purposive sampling with some convenience sampling, which still offered new perspectives that contributed to the variability in the findings (see Section 4.1.3) and writing memos (see Section 4.1.2). Moreover, a strength of using CGT is that it allowed me to draw on previous literature and theories to guide the direction of this study. This enables researchers to draw on a secondary source of data, encourages them to think about their analysis at a critical level and develops theoretical sensitivity (Strauss & Corbin, 1991). Referring to previous literature was, therefore, essential during the analytic process as I developed the concepts and established theoretical sensitivity. An example of referring to an existing theory in developing the concept of 'relationships' was when I explored how the suicide impacted on relationships in the family. I noted from the earlier interviews that participants discussed how the suicide brought the family members together because of their shared loss of the deceased. However, participants also disclosed how people in their social support networks distanced themselves or avoided participants, because participants felt others did not know how to address the suicide with them. To develop theoretical sensitivity, I found an article by Brown (2012) who cited Murray Bowen (1978) and his work on the Family Systems Theory. Brown (2012, p.2) states:

A Bowen family systems view of loss considers the impact the death of an individual has for the family as a functional unit; a unit where each member's coping and development is interdependent, hence any loss will have immediate and long term reverberations for every member and all other connected relationships.

According to Bowen, a family member's adaptation to a death was strongly influenced by four factors: the facts of the death, for example if it was sudden, anticipated; the protective factors of extended family and community; the role of the deceased in the family unit, and the level of family cohesion. Analysing my data, I explored how the suicide impacted on the dynamics in the family unit and the relationship between family members and I found many similarities, but also differences with Bowen's theory. I noted that the deceased's living circumstances and the nature of their relationship with the participant were influential in how the suicide affected the family. Although most participants were greatly affected by the suicide, there were less obvious changes in the family unit of participants who did not live with the deceased compared with those living with the deceased. Moreover, regardless of the deceased's living circumstances, participants who had a closer relationship with the deceased were greatly affected and their grief impacted on the family dynamics. Drawing on Bowen's theory was insightful in developing theoretical sensitivity and I wrote memos to record how the suicide

led to the different dimensions in the relationships in the family becoming closer, leading to changes, causing conflict or resulting in the breaking of relationships. The suicide impacted not only on the participants, but affected the wider family unit and social support networks. As a result, I added questions to ask subsequent participants and conceptualised this data in the element of 'changing nature of relationships with others'. Table 4.4 summarises the different categories in this element and contains the questions I added to the interview schedule.

Table 4.4: Sub-themes and additional questions added to the interview schedule in order to develop the element of 'Changing Nature of Relationships' (others)

Sub-themes	Description	Questions added to the original interview schedule
Relationship with others (Breaking, changing and new relationships)	Loss of deceased caused dynamic shifts in the family unit according to their role, especially if deceased was living at home or away.	What impact has the suicide had on the family? Has the suicide affected your relationship with other family members?
-The family	Relationships in the family became closer, fractured or new ones developed with extended family members of the deceased	Does experiencing a suicide cause fear of losing others? Do you feel others have changed their attitude towards you when hearing about the suicide?
-Others	Societal attitudes and stigma to suicide evident in relationships with others (community, social networks), resulting in avoidance, self-isolation or rejection by others New relationships (romantic partners, SOBS)	Did you feel you had to hide or conceal the cause of death from others?

An additional example of referring to literature was during the analysis of interviews with Harry and Cath. I was struck by Cath's words when she said, "*we've got photographs up on wall in bedroom about 4, so I'll give her a kiss in the morning, say a few words*". As I wrote memos, I used the word 'ritual' and referred to the existing literature to explore this in the context of bereavement and grief. As a result, I found an interesting paper by Castle and Phillips (2003, p.43) who provided a clear definition of rituals as "*an expressive, symbolic act that creates a special time and space in which the participants experience themselves as unique.*" Castle and Phillips (2003, p.43) suggest rituals are important for the bereaved "to

accept the reality of the death". From their perspective, some rituals offered structure for the bereaved and to a degree had healing properties. What became evident from these authors are the symbolic elements in rituals symbolising the attachment between the bereaved and the deceased.

This was true in this study as rituals were developed by participants to cope with the suicide and helped them to continue a relationship with the deceased. This was important to keep the deceased's memory and legacy alive. Rituals were important in helping participants adapt to the loss of the deceased as they transitioned from their life before the suicide to the 'new normal'. Analysing the data, I identified how some rituals were organised, others spontaneous, some ever changing and others constant. Some were conducted in private or public spaces. Public rituals included commemorating the death anniversary or marking the deceased's birthday with other family members. In private, some participants drew comfort from holding material possessions of the deceased, which I had labelled 'symbolism' to reflect the importance of these objects and linked in with Neimeyer's work on continuing bonds with the deceased (see Figure 4.1: Example of a memo from the first joint interview), To develop theoretical sensitivity, I examined why, how and in which ways participants kept a relationship with the deceased that highlighted important distinctions. Regardless of the kinship or closeness of their relationship with the deceased, most participants constructed an idolised version of the person who died, which was different from how they described the deceased before the suicide. This reconceptualisation of the deceased identified a dynamic shift in the participant's relationship with the deceased, which was important to their way of coping with the suicide. Notably, I found only a few participants kept the ashes of the deceased in order to continue a physical bond. Also, only two participants shared in detail how they spent time with the body of the deceased at the Chapel of Rest, whereas some participants did not, because, for them, the body did not characterise the deceased. It became important to highlight this distinction and I labelled a code the 'body' to refer to the physical representation of the deceased, including the ashes. As I developed theoretical sensitivity, I integrated these concepts into the concept of 'the body, rituals and symbolism' after I had interviewed 13 participants (see Diagram 4.1). Eventually, I re-conceptualised all these different elements from this data into the 'changing nature of relationships with the deceased' (as summarised in Table 4.5).

Table 4.5: Sub-themes and additional questions added to the interview schedule in order to develop the element of 'Changing Nature of Relationships' (deceased)

Sub-themes	Description	Questions added to the original interview schedule
<p>Relationship with the deceased</p> <p>(Breaking, changing and new relationships)</p> <p>-The deceased</p>	<p>The suicide was the physical breaking of the bond and resulted in a changed relationship with the deceased.</p> <p>The relationship with the deceased links in with the afterlife and connecting to them on a spiritual/religious level</p> <p>Symbolic ties with the deceased, important in continuing a relationship. These included objects, rituals and memorials</p>	<p>How do you remember your deceased?</p> <p>When you think about the deceased, are they the same age as when they died or do you believe they have aged or grown older over time?</p>
<p>-Reminders of comfort / discomfort</p>	<p>The body to some is now an empty physical vessel rather than a representation of the deceased. However, many participants had a strong attachment to the body. For example, dressing the body, visiting the body and laying the body to rest. The post-mortem was seen as the mutilation of the deceased</p>	<p>Are there any things, which are important to you that belonged to the deceased? Why?</p> <p>Have you created any rituals after the suicide?</p> <p>Was there a particular way you organised the funeral?</p> <p>Did you see the (deceased)?</p>

Another example of developing theoretical sensitivity refers to the 'new normal' that is found in popular bereavement literature and reflects how the bereaved adjust to life after death (Gee, 2010; Gilsdorf, 2010). A few participants talked about the 'new normal' to describe how their life had changed after the suicide, therefore I labelled the data with this code. I wanted to examine what, why and how participants constructed their 'new normal' from their experiences, therefore I questioned the participants. The analysis provided some insight into what participants described as 'normal' before the suicide. This included their relationship and history with the deceased. After the suicide, participants described the void left by the deceased and how the death impacted their social world, for example, losing their sense of identity, a loss of a future without the deceased and changes in the family unit. Key to social constructivism is understanding how individuals construct their social worlds through their interactions with others. Therefore, I wanted to explore how participants reconstructed an altered social reality as they accommodated their loss. The suicide was a catalyst for change,

which Christine described as, “*it’s having to sort of start again*”. Constant comparison of the data identified different ways participants reconstructed their own ‘new’ normal, which were individual and personal rather than following the societal norms of dealing with death and bereavement. For example, a few participants shared how the suicide motivated them to become actively involved in raising awareness of suicide and supporting other suicide survivors, which would not have been possible before the death. Participants also spoke about how the suicide had shaped their view on life and how they developed resilience in dealing with life’s stressors, so they appreciated their family and friends more. However, the ‘new normal’ for many participants was still predominantly focused on coming to terms with their loss, finding ways of coping and still grieving for the deceased. To develop theoretical sensitivity, I added a question about respondents’ changing perspectives on life (see Table 4.6) which provided a summary of different aspects of the ‘new normal’.

Table 4.6: Sub-themes and additional questions added to the interview schedule in order to develop the element of the ‘New Normal’

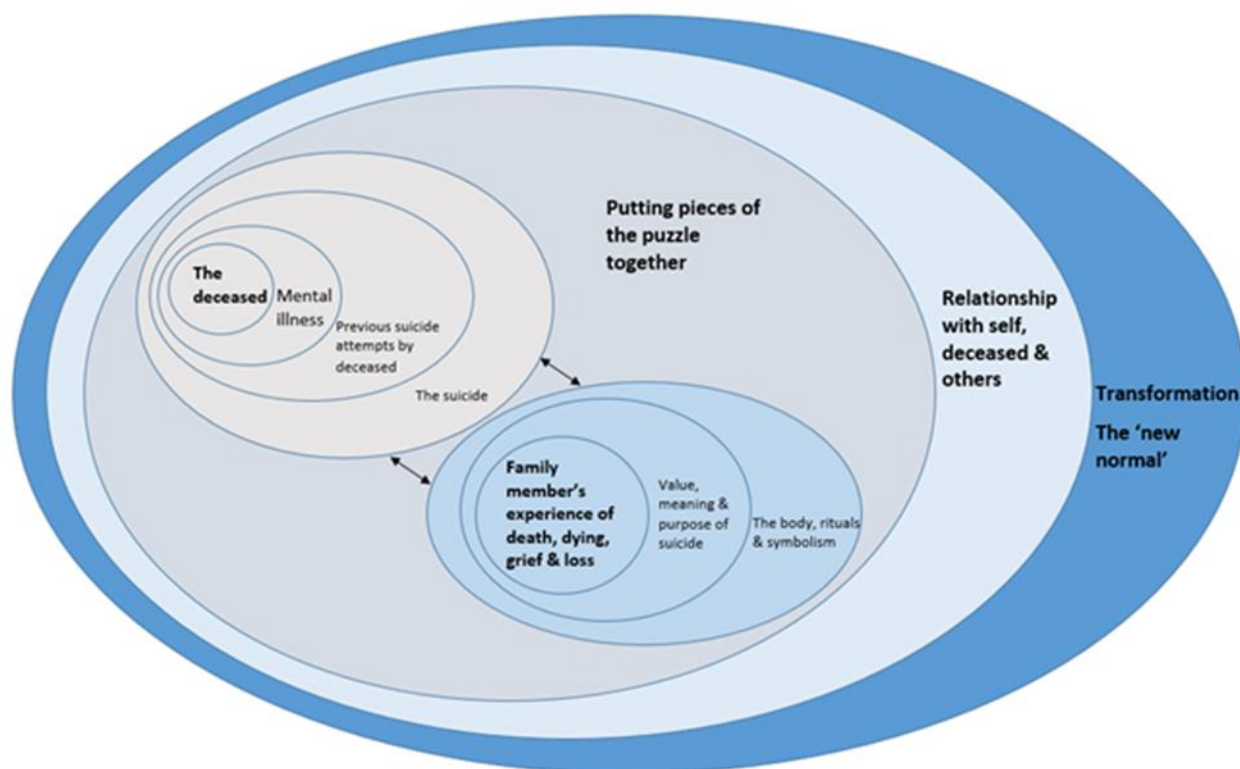
Sub-themes	Description	Questions added to the original interview schedule
<ul style="list-style-type: none"> -Change in outlook on life -Struggling with the loss -Personal change & growth 	<p>‘New normal’ refers to life after the suicide as participants accommodate the suicide.</p> <p>There was a fluctuation between struggling with the loss and finding positive personal growth.</p>	<p>Has your perspective on life changed since the suicide?</p> <p>How?</p>

As stated earlier, my preference for creating tools, such as flow charts, has proved useful in visually communicating information (see Appendix 8: PST process of recruiting participants). Another way of being creative is using diagrams, which Buckley and Waring (2013) propose are an important visual tool at any stage in the research process. In grounded theory, diagrams enable the researcher to illustrate visual representations of their ideas and key concepts at an abstract level and to highlight their properties and the relationship between them (Charmaz, 2014). Therefore, I use the term ‘diagram’ to refer to the visual representation of the emerging theory or findings and the term ‘model’ is the narrative explanation of the emerging theory. One example of a diagram I developed, is ‘putting the pieces of the puzzle together’ (see Section 4.1.2: Figure 4.2). As I pursued different avenues

of inquiry, new insights contributed to the construction of revised diagrams that documented the changing nature of the analysis. Diagrams also enabled me to develop theoretical sensitivity by checking how they related to participant's experiences during data collection and identifying gaps in the models.

The continual process of analysis enabled me to identify a wealth of emerging insights based on my interpretation of the data. Subsequently, I had to consider how to organise and categorise my emergent findings and analysis. Charmaz (2014) encourages the researcher to be creative during the research process and presenting findings in creative ways is also beneficial in disseminating the study's contribution to knowledge in appealing to a wider audience (Birks & Mills, 2015). During the research process, I developed various diagrams to capture the emergent findings, for example Diagram 4.1 after the analysis of 13 participant's data. This illustrates key concepts in the model displayed in concentric circles to symbolise the fluidity of the theory and relationships between the concepts. The analysis identified that participants' experiences were dynamic and continually changing as they fluctuated between struggling with the suicide and finding positive personal growth. Establishing a deeper understanding of the impact of suicide on participants, required setting the context of their story before the suicide to gain an insight into how they reconstructed their social worlds or 'new normal'. Considering the focus of the study is the family member and the suicide by the deceased, they are placed at the core of the model to emphasise the importance of the relationship between them. Two-way arrows closely connect the family member and the deceased to convey a sense of direction, direct relationship and represent active processes in the theory. Importantly, the consequences of the key event of the suicide caused a ripple effect in a family member's life, as visually represented by the arrangement of the concepts in the diagrams. I built around the core concepts by introducing key elements that relate to life after the suicide, which are strongly connected and inter-related to life before the suicide. The final element of the model is 'transformation' which incorporates the code 'new normal', This encompasses all the inner elements to capture how the family members reconstructed their social realities after the suicide.

Diagram 4.1: Tentative conceptual model after 13 interviews



Analysing 17 participants' data, I found the categories of the model were saturated and no new theoretical insights emerged. Glaser and Strauss (1967, p.61-62) state.

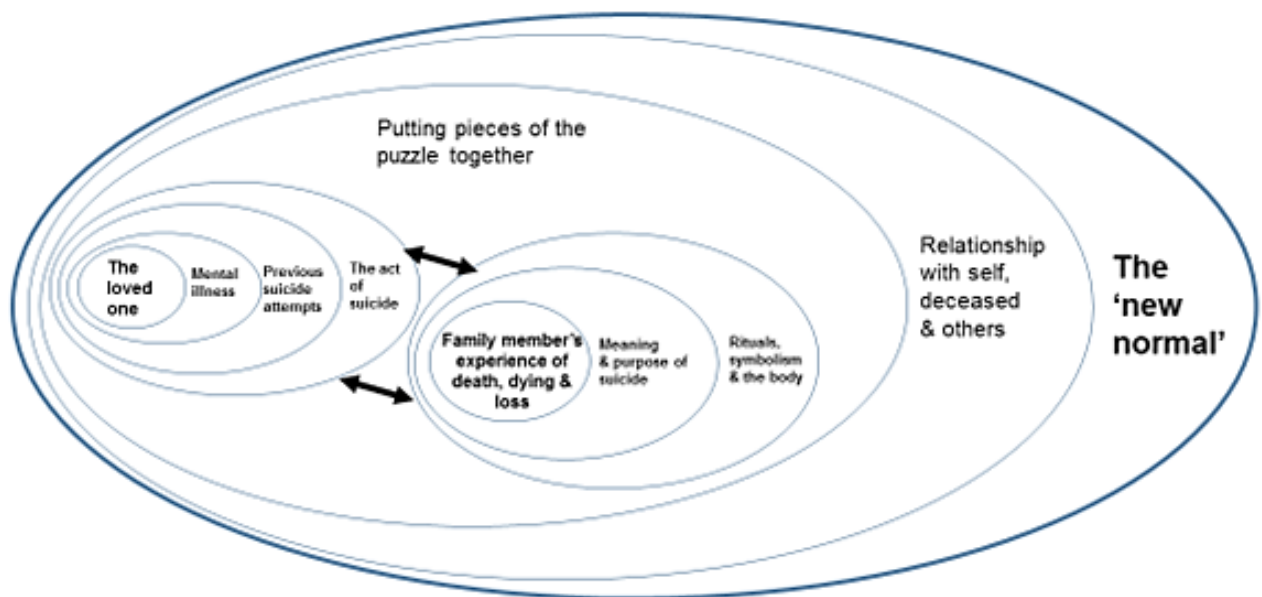
When saturation occurs, the analyst will usually find that some gap in his theory, especially in his major categories, is almost, if not completely filled. In trying to reach saturation he maximises differences in his groups in order to maximize the varieties of data bearing on a category, and thereby develops as many diverse properties of the category as possible.

At this point, I developed Diagram 4.2, which is the tentative conceptual model used in the focus group and is very similar in content, style and structure to the previous version (Diagram 4.1). Slight changes were made to the diagram, for example, I label the person who died as the deceased in an earlier model in the analysis (see Diagram 4.1). However, I became aware of the term the 'loved one' during a joint interview with Thomas and Victoria when she said, "one of our thoughts is that you can't necessarily blame others for the fact of your loved one's death". This term is used by Andriessen (2009, p.43) in his definition of a suicide survivor who has lost 'a significant other (or a loved one)'. Reviewing the literature also identifies that many studies on individuals bereaved by suicide or other types of death use the 'loved one' to refer to person who died (Burke & Neimeyer, 2014; Cvinar, 2005; Feigelman et al., 2009a; Joiner, 2005; McNeil, 2013; McKay & Tighe, 2014; Murphy et al.,

2003b; Neimeyer et al., 2006; Owens et al., 2011). Consequently, and in keeping with my participants' usage, I used the 'loved one' to refer to the decedent in two tentative models I developed during the analysis including, crucially, the one I shared with participants in the focus group (see Diagrams 4.1 and 4.2). However, away from the discourse of the participants in my study this term may be criticised because it makes the assumption that the person who died was loved or had a close kinship or relationship with the bereaved. In addition, the 'loved one' is often used to refer to the bereaved in the literature. For both these reasons it was replaced with the more neutral and less ambiguous term 'deceased' in the analysis following the focus group and in the final model (see Diagram 5.1).

Presenting the diagram was a valuable tool in effectively communicating a complex tentative theory (see Section 3.7.3). Buckley and Waring (2013) propose that sharing diagrams with participants in theory building exercises is conducive to checking the appropriateness of the tentative findings.

Diagram 4.2: Tentative conceptual model shared at the focus group



4.1.5 Analysis of the focus group

A full account of how data was gathered from the focus group was discussed in Section 3.5.3. By introducing a focus group to the study, I wanted to explore the tentative conceptual model (see Diagram 4.2) and comparatively analyse the data. In terms of the analysis for the focus

group data, I typed verbatim transcripts from the audio recording and developed a coding framework to include each element of the draft conceptual model.

In the focus group, I explained how my interpretation of interviewed participant's data had constructed each element of the conceptual model, which raised some interesting insights. As discussed in the reflexivity section on the focus group (see Section 3.7.), I shared with the group how some participants described the suicide as a 'choice' in the context of the severity of the deceased's mental illness. This was related to a sense of perceived burden on families, suicide attempts and suicidal ideation. Therefore, for these individuals, the suicide, in essence, was perceived to have released their pain. Some of the focus group participants strongly rejected this perception, as illustrated in the following excerpt:

Could I just say one thing, you use the word 'choice' quite a lot and I don't agree at all with the word choice [...] I think using the word choice you make it sound a very rational act and it's a completely irrational act in my opinion. I personally think it's the wrong, I don't know if you could find another word but from my point of view it that just doesn't ring true. (Rebecca)

It's the interviewees that use the word choice? (Sarah)

Yes, half of them do. (me)

Right. (Sarah)

I wasn't interviewed by you, but I never would have used the word the choice. (Rebecca)

As I wrote memos, I reflected on whether focus group participants did not openly share that they had been interviewed or if they found it difficult to vocalise their disagreement with the majority of participants' views, as they wanted to continue accessing SOBS. Therefore, disclosing different views to the majority of the focus group may have potential consequences. However, other reasons for not sharing their views could be my interpretation of their words from the interviews, or that participants may have forgotten what they disclosed at the time of the interview. I also wondered whether participants wanted to maintain their anonymity by not disclosing too much, especially if their views identified them. Nonetheless, these insights into differences between participants' experiences and perceptions, and the feedback from the focus group on the draft conceptual model strengthened the appropriateness of my findings.

Comparatively analysing the focus group data within the interviews led to identifying new insights or strengthened each element of the model. Subsequently, further revisions resulted in Diagram 4.3. One example of a change I made was to reflect differences in awareness and perceptions of previous suicide attempts, and this had a very significant effect on how the

suicide impacted on participants. Known suicide attempts, especially multiple attempts, contributed to some family members anticipating the suicide, which influenced their perception of the suicide and its impact. This is described in more detail in the findings chapter. Therefore, the 'loved one' now includes 'known' suicide attempts' and 'undisclosed suicide attempts' which were integrated in "piecing the puzzle".

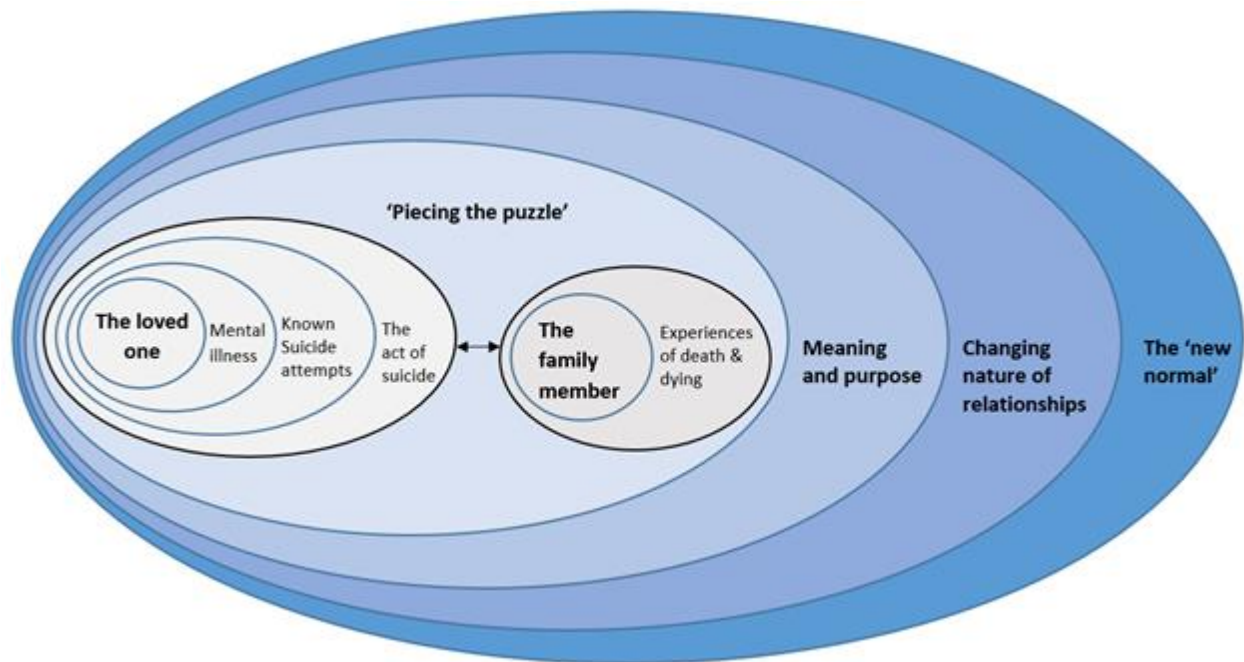
It became apparent that the concept of the 'family member's experience of death, dying and loss' had to be understood in the context of who they were before the suicide. Therefore, I conceptualised the element of the 'family member' to include their personal and situational circumstances. I also re-labelled 'death, dying and loss' as the concept of 'experiences of death and dying'. Separating the concept into a sub-property of the 'family member' captured the distinctiveness of the suicide compared with other types of deaths participants had experienced. At the time of developing the tentative conceptual model which I shared with the focus group (Diagram 4.2), I conceptualised 'loss' in the context of participants' previous experiences of death and dying. However, reflecting on the model after the focus group I realised that loss was a broader concept in the data, such as loss of self, the loss of relationships and loss of a future with the deceased.

In Diagram 4.2, the relationship between the 'loved one' (I was using this term at this stage) and 'the family member' before the suicide influenced how the 'meaning and the purpose' of the suicide was perceived by participants. Moreover, in "piecing the puzzle", participants had to draw on earlier memories of the 'loved one' before the suicide. Again, reflecting on the model, the 'family member's experience of death, dying and loss' included a sub-category of 'rituals, symbolism and the body' (see Section 4.1.4). At the time, I thought 'rituals, symbolism and the body' was more relevant in the family member concept and in how they constructed a relationship with the deceased. However, after the focus group, I realised that 'rituals, symbolism and the body' demonstrated ways in which participants maintained a relationship with the deceased, thus was a stronger concept in 'relationship with the deceased' to. Moreover, 'the loved one' represented the person before the suicide, whereas after the suicide participants had a different relationship with 'the deceased'. Subsequently, I re-conceptualised 'rituals, symbolism and the body' into the concept of 'changing nature of relationships'.

A further change was to the name of the concept of 'relationship with self, loved one and others'. This concept did not reflect the dynamic changes in relationships, such as breaking, changing and new relations for participants after the suicide (see Section 4.1.4). This realisation came at the focus group when a few participants reflected on how they had changed since their individual interviews. As a result, I reconceptualised 'relationship with self, loved one and others' into the overarching concept of 'changing nature of relationships',

to envelop all the different dimensions of relationships. Changes to the tentative conceptual model resulted in the version illustrating the impact of suicide on families, as shown in Diagram 4.3.

Diagram 4.3: Conceptual model on understanding the impact of suicide



4.1.6 Re-conceptualising the final model

Although Diagram 4.3 and the model addressed the study aim and objectives, on reflection the model did not provide a distinctive theoretical account of the impact of suicide by someone in receipt of mental health services on their family members. The mental health context of the study is central to the study objectives, so it was important that the findings and the model adequately highlighted that context. A strength of CGT is that the researcher has flexibility to re-examine the data in refining the theory (Charmaz, 2014), so in order to emphasise the mental health context and to highlight the original insights of the study, Diagram 4.3 was revised in order to address the following issues:

- There needed to be a clearer explanation of how the model illustrated the impact on family members of a suicide by someone in receipt of mental health services. The previous model presented a broad theoretical framework that could be applied to the

experiences of suicide bereavement and bereavement in general and which is discussed extensively in grief and suicide research (for example 'meaning and purpose', 'changing relationships' and the 'new normal').

- The labels of the key elements were too broad and descriptive and encapsulated many complex insights. It was therefore important to highlight the uniqueness of participants' experiences in the mental health context.
- Greater emphasis was needed on the unique insights regarding the impact on family members of a suicide by someone in receipt of mental health services, so that the theoretical and practical implications of the study could be highlighted and its unique contribution to knowledge identified.
- The previous diagram illustrated key elements arranged in concentric circles, but without reading the narrative explaining the model, it was unclear how the elements related to one another related to one another or over time.

The next chapter will present the revised model and the final diagram which addresses these issues.

Chapter Five: Findings

5.1 Introduction to the chapter

This chapter discusses the main findings that address the aim of the study: to understand the impact of suicide on families of people who were in receipt of mental health services. The chapter begins by providing information on the characteristics of the sample of both the participants and the decedents. There are two tables: firstly, Table 5.1 centres on the interviewed participants; and secondly, Table 5.2 relates to the focus group participants. In Table 5.1, some details are missing because the participants did not disclose information, or I deliberately omitted data to preserve anonymity. In Table 5.2, detailed information on focus group participants or their decedents is not available. The aim of the focus group was to collect and analyse participants' multiple perspectives on the emergent conceptual model in order to develop theoretical saturation of the data (see Chapter Three: Section 3.5). Therefore, personal information on the focus group participants was not collected. Section 5.2 introduces the narrative of the re-conceptualised Diagram 5.1, which is a visual representation of the findings. Before the main findings, three cases studies of participants are provided in Section 5.3 which exemplifies their experiences in relationship to the model. The three participants were chosen based on the different levels of their involvement in mental health services and their involvement in supporting the deceased.

Table 5.1: Information on the participants and the decedents

Participants' Details					Decedents' details						
Recruited via NHS PST or SOBS	Data collection	Participant pseudonym	Age	Gender	Kinship with deceased	Decedent pseudonym	Age	Gender	Time since the suicide	Method of suicide	Location of suicide
NHS	Joint Interview	Charlotte	35	Female	Partner	Steven	41	Male	2 years	Hanging	Outside
NHS		Connie	59	Female	Extended family member						
SOBS	Interview	Iris	70	Female	Mother	Joe	27	Male	16 years	Poisoning	Outside
SOBS	Joint Interview	Thomas	66	Male	Father	Adrian	29	Male	11 years	Hanging	Home
SOBS		Victoria	-	Female	Step-mother						
SOBS	Interview	Jonathan	68	Male	Husband	Kay	60	Female	1 year	Hanging	Home
SOBS	Joint Interview	Harry	67	Male	Father	Naomi	32	Female	1.5 years	Hanging	Home
SOBS		Cath	67	Female	Mother						
SOBS	Interview	Peter	54	Male	Husband	Maggie	49	Female	3 years	Hanging	Home
SOBS	Interview	Emma	58	Female	Extended family member	Debbie	48	Female	3 years	Hanging	Home
SOBS	Interview	Beth	51	Female	Mother	George	38	Male	2 years	Hanging	Home
SOBS	Interview	Hannah	31	Female	Daughter	Colin	67	Male	4 years	-	Outside
SOBS	Interview	Christine	56	Female	Mother	Sam	23	Male	3 months	Hanging	Outside
SOBS	Interview	Gemma	36	Female	Sister	Paul	39	Male	1.5 years	Poisoning	Home
SOBS	Interview	Helen	46	Female	Wife	Mick	47	Male	2 years	Hanging	Home
SOBS (HW)	Interview	Elizabeth	71	Female	Mother	Patrick	-	Male	17 years	Poisoning	Outside
SOBS (HW)	Interview	Violet	-	Female	Wife	Geoff	-	Male	19 years	Hanging	Home

KEY



Information is missing because data was not collected, data was omitted to preserve anonymity or participants did not disclose information



Joint interviews



Helpline Worker

Table 5.2: Focus group participants

Focus group participants			
Participant Pseudonym	Gender	Kinship with deceased	Deceased Pseudonym
Sarah	Female	Sister	Lyndsey
Judith	Female	Mother	
Penelope	Female	Mother	Chris
Keith	Male	Husband	Sandra
Douglas	Male	Father	Amanda
Cynthia	Female	Mother	
Rebecca	Female	Mother	Darryl

KEY



Participants who attended the focus group in couples

5.2 Introduction to the final model

The final model and diagram is shown at the end of this section (see Diagram 5.1), which is a visual representation of the findings. It provides greater emphasis on the mental health context of the study and in doing so, highlights the original findings. Notable aspects of the diagram are its structure, shape, as well as the content, and the elements are illustrated in vertical columns rather than concentric circles. The model is descriptive, however, underpinning some of the elements are explanatory processes and features, such as inserting a timeline in the diagram. This shows a clear sequence in the process of change over time from 'life before the suicide', to 'the act of suicide' and the 'impact on life after suicide'. The elements are inter-related and underpinning the model is the 'family member' and the 'deceased'. Contextualising the family member's social world pre-suicide and exploring how they reconstructed their social realities post-suicide, provides a clearer, deeper and richer account of the impact of the suicide. Therefore, this model is positioned within a social constructivist framework.

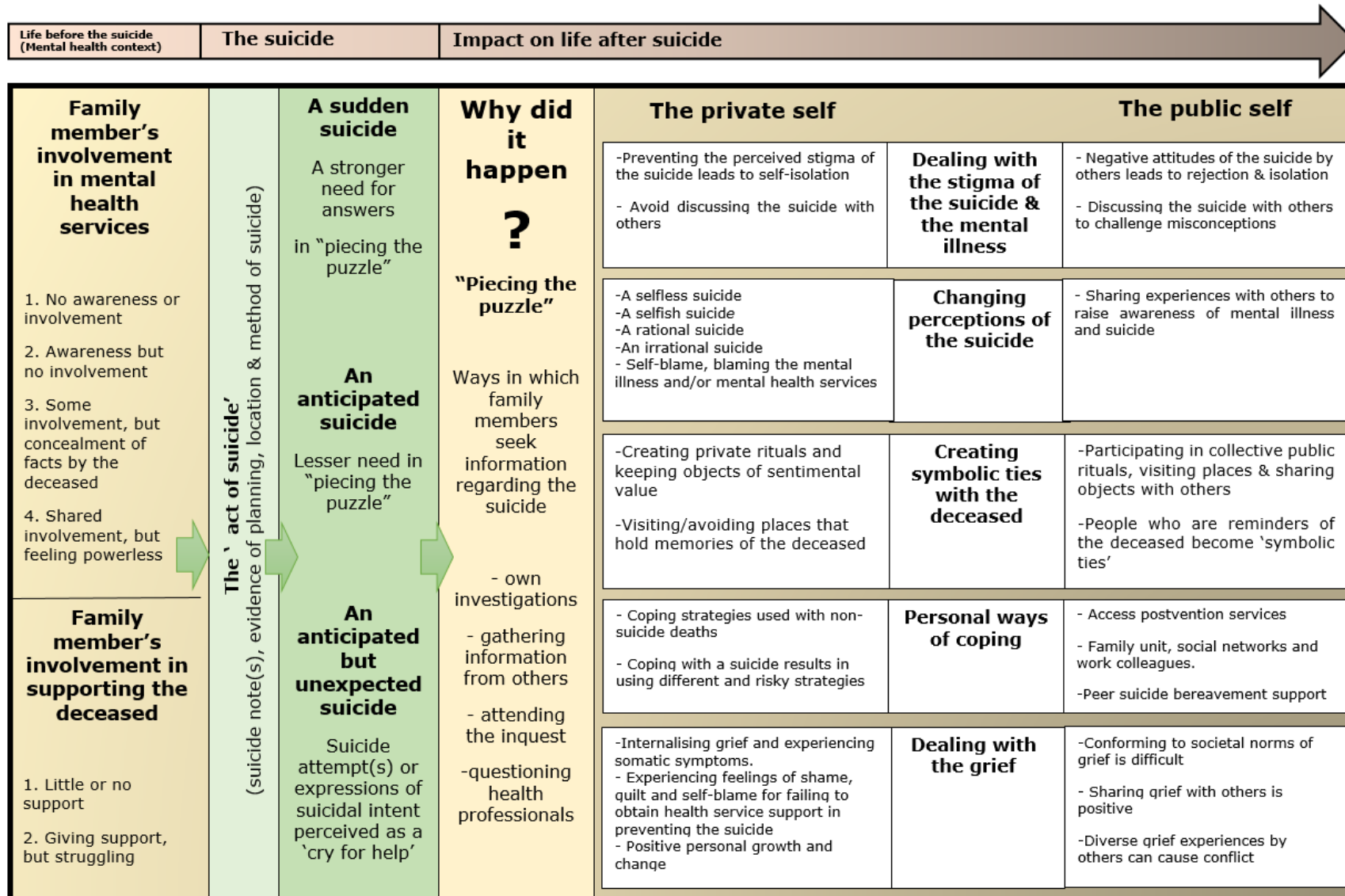
The diagram clearly contains and highlights content relating specifically to the involvement of mental health services, but undoubtedly, there are elements in the model that share common themes with suicides without the mental health context and other types of death. Importantly, the model contributes to addressing the following objectives of the study: to investigate suicide survivors' perceptions of the health service support which they and the deceased received before the suicide; to identify the individual needs and experiences of suicide survivors and to generate recommendations for improving services for suicide survivors. I will discuss these again when I reflect on how the study contributes to the understanding of the impact of suicide by someone in receipt of mental health services on their family members, and its unique contribution to knowledge (see Chapter Six: Discussion).

Three elements in the final Diagram, the 'family member', the 'act of suicide' and "piecing the puzzle" emphasise the impact of suicide on the family member, places the 'act of suicide' and its meaning as the key event and recognises the importance of "piecing the puzzle" as an active process in making sense of the suicide. The remaining four elements from the previous version (Diagram 4.3) of the "loved one" (referred to as the 'deceased' in Diagram 5.1), 'meaning and purpose', 'changing nature of relationships' and the 'new normal' have been deconstructed and reconceptualised into five main elements in the broader concept of 'impact on life after suicide' for the family member. The order of these five elements are structured to prioritise the mental health context and suicide first, beginning with 'dealing with the stigma of the suicide and the mental illness', followed by 'changing perceptions of the suicide'. The remaining three elements are; 'creating symbolic ties with the deceased'; 'personal ways of coping', and 'dealing with the grief'. Although these three elements share commonalities with

suicide in general or other types of death, I will highlight findings relating to the mental health context and suicide. The diagram also shows how the five elements are expressed or experienced in either private or public ways, which I describe as the 'private self' or 'public self'. This distinction was identified from the analysis and relates to how family members concealed (private) or showed parts of themselves (public) when dealing with the suicide (see Figure 4.1 and Section 4.1.1), and whether they expressed their grief and coping in private or public ways. The private self reflects an individual approach to coping or dealing with the suicide alone and hidden from others. The public self essentially reveals ways the family member acts or deals with the suicide with other people, often in a shared way.

This chapter is structured according to Diagram 5.1, beginning with 'life before the suicide', 'the act of suicide' and finally, the 'impact on life after suicide'. Each section consists of subthemes that will provide an in-depth account of the findings relating to the key elements in the diagram and include references to important points in the analysis.

Diagram 5.1: Understanding the impact of suicide by someone in receipt of mental health services on their family members



5.3 Case studies

The following three case studies exemplify how the conceptual model can be used to gain a deeper understanding of the impact of suicide on family members. Care has been taken to reduce the level of detail in these case studies to maintain anonymity.

5.3.1 Case study 1: Charlotte: (Limited awareness / no involvement with health services)

Charlotte's partner died by suicide two years ago and he had concealed his diagnosis and involvement in mental health services for many years. However, he had informed Charlotte that he had poor mental health, so she had some awareness of his engagement with health services but had no direct involvement. According to Charlotte, her partner had experienced negative attitudes from health professionals, including a lack of support, especially when he was suicidal. At times, Charlotte's well-being was detrimentally affected as she struggled to cope with her partner's depressive symptoms, changeability in his behaviour and noncompliance with medication.

The suicide was by hanging, outside the home and a suicide note was also left by the body. Although Steven had expressed suicidal intent on many occasions, he had made no suicide attempts, so Charlotte perceived the suicide as unexpected.

Impact on life after suicide

Subsequently, Charlotte had a strong need for answers, which she sought by conducting her own investigations and attending the inquest. She found out about her partner's mental health disorder, evidence of planning the suicide and his meeting with a CRISIS team, when he disclosed his intention to die by suicide. The suicide note was also an important part of "piecing the puzzle", because Steven clearly stated that the suicide was what he wanted, apologised for the suicide and said Charlotte should not blame herself.

'Dealing with the stigma of the MI & suicide'

Charlotte dealt with the perceived stigma of the suicide by avoiding others in order to protect herself and isolated herself. Furthermore, Charlotte explained how in public others avoided her because she believed they felt uncomfortable discussing the suicide. Charlotte also disclosed how she encountered stigma from others who voiced negative opinions of the suicide. Consequently, Charlotte challenged the misconceptions and stigma of the suicide by sharing the mental health context of Steven's death with others in her social network and participating in this study.

'Changing perceptions of the suicide'

Charlotte reflected on her changing perceptions of Steven's death. Charlotte perceived the suicide as selfless, because he was relieving the burden of his mental illness from others and a rational choice, as Steven was releasing himself from his pain of living with a lifelong mental illness. Critically, Charlotte blamed and felt angry at mental health services for failing to prevent Steven's suicide due to the lack of support they offered him, especially when he expressed suicidal intent.

Charlotte's motivation for participating in the study was partly a result of wishing to change others' misconceptions of the suicide in the public domain by raising awareness of the difficulties experienced by people in receipt of mental health services. Charlotte highlighted the important issue of health professionals maintaining patient confidentiality, but she recommended that health services should communicate better with families and involve them in care planning, especially if the patient had concealed facts regarding their care or had expressed suicidal intent. This would enable families to support patients more effectively by having a better understanding of the mental illness, their needs and how to deal with crises, which may possibly prevent future suicides. Essentially, she believed that health services should implement a more responsive, effective and timely intervention for patients, especially when they were suicidal.

'Creating symbolic ties with the deceased'

Charlotte shared many examples of how she created symbolic ties with the deceased that were expressed in private or shown to others in public. Charlotte disclosed her personalised ways of maintaining a relationship with Steven in private, including creating rituals, keeping a 'shrine' and some of his ashes. These symbolic ties were hidden from others, because Charlotte she felt deviated from societal norms and others would not understand her ways of maintaining a relationship with the deceased. However, in public, she engaged in collective rituals and also shared the suicide note with key family members.

'Personal ways of coping'

Charlotte constructed personal ways of coping in private, including drawing on the symbolic ties with Steven, but also adopting risky behaviours, because she had no regard for her personal safety. Charlotte received support from family and friends, which was overwhelming at times, resulting in self-isolation. Immediately after the suicide, different types of postvention services were briefly accessed including a consultation with a counsellor and medication because Charlotte struggled to cope. However, these were ineffective at the time, but now two years after the suicide, Charlotte recognised that she required professional support, and she was ready to try CBT or a talking therapy again.

'Dealing with the grief'

Charlotte experienced difficulties in making sense of the suicide, because of Steven's concealment of his mental illness and his engagement with mental health services, which further complicated her grief as she struggled to find effective coping strategies. Charlotte experienced symptoms such as poor health, disturbed sleeping patterns, loss of appetite, anxiety, depression, self-blame, and hopelessness. After the suicide, there were momentary feelings of relief followed by guilt. Charlotte felt she could have done more to prevent the suicide or been more assertive in seeking help from health services for Steven. In addition, due to the distinctiveness of the suicide, Charlotte found it difficult conforming to societal norms of grief and 'masked' her grief to prevent distressing others. At times, Charlotte engaged in sharing grief in public with significant others, especially with Steven's family and was positive because of the collective sense of loss.

5.3.2 Case study 2: Iris (some involvement but concealment of facts by the deceased)

Sixteen years ago Iris lost her son, Joe, to suicide, who was accessing mental health services three months prior to his death. The method of the suicide was poisoning, which took place outside the home and a note was not left. Iris perceived the suicide as unexpected, because she had limited knowledge of his mental illness or engagement with mental health services and there had been no known suicide attempts or expressions of suicidal intent.

Impact on life after suicide

"Piecing the puzzle"

Iris had a strong need for answers as to why the suicide occurred and during her investigations she found out about Joe's financial difficulties, non-compliance with medication and expression of suicidal intent to his treating clinician shortly before his death. The inquest also identified an undisclosed suicide attempt, but he had been disturbed. Over time, Iris had accepted that she would never truly know the answers to her questions about Joe's suicide, which helped her to 'accommodate' her loss.

'Dealing with the stigma of the MI & suicide'

Iris disclosed her avoidance of others as a way of coping and protecting herself from the perceived stigma of the suicide. Hearing others' negative views of a suicide without knowing about her son's mental illness was distressing. Others also avoided Iris because, she believed, they did not know how to discuss the suicide. Therefore, to challenge the stigma of the suicide

and mental illness, she is an advocate for suicide survivors and publicly shares her experiences with others.

'Changing perceptions of the suicide'

Iris is a Christian and although she believes suicide is not considered a mortal sin, her son's death caused her religious conflict. To find out whether Joe was at peace, she visited a spiritualist medium, which she found comforting. Iris strongly perceived that her son's mental illness contributed to his suicide because he had poor mental capacity, therefore the suicide was seen as irrational. Sharing her son's story in public and participating in this study was a way of challenging the negative misconceptions of the suicide and mental illness.

'Creating symbolic ties with the deceased'

To continue a bond with her son, Iris keeps sentimental objects, such as photographs and some of his belongings, which she draws comfort from. Iris has also participated in shared rituals with others in public, such as setting up a public memorial for her son.

'Personal ways of coping'

Personal ways of coping included drawing on her religion, which brought her comfort, but also a belief of being reunited with her son in the afterlife. Iris found effective ways of coping by seeking support from her family and close social networks. However, Iris wanted to meet others who had a shared sense of loss and accessed a bereavement support group, but found it did not meet her needs as a suicide survivor. She therefore accessed SOBS and this helped her cope, but she also felt positive emotions by supporting others in the group which helped her construct a 'new normal' and a sense of identity.

'Dealing with the grief'

Iris internalised her grief and expressed feelings of shame, guilt and self-blame for failing to be more actively involved in her son's care and prevent the suicide. Additionally, Iris shared her grief with significant others, such as her immediate family and close friends that often included collective rituals, for example marking Joe's birthday and death anniversary. Sharing her grief experiences at SOBS has been beneficial for Iris and also for supporting the newly bereaved to reassure them that grief is unique.

5.3.3 Case Study 3: Helen (fully aware and involved with mental health services)

Helen lost her husband, Mick, to suicide two years ago and he had been intermittently in receipt of mental health services for approximately eight years. Helen was fully involved in caring for and supporting her husband. However, both had negative experiences of mental health services because of; long waiting times to access services, health professionals ignoring their concerns about his deteriorating mental health, cancellations of appointments and lack of professionalism by health staff. Helen described how mental health services held power, which left them feeling powerless. Helen was aware of her husband's expressions of suicidal intent and multiple attempts, but these were considered a 'cry for help' because he talked about his future plans and was actively engaged in seeking treatment from mental health services. The suicide was by hanging at their home and no note was left. Helen perceived her husband's death as sudden, although there was some anticipation because he had a history of suicidal behaviour and severe mental illness.

Impact on life after suicide

"Piecing the puzzle"

Helen did not have a strong need to find answers regarding the suicide, but attended the inquest to learn more about her husband's death and receive information from mental health services about his treatment and care. No new facts were revealed.

'Dealing with the stigma of the MI & suicide'

Helen disclosed her avoidance of others, because she felt they did not understand her lived experience as a suicide survivor. However, others also avoided her which she perceived as resulting from the stigma of the suicide.

'Changing perceptions of the suicide'

Helen expressed that her changing perceptions of the suicide fluctuated between a selfless act, a choice, irrational, and rational. The perception of an irrational suicide strongly emerged because of the mental illness. However, the suicide was rational because the method was different compared with previous attempts that followed a similar pattern and there was evidence of planning. Helen had a great deal of anger and blame towards mental health services for not providing her husband with effective and timely support, which may have prevented the suicide. Therefore, by participating in the study, Helen shared her experiences with others to highlight her concerns to health services, to support other suicide survivors, but also to prevent future suicides.

'Creating symbolic ties with the deceased'

Keeping 'symbolic ties with the deceased' was important for Helen to keep her husband's memory alive. Helen showed her 'public' self through collective rituals that were shared with other family members to keep Mick's memory alive, although this was at times distressing because they were relatively recently bereaved.

'Personal ways of coping'

Helen's private ways of coping included gardening and taking long walks. Helen explained that at times she struggled to cope, but in public she pretended she was coping by concealing her grief. Shared coping strategies included attending SOBS, because Helen had a great need to find others who had experienced a suicide of a significant other, which she found helpful. She also coped by accessing counselling and drawing support from her work colleagues, friends and children. This was important because she lacked wider family and social support networks.

'Dealing with the grief'

Helen disclosed feelings of self-blame, guilt, disturbed sleeping patterns, hopelessness, and blame and anger towards health services for failing to prevent the suicide. However, Helen described building her resilience to life's stressors and had a changed outlook on life. To deal with her grief, it was important for Helen to draw on her symbolic ties with her husband and also use her personal coping strategies. Sharing her grief with other family members was also important and comforting when openly discussing their feelings and remembering her husband.

5.4 Life before the suicide

The first element on the left-hand side in the diagram sets the context of the family member's 'life before the suicide' and captures their relationship with the deceased. This area was explored in some depth to address the aim and one objective of the study; to investigate family members' perceptions of the service support, which they and the deceased received. The analysis uncovered clear differences between participants' experiences related to their involvement in mental health services used by the decedent. Furthermore, examining the family member's personal context in the support of the deceased, sets the background to gain a deeper understanding of the impact of suicide.

5.4.1 The family member's involvement in mental health services

The analysis identified four different aspects relating to the family member's involvement in mental health services accessed by the deceased. Firstly, family members who had 'no awareness or involvement in mental health services', because they were not informed by the deceased. Secondly, 'awareness but no involvement' and thirdly, 'some involvement, but concealment of facts by the deceased'. The fourth aspect reflected the experiences of most participants; 'shared involvement with the deceased but feeling powerless'. Clear issues of 'power and powerlessness' were identified from family member's involvement in mental health services.

To contextualise the decedent's mental illness and engagement with mental health services prior to the suicide, the majority were diagnosed with a mental illness in adulthood, most had depression and a few had bipolar disorder. Four decedents were diagnosed with a mental illness immediately before the suicide and had started receiving treatment or were waiting for referral into mental health services. This meant participants had little knowledge of the mental health context of the deceased. Regardless of the decedents' living circumstances, nearly two-thirds of the participants provided the deceased with informal care, support and engaged with mental health services.

The first three aspects of the model identify family members who had limited or no awareness of the mental health context of the deceased or involvement in mental health services. There were a number of reasons why this was the case: decedents lived alone; lived with and/or were receiving care from significant others; did not want family members involved in their care; had an estranged relationship with family members; or concealed these facts from participants.

Most often participants with limited or no awareness of the decedent's mental health context perceived the suicide as sudden, which elicited intense grief reactions as they tried to make sense of the suicide and search for explanations as to why it happened. These participants shared similarities with participants whose deceased was diagnosed with a mental illness shortly prior to their suicide. Peter's wife was diagnosed with a severe mental illness before her suicide and although he was aware that she had been to see her doctor, he was unaware of her diagnosis until after the suicide,

She hasn't been suffering for it for a long time, I didn't see it as being a big thing at the time I didn't see it as a serious illness, it's only afterwards when I've thought and talked and looked at it, I can see it was serious illness but it was short term one, so if it was so painful that she couldn't cope with it, she had to take her life.

Thomas and Victoria had awareness but no involvement in their son/step-son's care because he lived with his mother who was his primary care-giver. As a result, Victoria felt "*we don't know anything, we don't even know what the doctor looked like, because when he was being treated for his condition, we weren't there*". Although the suicide came as a shock, the suicide was anticipated, because the deceased had been in receipt of mental health services for many years.

Concealment of facts by the deceased strongly emerged from the analysis and to a degree, participants believed that decedents wanted to prevent distressing others or to avoid the perceived stigma of being labelled with a mental illness. However, a few participants believed the mental illness was to blame for the concealment of these facts by the deceased, rather than a rational decision to exclude families in their treatment. In addition, a minority of participants who knew about the mental illness and were involved in mental health services, were unaware of some facts relating to the deceased's treatment, missed appointments, non-compliance with medication, expressions of suicide ideation to others or undisclosed suicide attempts. Cath, who was fully aware of her daughter's engagement with mental health services, recounted the time her daughter disclosed, "*it's come back again mum [...] unknown to me she'd stopped taking her tablets, because she felt she was happy.*"

The fourth aspect; 'shared involvement with the deceased, but feeling powerless' refers to issues of power in relation to health services and/or health professionals. Most participants voiced dissatisfaction towards health professionals and services regarding the treatment and care of the decedent. There was a strong belief that health professionals were 'experts', yet the majority of participants had criticisms. One main issue related to health professionals' reluctance to act on the concerns of the decedents or participants due to the deteriorating mental illness. Christine shared her frustration with health services regarding her son,

I think maybe I think they'd taken me a bit more seriously really because I feel as if they did listen to what I said, but most of what they were dealing with was what he said and I can see it's a difficult situation, but he was living with me and I was seeing him all the time, so maybe if there was some way that they could have maybe taken what I said a bit more seriously

This caused feelings of frustration, blame and anger as there was an expectation that staff would appropriately treat the deceased to an extent where the mental illness was manageable. Importantly, the decedent's relationship with health professionals was influential in whether they were compliant with their medication, treatment or engagement with health services. Some participants reported health professionals as being disengaged from decedents or had a fractious relationship, which was problematic. Staff were perceived as

lacking professionalism, empathy, compassion, care and sensitivity with the deceased. Critically, none of the participants were informed by health professionals regarding how to best support the decedents. The lack of continuity in care and high turnover of staff left little time to build a relationship between the deceased, family member and health professionals. Participants reported that health professionals failed to administer treatment, conduct tests to accurately diagnose the deceased's mental illness, lacked urgency with referrals into services and refused to refer the deceased into services. For example, Helen shared her experience of struggling to receive support for her suicidal husband from his treating clinician,

Four times they cancelled his appointment [...] I just stood me ground in the end and I just said you know we're not moving out of this building until he sees somebody. He had one session then the week after but then he actually died the day after that

These issues were considered as barriers to the decedents receiving effective and responsive support that met their needs or expectations and importantly, preventing the suicide. Participants felt powerless, helpless and ignored, but also lacked confidence in health services effectively treating the decedents in a timely manner. After the suicide, participants considered these events as missed opportunities that generated strong feelings of blame and anger towards health services for failing to prevent the suicide. Moreover, these experiences affected the participants' perceptions of health services and postvention they received from clinicians (see Section 5.6.5).

The analysis identified the complex area of patient rights, confidentiality and the involvement of families in the care of the decedents who lacked mental capacity that led to participants expressing feelings of powerlessness. An important finding raised by Charlotte in her case study (see Section 5.3.1) and re-iterated by many participants was the need for health professionals to involve families in the care-planning and to communicate with them regarding the patient's treatment. Participants felt they would have been better able to support the deceased, however, they acknowledged that health professionals had to maintain patient confidentiality. Most participants who were aware or involved in the deceased's care, respected the deceased's privacy and autonomy in their own care and the deceased often took responsibility for their appointments with health services, compliance with medication or choosing treatment options. Some participants did not accompany the decedents to appointments so that they had privacy and could disclose their innermost thoughts to health professionals that may have distressed participants.

The majority of participants, however, were aware of the deceased's engagement with health services and/or regularly attended appointments with them. Some participants were

advocates for the deceased to ensure they were appropriately treated, particularly if the decedent had poor mental capacity, was vulnerable and/or distressed or they had negative experiences with mental health services.

I actually attended one of the sessions and even though her presentation was extremely you know agitated and clearly saying she didn't want to be here anymore, she'd had enough. Snot coming down her nose, banging her head and she took her life a few days later actually. There wasn't even any assessment actually after that, I actually was the one that said are you not going to assess the suicide risk when she's not got capacity? (Sarah)

Participants who perceived the deceased had poor mental capacity expected health professionals to navigate patient confidentiality and involve them in decision making regarding the deceased's care. A few loved ones had instructed health professionals not to share their personal information with families, which became evident at the inquest when "piecing the puzzle" (see Section 5.6.1). Participants who were unaware of the decedent's mental illness, shared their disappointment with health professionals who had failed to inform them of the deceased's wellbeing, especially if expressions of suicidal intent and suicide attempts were made.

Participants also highlighted how barriers to accessing mental health services related to long waiting lists, time taken to be referred into services and non-allocation of appointments. The perceived poor quality of mental health services was an issue relating to the lack of care by staff to patients, cancellation of support sessions and poor interaction with patients. Another problematic issue raised by participants was of reluctance or resistance by decedents to access mental health services if they had poor mental capacity. At times, when the deceased's mental health deteriorated, they refused treatment from mental health services, causing difficulties for participants to respect the deceased's rights and choices. Therefore, a few participants attempted to intervene on behalf of the deceased to access emergency mental health services support. For example, Jonathan recounted seeking help for his wife, "*she said don't section me, don't call them and grabbed that phone and whenever I tried to get help she'd grab the phone and fight with me.*" To an extent, Jonathan felt pressured to protect his wife out of loyalty and love, which conflicted with his need to find her professional help.

Participants also raised criticisms of health services of their treatment of decedents following suicide attempts. They expected health services and staff to take these attempts seriously by implementing urgent, responsive and appropriate measures to prevent further suicide attempts. Health professionals treated the physical symptoms of suicide attempts, rather than holistically treating the mental and psychological consequences. Subsequently, health services and staff became a source of anger, blame and frustration for participants and

decedents who felt powerless, disrespected, voiceless and disempowered. Furthermore, after the suicide, these criticisms of health services and clinicians affected their perceptions of the support they received from health services, which for many was ineffective (see Section 5.6).

5.4.2 Family member's involvement in supporting the "deceased"

'Life before the suicide' reflects family members' personal context of supporting or caring for the decedents and focuses on two different perspectives; 'little or no support' and 'giving support but struggling'. The personal context of participants and their experiences of support or care to the deceased strongly influenced how the suicide impacted on family members. Differences emerged in participants, such as the anticipation or unexpectedness of the death and mixed perceptions of the suicide, which affected the intensity of their coping and grieving (see Section 5.6). As stated earlier (see Section 5.4.1), some decedents lived alone, had an estranged relationship with participants, lived with significant others, accessed health services before the suicide for a short time only, or had concealed facts. Subsequently, some participants provided 'little or no support' to the deceased and had a fragmented picture of their personal and social context. On the contrary, most participants had a clear understanding of the life of the deceased if they lived together. At some level, most participants were 'giving support, but struggling' with the challenges encountered from the decedents.

Although a mental illness is a risk factor for suicide (Samaritans, 2016), certain life stressors can also increase the risk of suicide and, in this study, decedents experienced relationship problems, loneliness, bereavement, financial difficulties, employment issues, challenges of finding employment, and misuse of alcohol or drugs. Participants who were unaware of their stresses and the mental health context found that changeability in the deceased's personality and behaviour was confusing and difficult to understand. Participants, at the time thought the deceased experienced 'low moods' because of life stressors, but these changes were temporary. All of these are known factors increasing the risk of suicide, especially in males (DH, 2015a). However, often overlooked in suicide research are female life stressors and the findings highlighted fertility problems, loss of identity and feelings of being an inadequate mother. Jonathan shared how his wife felt "*she didn't have an identity, she was wondering who am I, what am I, because I'm no longer going to be needed as a mother, she couldn't see a role*".

The living circumstances of deceased were also important. Approximately half of the decedents were living with the participants, three lived alone and three were living with their partners. Participants not living with the person who died had limited insight into the

challenges they faced compared with participants living with the deceased. The analysis uncovered participants' irregular contact with the decedents, estranged relationships or periods of absence. Additionally, some deceased lived with significant others, such as their partner or a parent, who was actively involved in their care with mental health services. Nevertheless, participants still experienced anxiety, concern, stress and worry for the decedents, especially apparent when participants saw stark changes in the deceased's behaviour or personality. Thomas recounted the final time he met his son after a long time, *"we could tell we'd lost him then, we could, it was in his eyes"*.

Exploring the closeness of the relationships between the deceased and family members offers insight into the impact of suicide. Many participants had had a close relationship with the decedent, because they had maintained both a strong emotional bond and frequent contact. Nonetheless, there were differences between participants who were biologically related or non-biologically related to the deceased. For example, Victoria was not biologically related to her step-son and found it difficult to support him, *"I know I wouldn't have felt comfortable in interfering with that relationship that he had with his mother and his mother had with him, and the control that she had over the situation."*

Participants not biologically related to the deceased, such as partners, had to draw on limited knowledge about the decedent's life to identify life stressors that may have contributed to changes in their loved one's personality. Some participants gathered information from the deceased's extended family members and friends or recalled conversations. For example, Jonathan shared, *"I think looking back she was always anxious, no doubt about it and she was controlling and that was because of, I think of the way she was brought up"*.

Biologically related participants were mainly parents, but also included siblings and a participant who lost a parent. These participants were able to offer a deeper insight into the nature of their relationship with the deceased by drawing on earlier memories. They recalled their own childhood memories of growing up with the decedents, which at times was difficult, leading to an estranged relationship as exemplified by Hannah who lost her father, she said, *"I try not to miss him because I've still got that anger there that I won't allow myself to feel upset, because I won't let him upset me, because he's done this."*

Parent participants remembered experiences with their children from birth when they were growing up into adulthood. These participants contextualised who the deceased was in terms of their personality and behaviour in order to understand how some of these traits manifested into adulthood. For example, many parent participants reported that as children the decedents displayed anti-social and challenging behaviour, which raised concerns for their families and schools.

Yeh, they put him down as a naughty child, but that's what it was all about to start with, and then he was quite naughty in school and then at 16 he'd started dabbling in drugs. He put all my windows through in my house, he did detox a few times, didn't stick at it, he disappeared, like I said he disappeared, he was in and out of our lives all the time. (Beth)

Subsequently, many participants consulted health services to establish if any underlying medical condition could explain the deceased's behaviour. Critically, only one decedent was diagnosed with a mental illness in childhood. The others were diagnosed with a mental illness in young adulthood and in a few cases, as older adults. Participants expressed the view that the lack of a medical diagnosis or an understanding of their child's difficult behaviour caused conflict in their relationship and was challenging.

An interesting finding recognised how participants formed various perceptions of the mental illness. It was important for participants to share who the deceased was before they experienced a severe mental illness. In these instances, participants blamed the mental illness for changes in the deceased's personality and behaviour (see Section 5.4). A minority of participants considered mental illness as a separate entity to the decedent that caused the changeability in the deceased's personality or behaviour. The mental illness, was therefore recognised to influence expressions of suicidal intent, self-harm, suicide attempts and the suicide. Mental illness was also thought to be comparable with a terminal illness as exemplified by Cath who said, *"I think it's like cancer of the brain, it's something that eats away at them"*. In a similar vein, Christine shared how she perceived her son *"as terminally ill as my husband was, just in a different way."* These perspectives highlight that many people in wider society fail to understand mental illness, because the symptoms are often invisible to others. Participants further recognised a societal assumption that a physical illness, such as cancer, received compassion and sympathy because of the visibility of a physically debilitating illness. According to participants, misconceptions of mental illness in society resulted from a lack of awareness, knowledge and stigma.

At least half of the participants living with decedents had a greater insight into how the mental illness adversely affected their lives compared with participants who did not live with the person who died. Certainly, decedents diagnosed with a mental illness over a longer time provided a greater understanding for participants to make sense of the changeability in their personality and actions. However, Christine, whose son was referred to mental health services immediately prior to the suicide, described his unpredictable behaviour resulted in her *"living on a knife edge all the time"*. Participants recognised mental illness as being a serious problem, potentially life long and requiring long term treatment. Therefore, they felt compassion and sympathy for the deceased.

Living with the deceased in the wider family unit was also a source of tension for participants, as the deceased's behaviour or attitude had repercussions on other family members. Helen shared how her teenage son found it difficult to deal with his father's depression, "*my son was saying to him I can't go on like this dad, you're making me feel bad and I don't know what to do and I hate living here and I don't want to live here*". In these instances, prioritising the deceased over other family members elicited feelings of guilt for participants, as they were unable to spend quality time with other family members. It was difficult to strike a balance of care with supporting other family members, but also having little time for themselves.

The participant's relationship with the deceased was challenging if they expressed suicidal ideation or made suicide attempts. These events resulted in mixed views, but most participants did not believe these expressions were serious intentions to die but were strongly influenced by the mental illness. Shaping this belief was the changeability in the deceased's behaviour, because there were moments when they expressed their desire to live, planned a future and sought ways to improve their health. Decedents also attempted to engage in different types of holistic treatments or seek help from others in order to find a way of effectively managing their illness. At times, the deceased reverted to their 'normal' self or reported how they felt a burden on their families.

Other participants believed the deceased did not want to die and blamed their poor mental capacity as influential in the suicide attempts.

During the time we were together, there were at least six disappearances from home, and four previous attempts [...] I think his attitude would have been if this works it deals with it, it sorts out my pain, and if it doesn't there'll always be another time, it was like Russian roulette. (Elizabeth)

Participants were constantly alert to changes in the deceased's behaviour and often monitored them to ensure suicidal expressions did not lead to suicide. As well as voicing suicidal intent, a few decedents self-harmed, which highlighted the seriousness of the mental illness for participants. Therefore, hearing expressions of suicidal intent caused a great deal of anguish, distress, intense discomfort, stress and anxiety. However, after the suicide, a few participants reflected that these were perhaps serious intentions to end life, and they should have done more to prevent a suicide, thereby adding to their guilt and self-blame.

A noteworthy finding was the participants' perception of the decedents' suicide attempts that were discovered when comparatively analysing the data. I noted some suicide attempts were known to the participants, whereas, undisclosed suicide attempts were only identified when "piecing the puzzle" (see Section 5.6.1). Nine participants were aware of suicide attempts and

their experiences influenced their perceptions of the suicide and its impact (see Section 5.6.3). Many decedents followed a similar pattern in their suicide attempts; they disclosed their attempt to the participants or displayed notable changes in their behaviour that alerted participants to suicide attempts, such as feeling agitated or the deceased withdrawing from others. After the suicide, a few participants compared the suicide with suicide attempts and found differences, which changed their perceptions of a suicide.

Another important finding related to the participant's issues of powerlessness and helplessness because they perceived themselves as failing to effectively support the deceased and prevent suicide attempts. This resulted in self-blame, guilt, frustration and constant anxiety from worrying about the decedents. Moreover, a number of participants directed blame and anger towards the deceased for putting them through the ordeal of multiple suicide attempts. After a suicide, there were feelings of relief, guilt, and difficulties in grieving and coping. Gemma echoed the sentiment of a few other participants when she said:

I used to get angry with him, I'd just be well fine, go on then, I'm sick of you going on and on and on about it, do it! And in some ways we all felt like that and it sounds awful, but we all thought just do it, just get it over and done with it, because you'll be happier in the fact that you'll be at peace and we'll be happier in a way because the whole mess will be over with.

Participants' strategies of coping when caring for or supporting the deceased raised insights, for example, one participant disclosed how she lived with her partner, but still rented a flat where she could stay when she needed respite. Other participants made an effort to distract themselves in their jobs and/or seek support from other family members, friends, work colleagues or their religion. Critically, none of the participants received any support or information from health professionals while caring or supporting the deceased and raised feelings of powerlessness. Furthermore, the difficulties of not knowing how to effectively care for or support the deceased detrimentally impacted on the participant's own emotional and mental wellbeing. Participants recounted the changeability in the decedent's behaviour or that their actions caused tension, conflict, confusion and elicited feelings in participants such as resentment, frustration and anger. While these feelings were momentary for many participants, they resulted in intense feelings of distress, guilt and shame as the strain of caring for someone with a mental illness took its toll. Charlotte recalled how living with her partner negatively impacted her mental wellbeing, "*he was going downhill rapid and he was hard work with me*". Participants experienced loss of appetite, lack of sleep, poor concentration, fatigue, anxiety, low self-esteem and helplessness from feeling inadequate in effectively supporting the deceased.

I really struggled because I felt as if I couldn't just leave him, so I think probably I needed a bit more help at that time, but I don't really know what they could have offered me, even just an acknowledgment that I was struggling with him really. (Christine)

Regardless of whether participants were living or not living with the decedents, there was a general sense of regret that they should have done more to prevent the suicide or been more influential in their care from health services. This notion of disempowerment and self-blame intensified the grief experiences of most participants, because they felt guilty for failing to prevent the suicide.

5.5 The 'suicide'

The 'act of suicide' signalled the change in time and circumstances for participants from 'life before the suicide', to 'the impact on life after suicide'. The 'act of suicide' contains facts relating to the method, location of the suicide, suicide note(s), and evidence of planning. These facts contributed to the impact of suicide on participants and how they made sense of it, especially when compared with other types of death. Nearly all the suicides both male and female, were by hanging. Other methods included drugs overdose, poisoning, and jumping from a great height.

Compared with other types of death, the 'act of suicide' was distinctive, as conceptualised by Jonathan:

The difference is because it's something that somebody's decided to do, they've taken it upon themselves to take their own life. They've made that conscious decision to end their life when they didn't have to. They've decided, they've left you with no goodbyes, no reason as to why they've done it, you're not able to say goodbye. When a person is terminally ill and you can bring closure and you can say what you want to say to your loved one. You're deprived of that, it's taken away from you, that's gone, they've taken that away from you.

Participants compared known suicide attempts with the method of suicide and a few participants did not recall any changes in the deceased's behaviour that suggested an imminent suicide. However, six participants found clear differences, because they noted changes in the pattern of behaviour and attitude of the person who died. For example, known suicide attempts were often vocalised or the deceased's behaviour raised suspicion, but with the suicide there was 'silence'.

*Because before he told me and he said to me straight away I've taken tablets I'm stupid I've taken tablets, this time I didn't get nothing from him and I thought there's a difference between taking a tablet and telling someone and hanging yourself and not saying when he always has before you know.
(Helen)*

Connie and Charlotte offered a very different perspective on the method of suicide by the decedent, because they believed it was chosen to minimise damage to the body and prevent distress for the family. Others perceived the method of suicide as being practical, requiring less time in preparation and would prove fatal. There was evidence of planning the suicide in a number of cases, for example, one decedent hid his car from view and locked himself inside his house. Others bought items for the method of suicide a few weeks before the suicide and put their affairs in order. The findings also uncovered the location of the suicide as important for participants in making sense of the suicide. Comprehending what motivated the deceased to choose a particular location and why, added confusion for many participants. Approximately half the decedents died at home, leading to speculative conclusions by participants regarding why that was the chosen place. The participants believed that the decedents may have thought that they would not be interrupted in the act, it was less time intensive than finding an alternative location, and the body would be found. Three participants described the suicide as opportunistic, for example, Harry and Cath shared their daughter's caring responsibility with her partner and had been monitoring her since her last known suicide attempt. The only time their daughter was alone at home she took her own life. Moreover, a few decedents had made suicide attempts outside the home and had been disturbed. Consequently, participants considered the suicide at home as a practical option, private and with less chance of interruption. Interestingly, a suicide at home did not result in uneasiness for participants who continued to live in the place where the person died. However, one participant not living with the deceased, felt a suicide at home was selfish, because of the perceived distress for families.

Participants considered a suicide outside the home as an attentive and thoughtful gesture by the deceased to prevent them from experiencing the trauma of finding the body. This minimised distress and protected participants from the constant reminder of the place of death.

My view is that he decided to hang himself in the garden because there was a handy place for that to work, but it was, I thought considerate of him to do this, outside the house rather than inside the house. For me if I had found anybody inside the house, I would not feel happy living in that house, knowing that had happened in there [...] and the second thing is that he was where it was going to be successful quickly and he didn't have to make special arrangements to be far away and maybe or maybe not successful,

because you would have to find a suitable alternative place where you could be private and manage in the time available. (Victoria)

Another distinctive feature of 'the act of suicide' is the handwritten suicide note(s) left by six of the decedents; four males and two females. Further references to the suicide note are given in "piecing the puzzle" (see Section 5.6.1). To an extent, suicide notes indicated planning of the suicide and nearly all the notes were found at the place of suicide. One participant, however, found copies of the suicide note hidden in the deceased's bedroom when "piecing the puzzle". Two decedents left multiple suicide notes addressed to their family, the Police and the coroner. The notes addressed to the Police and the coroner were confessions by the deceased that they had taken their own life without any involvement or coercion by others. Comparatively analysing the data, I found suicide notes were left by: two decedents with no prior suicide attempts, two decedents with undisclosed suicide attempts, and two decedents with known suicide attempts. The importance of the suicide note(s) is that they potentially document the final thoughts of the deceased before the suicide, but resulted in differing perspectives by participants. From two sets of joint interviews, two decedents left suicide notes. Charlotte, Connie, Thomas and Victoria found the notes were helpful to understand why the deceased had ended their life. The notes clearly stated the decedent's intention to die, sharing how they had struggled with their illness, how they perceived themselves as a burden on their family and their desire to be at peace. However, Charlotte and Connie's deceased did not have any previous suicide attempts, so the suicide note was detailed, lengthy, personal and thoughtful; clearly stating why he had wanted to end his life.

A different perspective on suicide notes emerged from four interviewed participants who found little comfort from the notes. In these cases, suicide notes were instructions by decedents on their funeral, admissions of undisclosed suicide attempts or sharing personal information to put their affairs in order. There was a level of disappointment from these notes because there was no clarity around understanding why the suicide occurred. Also, the notes did not contain any words that had personal significance for participants or offer any acknowledgement to the family left behind. One participant believed the suicide note reflected the poor mental capacity of the deceased prior to the suicide, because her handwriting was out of character. Only one participant, who did not receive a suicide note, reported she wished her son had left one, because it would have provided evidence for the coroner that the suicide resulted from his poor mental capacity. This would have made it easier for the participant and others to acknowledge the suicide.

5.5.1 The anticipation or unexpectedness of the suicide

Comparatively analysing participants' data revealed three key immediate perceptions of the suicide at the time of the event: 'a sudden suicide', 'an anticipated suicide' and 'an anticipated but unexpected suicide'. These views were affected by the mental health context of the suicide and directly affected "piecing the puzzle" by family members (see Section 5.6.1), consequently the 'impact on life after suicide' (see Section 5.6).

5.5.1.1 An unexpected suicide

Nine participants perceived the suicide as unexpected. Five of these were unaware of the decedent's mental illness or involvement in mental health services, because these facts were concealed from them. However, two participants had limited awareness, but no involvement in mental health services and two participants were fully involved with the deceased's care by mental health services. The four participants who had some awareness of the mental illness and in some cases expressions of suicidal intent and suicide attempt(s) felt the suicide was still unexpected, because the deceased had expressed hope and made plans for the future. Helen who was fully involved in caring for her husband and aware of multiple suicide attempts said, "*I never ever thought he'd do, never even entered my head that he'd ever do it at all.*" A sudden suicide resulted in a stronger grief intensity compared with those who anticipated a suicide, which lead to a greater need for "piecing the puzzle" (see Section 5.6.1).

5.5.1.2 An anticipated but unexpected suicide

Chapter Two highlighted how a suicide could be perceived as sudden or anticipated, however, four participants perceived the suicide as anticipated but unexpected. This resulted in different grief experiences as they oscillated between perceptions of a rational and irrational suicide, thereby causing confusion in making sense of the death. All four participants were fully aware of the deceased's mental illness and involved in their care provided by mental health services. Two decedents had multiple known suicide attempts and one decedent had made no suicide attempts, but had expressed suicidal intent on multiple occasions. The decedents had been diagnosed with severe mental illnesses over a long-time, therefore, these participants had an in-depth experience of witnessing the unpredictability in the deceased's behaviour who fluctuated between their 'normal' self to expressing suicidal intent and attempts. To an extent, these experiences led to an anticipation of the suicide, yet the suddenness of the death caused shock because they did not expect the decedent to die so soon. Moreover, participants hoped

their support and love would have prevented the suicide or the decedents would find a way of living with their mental illness. Jonathan exemplified the conflicting emotions he experienced with his wife by saying, *"she said to me you know I've had enough don't you? I said yes I know, but think of the legacy that you're going to leave, don't do it, don't leave. I never thought she would."*

These mixed perceptions of the suicide to some extent motivated a need for answers, but, for many, to a lesser extent compared with those who did not expect the suicide. However, the unexpectedness of the suicide resulted in intense grief reactions, but also moments of peace and understanding, because of their knowledge of the deceased's mental illness and why they died by suicide (see Section 5.6).

5.5.1.3 An anticipated suicide

Four participants believed the suicide was anticipated. Two participants had full knowledge of the deceased's involvement with mental health services and awareness of multiple suicide attempts. Two participants had some awareness, but limited knowledge of the deceased's involvement in mental health services and one decedent had made undisclosed multiple suicide attempts. Participants anticipated the suicide because the decedents had been intermittently accessing mental health services over a long time, had a severe mental illness, made suicide attempts and expressed suicidal intent. Notably, all four decedents were young males whose lives were chaotic, had a history of drug and alcohol misuse, self-harmed and were non-compliant with medication. A few participants anticipated the suicide based on their understanding of factors increasing the risk of suicide. However, an anticipated suicide resulted in a different grief experience for Gemma because of her estranged relationship with her brother, *"what I've gone through is not something I should be sobbing my eyes out about because I knew he was going to do it anyway and he was doing my head in you know, so therefore I have no right to be upset."* There was still an element of shock for the participants and they had a lesser need or no need for "piecing the puzzle", because they were able to make sense of the suicide.

5.6 Impact on life after suicide

The following sections will examine in detail the key findings addressing the impact of suicide on family members and highlight differences in how they experienced and expressed ways of dealing with the suicide in private and public. Six key elements are discussed: "piecing the puzzle"; 'dealing with the stigma of the suicide and the mental illness'; 'changing perceptions

of the suicide'; 'creating symbolic ties with the deceased'; 'personal ways of coping', and 'dealing with the grief'.

5.6.1 "Piecing the puzzle"

"Piecing the puzzle" (see Section 4.1.2: Table 4.2) is an *in vivo* code that captured an active process of the participants' searching for answers as to why the suicide occurred and to make sense of the event. Arguably, other types of death can motivate a need to find answers, but this was distinct for participants compared with other experiences of death. "Piecing the puzzle" compelled participants to draw on their 'life before the suicide' with the deceased, the 'act of suicide', the deceased's involvement in mental health services and whether the suicide was expected and/or unexpected. Longer bereaved participants had gone through this process and accepted they would never fully know the truth, whereas, participants who were recently bereaved still had a strong need to find answers. Hannah said,

I wanted to know more, trying to piece the bits together what he'd actually said to the doctor That's the thing, it's just the unknown that's so frustrating [...] essentially I never will know and that's the most annoying thing you know, or thinking if I'd have done this if I'd have done that. I suppose to a certain extent, that will be with me for life.

On the other hand, participants who anticipated the suicide had a lesser need to find answers compared to participants who perceived the suicide as sudden.

The participants shared different ways they searched for answers, explanations or clues as to why the deceased died and many undertook their own investigations. Reading and researching the deceased's mental illness was helpful for a minority of participants to find answers, increase their knowledge and gain some understanding of what the deceased experienced. For example, Christine whose son was recently referred into mental health services stated, "*I think having read stuff since then, I think he probably had been psychotic all along but being depressed he was probably starting first symptoms of some sort of psychotic illness.*" I also found this was particularly important for Charlotte, Connie and Peter who were unaware of the decedent's mental illness until after the suicide, or participants whose decedent's mental illness was diagnosed shortly before the suicide. An additional way in which participants found explanations to the suicide was by recalling earlier memories and conversations with the deceased, to find clues of an imminent suicide or if they were indirectly saying goodbye.

Five participants whose decedents died outside the home visited the location of the suicide to find clues as to why that place was chosen or if there were any visible reminders of the deceased. Additionally, they wanted to visualise where the deceased died and pay respects. Hannah shared that,

only about a year ago but I just felt like I wanted to go [...] I thought it might help me make it real, just accept it maybe which I know he's dead but I do sometimes think it can't be true

As stated earlier (see Section 5.5), six of the decedents had left suicide notes, which were important in "piecing the puzzle" and making sense of the death. The notes contained the final words written by the deceased, which may have given an insight into the deceased's thinking prior to the suicide or the suggested reason of the suicide. Thomas shared his opinion of his son's death, *"he mentioned in the note that he was sorry but the last five years had been torture, so it was to relieve his own pain yes."* Four participants, including Peter, found the suicide note unhelpful because, *"well it didn't really answer anything [...] there was no logic."*

A less commonly reported way of finding answers overlooked in suicide bereavement research is the use of mediums or spiritualists to contact the deceased. Five interviewed participants attempted to establish communication with the deceased to find out why the suicide occurred, where the deceased was in the afterlife and if they were at peace. Supporting this view was Iris who disclosed, *"by the spring after he'd died in the August, I was desperate to know that he was alright to be really, really sure and it drove me to go to a medium a spiritualist medium."* Visiting mediums or spiritualists resulted in mixed feelings for participants. Three participants found comfort and reassurance from their reading and felt they had indirectly contacted the deceased. However, two did not feel any comfort as they were sceptical about the afterlife, but had followed others peoples' suggestions of meeting a medium.

Comparatively analysing the data identified differences between participants who were living or not living with the deceased. Participants living with the deceased questioned people in the deceased's social network, searched the deceased's belongings, their home and checked their mobile telephones. Additionally, the decedents' computers were checked for the internet history and found links to websites on methods of suicide as exemplified by Emma, *"I looked and I was shocked, they say exactly what to do, exactly, where, how."* Evidence gathered by the participants helped them make sense of the suicide, or contributed to their 'changing perceptions of the suicide'. A few participants, including Iris, found evidence of the deceased putting their affairs in order, such as taking care of their finances and disposing of their belongings. The search for answers also led participants to investigate whether the suicide

was intentional, planned, rational, a choice, opportunistic or irrational, resulting from poor mental capacity.

Participants not living with the deceased had limited or no access to the deceased's house or belongings. This was especially difficult for two participants, because their daughter was living with her partner who had disposed of most of her belongings without their knowledge. Nonetheless, participants still made some attempt at investigations in "piecing the puzzle" that included speaking to the deceased's significant others, friends and work colleagues.

Another way of finding answers for a few participants was speaking to others who had experienced a suicide of a significant other which motivated them to access SOBS, because their social network could not support them. Moreover, participants wanted to avoid distressing their immediate family members, so attending SOBS was a way of learning about others' suicide experiences, but also to find answers to their questions or explanations. A few participants reported they could have done things differently to prevent the suicide. However, hearing others' experiences helped these participants realise that regardless of what they could have done, they may not have been able to prevent the suicide and this often offered them some comfort.

A few participants spoke with healthcare staff treating the decedent and this most often occurred at the inquest. Notably, a few participants shared their negative experience of requesting the deceased's medical records from a Trust. Clinicians who had treated the deceased argued that patient confidentiality prohibited them from releasing patient records, which was a barrier in "piecing the puzzle" for these participants. However, attending the inquest was beneficial to most participants as the deceased's missed appointments, expressions of suicidal ideation to health professionals and undisclosed suicide attempts were discovered. The concealment of facts by the decedents resulted in more complicated grief and negatively impacted participants' mental health and wellbeing. These feelings also influenced how participants made sense of the suicide, as the concealment of facts confirmed participants' beliefs of their decedents' poor mental capacity. One issue raised by some participants was their concern at finding out these undisclosed facts, because they believed health services or staff should have informed them if there was a possible risk of suicide, therefore health services were accountable for the suicide. This was particularly evident when participants found failings by health services, missed opportunities or ineffective treatment of the deceased. Three participants used the inquest to voice their dissatisfaction at health services or health professionals, especially when they had raised concerns about the deceased's mental health prior to the suicide. When health professionals failed to involve the families or participants in the care of the decedent, (see Section 5.4), participants strongly argued that greater involvement and communication with families was essential.

The doctor's report said it was severe depression and it was dangerous. That's what upset me the most [...] there was no way anybody else was going to find out about it being dangerous, because he wasn't going to tell anybody else and I think with depression, people close to somebody needs to know about it. (Peter)

While attending the inquest, five participants found out that the decedents had recently been receiving treatment for their mental illness prior to the suicide which they had been unaware of. Although participants had noted slight changes in the deceased's personality, they assumed life stressors had caused 'low moods'. At the inquest, they learned the decedent had disclosed their suicidal intent and non-compliance with their medication to health professionals, because they thought it was ineffective when their mental health did not immediately improve. After the inquest, all the participants were satisfied with the knowledge they gained, including Connie who stated, *"it helped to put a line in a way under what happened. It did clear out all the questions"*.

In terms of the many participants who were involved in the care of the deceased and attended the inquest, they were aware of the facts relating to the decedent's treatment by health services. However, some participants gathered unexpected insights into the decedents, for example receiving the details of the post mortem. This was informative to establish whether other factors were influential in the suicide, especially if the deceased had had a chaotic lifestyle and misused alcohol and drugs. Beth, whose son had had a history of alcohol and drugs misuse, found the post-mortem results revealed no evidence of these substances, which led her to believe that the suicide was a rational act. Victoria also discovered the post-mortem was informative to determine whether the deceased's multiple suicide attempts by using alcohol and drugs had damaged his body. When no evidence was found of any internal damage, Victoria felt relieved. Nonetheless, not all the participants found the post-mortem helpful and for a number of participants, hearing about the suicide was too distressing. Receiving a detailed account of how the person died and listening to graphic details about the damage caused to the body was disturbing. Peter, in particular, found the post-mortem was a physical violation and mutilation of his wife (see Section 5.6.4).

A significant finding in "piecing the puzzle" was the importance of undisclosed suicide attempts compared with participants who had known of suicide attempts. Six participants found out about undisclosed suicide attempts at the inquest and this raised mixed feelings. Suicide attempts were mainly by hanging, medication overdose or attempted drowning. Hearing about the undisclosed attempts, Iris, Peter and Emma experienced further confusion, distress and ambiguity in making sense of the suicide. Constant comparison of the data identified that two of these participants lived with decedents and one participant did not. Again, this

concealment of facts contributed to participant's distress and although they had observed changes in the deceased's personality, they had not noticed anything unusual that would have alerted them to the suicide attempts.

In making sense of the suicide, participants felt undisclosed suicide attempts by the decedents were to avoid distressing their families, but were also perceived as serious intentions to die, therefore the suicide was unavoidable.

I found out that he'd tried four other times to do it and failed. Didn't know that, so I thought to myself well no matter what I'd have done or what his kids would've done, he'd have done it at some point. (Beth)

Iris and Charlotte, who both lived with the decedents, found out that the undisclosed suicide attempt was the same as the actual method of suicide and at the same location outside the home. However, Peter lived with his wife, but found out she had made repeated suicide attempts using different methods, both inside and outside the home. Beth, who did not live with her son, discovered he had made multiple attempts using different methods outside the home. For these participants, finding out about undisclosed suicide attempts resulted in 'changing perceptions of the suicide' (see Section 5.6.3).

At the focus group (see Chapter Three: Section 3.5.3), I shared my tentative findings on perceptions of suicide attempts from the interviews as rational acts. While "piecing the puzzle" (see Section 5.6.1), a minority of participants shared that they had obtained evidence of planning in suicide attempts. Participants reported searching the deceased's internet history with links to websites on methods of suicide, finding suicide notes, disclosure of suicide intent prior to the attempt and proof of multiple suicide attempts. However, many focus group participants strongly disagreed that suicide attempts were rational or planned, as suggested by Rebecca:

Because they've done it once or attempted to do it once or twice or three times it's a series of planned actions, a planned action and actually I don't think any of them are related, other than the fact that the person's mental capacity is very fragile. I don't think there's any other link and that when this very fragile mental capacity is over balanced, then that action happens again, but I cannot see that as a series of planned or planning, it's too rationale, too normal, too objective, it doesn't fit with what happened to our families. (Rebecca)

These perceptions captured the view that suicide attempts were irrational, resulting from poor mental capacity caused by the mental illness. Notably, these participants firmly believed that

the suicide was also an irrational act, regardless of the planning undertaken by the decedent (see Section 5.6.3).

Considering the decedents were in contact with mental health services 12 months prior to their death, the NHS Trust treating the patient conducted their own serious investigation. Seven participants mentioned their experience with the NHS and three participants felt satisfied because of the support and information they received by the lead investigators throughout the investigation process. However, four participants were critical of the investigation staff or the process of investigation. Staff conducting the investigation were criticised for not fully engaging with participants to keep them informed of the process or participants were not given answers to their questions. Additionally, participants did not feel that the NHS accepted accountability in failing to prevent the suicide by not implementing effective support when families raised concerns or after multiple suicide attempts. Another two participants disclosed that due to an oversight by the PST, they received a request to meet with a lead investigator one year after the suicide.

5.6.2 'Dealing with the stigma of the suicide and mental illness'

The stigma of suicide emerged strongly in the findings and impacted participants when they encountered negative attitudes from others regarding the deceased, the mental illness or the suicide. Stigma was originally conceptualised in Diagram 4.3 in the broader concept of the 'changing nature of relationships with others' (see Section 4.1.4, Table 4.4). To draw attention to these findings, they are now reconceptualised in 'dealing with the stigma of the suicide and the mental illness'.

5.6.2.1 *The private self*

This perceived stigma of the suicide certainly caused a great deal of distress in participants. Cath and Harry described their need to avoid the stigma of the suicide from others by isolating themselves.

*Do you know when we lost daughter we didn't go out for 10 weeks. We were all sat here and I says I says look I says we're going to have to go out, I says we can't carry on like this, we're just getting further and further down.
(Cath)*

Subsequently, some participants chose different identities, for example, participants who were husband or wife to the deceased became 'widow' or 'widower'. These labels were socially

accepted to denote the death of a partner, rather than alerting others to the loss of a significant other by suicide.

During data collection, I asked participants if they wished to define themselves after the suicide or not. Many participants were indifferent to being labelled as someone who lost someone to suicide, but some participants strongly felt that being labelled was unnecessary, public and open to stigma by others. On the other hand, a few participants preferred terms such as, 'suicide survivor', 'bereaved by suicide' or 'survivors of bereavement', because they captured their individual, but also collective identity (see Section 5.6.5.1: 'Personal Ways of Coping'). Reclaiming their own self-identity was empowering in regaining the sense of control which participants had lost after the suicide. Taking ownership of being a 'survivor' was a public admission and appreciation of their new self-identity, as shared by Victoria, "*that's why it's a good title to say 'survivors' because we are 'survivors of bereavement' not 'victims' as such*". Participants recounted societal perceptions of the bereaved as 'victims', which was disempowering, thus 'survivor' in the context of participants in this study, is empowering.

5.6.2.2 The public self

Although the majority of participants believed suicide was a selfless act, they encountered negative attitudes towards the suicide by others. The lack of awareness of suicide and the stigma as a result, emerged from participants' relationships with others, including the wider community and society. Charlotte stated, "*I also felt I lost my identity, it's a small town that I've become that girl whose boyfriend committed suicide*". This insight revealed how many participants were labelled with unwanted and undesirable identities that altered their sense of 'self'. To an extent, these identities reflected negative societal attitudes to suicide and perceived stigma for participants (see Section 5.6.2). Others stigmatised the suicide as a selfish act and these types of comments had negative ramifications for participants, resulting in anger, self-isolation and anxiety. Participants felt a need to defend the decedents from criticisms and challenged these misconceptions of suicide by increasing people's awareness of the complexity of suicide.

Most participants believed the negative societal attitudes of suicide and mental illness were driven by mainstream media. Inaccurate and sensationalised reporting of suicide often emerged from the intrusiveness of reporters at inquests. Reporters often disclosed intimate details of the deceased, their mental illness, and engagement with health services in the local media and in a few cases, nationwide. The sensationalised reporting of the suicide added to

the trauma of the suicide for some participants, resulting in reverberations in participants' communities, as highlighted by Iris.

At the inquest there were only five people [...] and there might have been 15,000 there, because we had headlines an inch tall and it just didn't look like there wasn't anything going for our son. And my husband I don't think hasn't forgiven me from that day to this day for that.

Many participants encountered the breaking of relationships with people who they expected support from post-suicide. Participants described the avoidance by others who felt uncomfortable talking about the suicide. However, many participants avoided others to minimise any distress to others, but also to protect themselves from answering difficult questions about the deceased and the suicide.

5.6.3 'Changing perceptions of the suicide'

The suicide reflected the immediate reactions by participants of an anticipated, unexpected and an anticipated but unexpected suicide (see Section 5.5.1). Participants' views dynamically fluctuated as they tried to make sense of the suicide. These findings were originally integrated into the broad concept of 'meaning and purpose' of the suicide (See Section 4.1.2, Table 4.3) in Diagram 4.3. However, to emphasise these insights in Diagram 5.1, I re-conceptualised 'changing perceptions of the suicide', which captures how participant reflected back on their 'life before the suicide' (see Section 5.4) and knowledge gained from "piecing the puzzle" (see Section 5.6.1).

5.6.3.1 The private self

The findings captured participants' diverse changing perceptions of the suicide as; selfless, selfish, rational, irrational, and a choice, because of the poor mental capacity of the deceased.

From the data, I interpreted an altruistic notion of suicide as a selfless act, which for most participants, was a way of taking a positive value from the tragedy of the suicide. Hannah echoed the view of many participants by saying, "*it was just like another knock, another knock and he probably thought I'm going to alleviate everybody's burden and he probably thought he was doing me a favour by not being here.*" This was an interesting insight, because Hannah was unaware of her father's mental illness or engagement with health services until the inquest. Many participants tried to empathise with the deceased's struggle of living with

their mental illness, including those who found out about the decedent's engagement with mental health services and undisclosed suicide attempts after the suicide. Nonetheless, finding out about the concealment of facts regarding the mental health context of the deceased contributed to their 'changing perceptions of the suicide' as they expressed feelings of confusion in making sense of the suicide. Critically, as stated before, there were feelings of blame towards health services for failing to provide better support to the deceased, actively involve families in the deceased's care or to communicate with families regarding the patient's risk of suicide, which may have prevented the suicide.

Some participants who were fully involved in the deceased's care, heard them express their feelings of being a burden, which became a source of anxiety and worry for their families. This emerged strongly in participants whose deceased had experienced a severe mental illness over a longer period. Again, the belief of a selfless suicide emerged, because these participants considered the mental illness as an invisible, chronic illness that required a lifetime of medication. In addition, the decedent's attempts at treating or coping with the mental illness had been unsuccessful, leaving little recourse to improve their mental health. The deterioration in the deceased's mental health made life difficult, causing periods of poor mental capacity and poor quality of life. Therefore, participants believed that the deceased could find no other option, but to end their life and release their pain of living with a mental illness.

Yeh, what could have they have done? But if he'd have stayed in hospital and he'd got medication, but you know thing is it's his life and his choice and did he want to spend a life on medication having ups and down and going through this? It was pretty rubbish for him weren't it really? (Charlotte)

A few suicide notes also clearly stated a sense of burden by the deceased and intention to end their life, so they and their families could be at peace. This was comforting and brought some ease to participants in finding meaning and purpose from the suicide.

The contentious debate of suicide as a choice, a rational act or mitigated by poor mental capacity was deliberated upon in Chapter Two (see Section 2.2.3.1) and discussed by participants who fluctuated between differing perspectives. Jonathan defined suicide as a "conscious decision to end their life", which reflected choice and a rational act, regardless of the mental health context. A suicide was an individual's autonomous decision and six participants described it as a choice. Shaping their beliefs was the factual evidence of the deceased's mental illness, engagement with mental health services, expressions of suicidal intent, suicide attempt(s) and evidence of planning the suicide. However, the deceased's

mental capacity added to competing tensions of a rational or irrational suicide in many participants, exemplified by Hannah:

On one hand, I've got to believe because when somebody's in that mind-set that you're not thinking sanely so he wasn't thinking, or it was either selfish or very brave isn't it? It must be brave to do that because I can't imagine being doing that, but it's also well yeh it's selfish, because in theory he knew that I had to sort it out. But then on one hand you could say that he was thinking about everybody else. He thought that he was burden to people, which I'm not saying he did think that, but if he did think that he was burden, then he was doing me a favour. So I'll never know that's the thing.

At the focus group (see Chapter Four: Section 4.1.5), I shared the word 'choice' in the context of a suicide by someone in receipt of mental health services, which raised a great deal of debate. From the focus group participants' perspectives, the suicide was an irrational act, because of the deceased's poor mental capacity. Therefore, suicide was not a choice, because choice alluded to a rational act. Upon reflection, I revisited the data and I conceptualised irrational suicide as an act by an individual whose mental illness had diminished their mental reasoning and reached their 'tipping point', thus the suicide was not a choice or an informed decision. I also re-conceptualised rational suicide as an individual's decision to end life, because they believed the mental illness prevented them from living life the way they wanted and they perceived that they had little or no hope of their quality of life improving.

A selfish suicide was reported by a minority of participants who considered the death as rational and a choice, without regard to the consequences on those left behind. Hannah alluded to a selfish suicide, but two other participants, including Emma felt, "*I thought she'd abandoned people around her, quite selfishly if I'm honest, because she was going to be out, she was going to be at peace and they were going to go through hell*". Notably, prior to the suicide, the three participants' relationships with the decedents had, at times, been challenging and estranged. Consequently, from their experiences, it was difficult to find a purpose for the suicide because participants believed the suicide was deliberate, premature, uncaring, calculated, violent and inconsiderate. As a result, a selfish suicide evoked complex feelings of blame towards the deceased, because they had abandoned their significant others, resulting in immense anger, frustration and resentment. Nonetheless, regardless of their estranged relationship, these participants also felt sympathy and sadness for the loss of the deceased, because of the mental illness.

A noteworthy finding recognised how for seven participants, multiple known suicide attempts influenced their 'changing perceptions of the suicide'. Participants compared the method of suicide attempts with the suicide to establish if the suicide was intentional or a 'cry for help'.

Most participants perceived suicide attempts resulted from poor mental capacity and were opportunistic rather than a serious intent to die. In a few cases, multiple suicide attempts followed a similar pattern, such as using the same method and location. On the other hand, the actual suicide used a different method and location, which demonstrated the deceased's serious intention to die and was more likely to be fatal.

5.6.3.2 *The public self*

Most participants were engaged in 'changing perceptions of the suicide' with others, which motivated many participants to challenge the misconceptions of the suicide and mental illness. Some family members publicly shared their experiences of suicide, the mental illness and engagement with mental health services to raise awareness. One strong motivation for the respondents to participate in this study was for health services to learn from their stories and act on their concerns. As stated many times before, the concealment of facts by the deceased and non-disclosure by health professionals contributed to participants experiencing grief reactions of greater intensity and which were more complicated. However, participants who had some or full involvement and awareness of the mental health context were able to make sense of the suicide, understand why the death occurred and accommodate the suicide better. Therefore, participants suggested that health services should actively involve or develop ways of effectively sharing information with family members so they had a greater insight regarding the patient's care. This approach would enable better support for the patient and their carers/families and potentially prevent suicides in the future.

Multiple references to positive growth were found that are also discussed in 'dealing with grief' (see Section 5.6.6). Participants who regularly attended SOBS over a number of years supported other suicide survivors at the meetings, especially those recently bereaved. A few participants were now advocates for suicide survivors and actively engaged in suicide prevention work. For example, two participants set up a suicide awareness charity in the deceased's name to prevent other families experiencing a suicide of a young person. Moreover, many participants expressed their motivation to take part in this study to help other suicide survivors and disseminate findings to mental health services to improve service provision.

5.6.4 'Creating symbolic ties with the deceased'

The suicide was the physical breaking of a relationship between the decedent and participant, but now a new relationship emerged. Researchers in grief and bereavement identify the role of continuing bonds with the deceased (Gillies & Neimeyer, 2006) and this was strongly evident in the study. For the majority of participants, the deceased is still an important part of their lives, although to a lesser extent for the three participants who had an estranged relationship with the deceased. Analysing the data uncovered ways in which participants used rituals, objects, people and places to maintain a relationship with the deceased both individually and collectively (see Section 4.1.1: Figure 4.1). To develop theoretical sensitivity, I elevated the multifaceted properties of these unique insights to a more abstract level in 'creating symbolic ties with the deceased'. The type of relationship between the family member and the deceased prior to the suicide certainly affected their relationship with the deceased following the event.

5.6.4.1 The private self

Participants expressed solitary and personal ways of remembering the deceased in order to maintain a bond, cope, and deal with the suicide. Participants gave symbolic attachment to the deceased via objects, people, places and rituals that held sentimental value to reminisce and evoke memories. Examples of objects included the decedents' belongings and photographs that were irreplaceable. Thus, disposing of the belongings of the deceased was to a degree, symbolically breaking a connection with the deceased and often distressing. Suicide notes were important to some participants, because they contained the decedent's thoughts before the suicide.

Four participants, Iris, Thomas, Victoria, Harry and Cath had living symbolic ties with the deceased through planting flowers or trees and these were visible markers of their bond. The process of cultivating and nurturing plants was ritualistic as it offered participants time for reflection, to remember the deceased, gain comfort from seeing plants grow and communicate with the person who died. In a joint interview, Thomas and Victoria shared an example of the importance of a living object:

A lady from the church she came in, brought a plant and we keep that plant and that's 11 years ago and we would not dream of losing that. (Thomas)

It symbolises Adrian really. (Victoria)

The deceased's favourite music and their scents were symbolic ties, for example, one participant shared wearing the decedent's clothes because she could smell his scent which

intensified her bond. Two participants kept the deceased's belongings as they had been left. While participants described symbolic ties with the deceased as comforting, a minority felt discomfort. Symbolic ties were reminders of a participant's loss, therefore objects were removed from sight, but kept safe until participants were ready to use them (see Section 5.6.6: 'Dealing with grief'). In some cases, the estranged relationship with the deceased had led to anger; so symbolic ties with the deceased were hidden or disposed of. Gemma reported avoiding places she had visited with her brother, because she did not want any reminders.

The analysis uncovered the diversity of rituals that were therapeutic for many participants to cope with the suicide and to keep a bond with the deceased (see Section 5.6.5). Rituals were personal, private, shared and in many instances newly created, as exemplified by Peter who spoke about the place where his wife had died at home:

I mean I think even now it's still in a strange way affecting me, there's a little area in the house I will walk round, I will not go through, I'll walk round it, or if I go up the steps I will not touch the bannister in a certain place.

Regardless of the nature of the relationship participants had with the deceased, they focused on the positive attributes of the person who died by drawing on happier memories. Most participants developed an idolised version of the deceased, which captured a notable change in their relationship. This was strongly evident in participants who were longer bereaved, but different for those recently bereaved, as reflected by Christine whose son died three months ago, "I remember him now as quite ill, but I know from sort of previous bereavements that in time it'll get replaced with sort of better memories."

Although three participants had a challenging relationship with the deceased, they experienced mixed feelings of remembering them. They perceived the suicide as selfish, but there was still an element of guilt, because they were not remembering the deceased in a positive way, as they had with others who had died. There was also a moral obligation and responsibility for some participants to honour the memory of the deceased, or how they thought the deceased wanted to be remembered. However, the emotional toll in maintaining an intense relationship with the deceased was a source of immense distress for two participants. One participant described how the decedent was still in control of his life and that he felt guilty if he tried to 'move on'.

As found with other types of deaths, the participant's relationship with the 'body', including the ashes was important, because it reflected the person who died. Therefore, participants took care in how the deceased was dressed, buried, cremated and laid to rest. As highlighted earlier, the post-mortem raised a considerable amount of distress for one participant, because

it was a physical violation and mutilation of the deceased by a stranger. Two participants further reported immense relief when reunited with the deceased at the Chapel of Rest and spending time with the body offered participants a chance to talk to the deceased, touch the body and say goodbye. Helen, whose husband survived his suicide attempt, reported she had an opportunity to spend time with her husband in hospital before she made the agonising decision to switch off his life support when she was ready to say goodbye.

A different experience with the body emerged for Peter whose wife had always expressed her desire for a burial alongside her husband, but in her suicide note had stated she wanted a cremation. This caused intense distress for Peter to resolve how to lay his wife to rest and he decided on a burial. Shortly before her death, Peter's wife was receiving treatment from health services, so he strongly believed his wife's suicide and her request for a cremation reflected poor mental capacity at the time. However, Hannah, Christine and Gemma did not find any attachment to the body and did not view it, because the body was only an empty vessel and did not reflect the person who died.

Many participants shared how they kept the ashes for many years before finally laying them to rest when they accepted the reality of the death. Scattering the ashes was breaking the physical bond with the deceased. Notably, four participants, Charlotte, Harry, Cath and Helen, still keep some of the ashes to maintain a physical bond with the deceased, which was a source of comfort.

5.6.4.2 The public self

'Creating a symbolic tie with the deceased' for many participants included being involved in collective activities with others to keep their memory alive. This was especially important for participants who had younger children, because the deceased was part of their legacy as explained by Violet,

He's still my children's father, we can't contact him, we can't touch him, we can't hear him, but he's still part of the family because he lives on in them, so to not talk about him is almost denying him.

Commonly reported shared rituals were often influenced by religious or secular beliefs that included the funeral and laying the deceased to rest. Regular collective rituals included marking the deceased's birthday, the death anniversary and remembering them on special occasions. Charlotte and Connie mentioned that every Christmas, they set a place for the deceased at the dinner table. People as symbolic ties with the deceased became evident with

participants who had children or grandchildren. People were a biological link with the deceased and a strong reminder for participants if they identified similarities in physical or personality characteristics of the deceased.

As discussed earlier in “piecing the puzzle” (see Section 5.6.1), five participants visited spiritualists or mediums to make contact with the deceased, resulting in mixed feelings. Beth and Hannah only made one visit to a medium on others’ recommendations, but they had no spiritual beliefs or belief in life after death. Nonetheless, they still visited mediums as they thought they would find insights about the deceased, or they had unanswered questions. Beth attended a group reading and did not receive a personal reading from the medium, therefore, remained unconvinced of life after death. Although Hannah was at first sceptical about life after death, she attended an individual reading with a medium and heard details about the deceased unknown to others, which added more confusion. Nonetheless, these two participants found the ambiguity of the reading did not meet their expectations and offered little evidence to convince them that there was an afterlife.

Iris, Harry and Cath were in regular contact with one or multiple mediums and had strong spiritual beliefs in life after death. Harry and Cath had a strong need to contact the deceased in “piecing the puzzle” and making sense of the suicide. All three participants wanted to make contact with the deceased to seek reassurance that they were at peace or to find comfort that they would be reunited in the afterlife. To an extent, four participants heard confirmation from the medium/spiritualist that the deceased was at peace. Two participants also received affirmation that life was too difficult for the deceased, which resulted in the suicide. Interestingly, three participants found the medium/spiritualist made references to events in the participants’ lives that were private and undisclosed to others. Therefore, this provided validation that the medium/spiritualist was authentic. Notably, three participants disclosed feeling the spiritual presence of the deceased, seeing an apparition and encountering inexplicable events. Consequently, participants found reassurance that the deceased was still a part of their life.

A unique finding was the difficulty of sharing the ‘body’ with significant others. Beth described her ordeal with her son’s extended family over the ownership of his ashes and choosing his final resting place. After a year of keeping her son’s ashes, Beth decided to scatter the ashes but was faced with animosity from his family, resulting in the breaking of relationships.

5.6.5 ‘Personal ways of coping’

This concept developed from ‘changing nature of relationships with the self’ (see Section 4.1.1, Table 4.1). However, reconceptualising ‘personal ways of coping’, captures the ways in

which family members developed individual coping strategies. Often, private coping styles were not shown to others, because they were socially unacceptable or participants would be perceived as not coping. Many participants also disclosed their preference for solitary coping strategies to have time to themselves away from others. On the other hand, some coping styles adhered to societal assumptions of 'normal' coping and consequently were expressed in a more public way. Certainly, coping with a suicide had been or still was a painful process for many participants, so these findings contribute to addressing one objective of the study; to identify their needs after the suicide. Critically, none of the participants received any information on support organisations from health professionals.

5.6.5.1 The private self

Participants expressed an overwhelming desire to become their 'normal' self as it was before they experienced the suicide, which motivated them to find different ways of coping. Some participants echoed Harry who stated, "*we just deal with it ourselves*", which shows that participants started to develop their own coping strategies. Participants preferred time alone away from others to do activities they enjoyed doing that were relaxing and comforting, such as walking, reading and gardening. A few participants searched for information on suicide, the deceased's mental illness or resources on grief and bereavement. Reading biographical accounts of suicide survivors or individuals who attempted suicide was also beneficial.

The majority of participants also used coping methods developed from previous experiences of deaths. Participants had lost parents, siblings and grandparents to natural death, poor health or terminal illness. Christine believed that losing her husband to a terminal illness a few years prior to her son's suicide, prepared her to use the same coping strategies to deal with her son's suicide. She kept herself busy and removed many photographs or mementos of her husband and son, because they reminded her of her loss. Personalised ways of coping also incorporated 'creating symbolic ties with the deceased', as discussed earlier (see Section 5.6.4).

Four participants found their religion, Christianity, helped them cope with the suicide and offered a great deal of comfort. Religious beliefs influenced participants in how they maintained a relationship with the deceased, especially because they believed they would be reunited in the afterlife. Thomas shared how his son contacted him one month before he died to ask about his father's religious beliefs. Thomas perceived this conversation as his son's intention to prepare for the suicide and believed he would be at peace in the afterlife. Victoria found comfort knowing, "*God was holding him in that journey from human death to eternal*

life." Moreover, having strong religious beliefs enabled participants to believe that the suicide was God's will. While suicide is not considered a mortal sin in the majority of sects in Christianity, there was still some distress to participants who questioned whether the deceased was at peace or if they would be reunited in the afterlife. Iris revealed,

I struggled for a long time about what God had to say for someone who took their own life. I have come to an acceptance now that he's ok and that he was ill and when you are ill, it's a different issue to when you're in your right mind so to speak

Although the aforementioned individual coping mechanisms were described as effective, other strategies were negative. To a degree, coping also involved blocking out memories of the suicide, or using avoidance and distraction. A few participants channelled their anger and blame towards others; such as health services, health professionals or the deceased. Another finding captured a few participants disregard for their own personal welfare and safety, because the suicide had taken away the decedent and their pleasure in life. This resulted in some participants adopting risky behaviours, such as misusing alcohol or over-working to cope with the suicide. I interpreted distraction as a way of coping to over-ride their grief and avoid thinking about the suicide. Although none of the participants in the study disclosed self-harm, suicidal intention or suicide attempts, the trauma of the suicide for three participants evoked suicidal thoughts in the immediate aftermath of the suicide.

Many participants reported they still had unresolved feelings and recognised a need to find professional support once they were ready. It was argued by participants that health professionals with a lived experience of the suicide, or those who were appropriately trained in supporting suicide survivors would be effective. However, a small number of participants could not identify what type of postvention they required, but reported the need to talk and be listened to, as suggested by Charlotte,

I think I need some sort of therapy. I don't know, talking therapy I don't know, maybe just to get it out. I'm panicking that I'm stuck with this forever and I'm always going to feel like this and I want help to get it out

5.6.5.2 The public self

Referring to symbolic interactionism theory (see Chapter Three: Section 3.1.2), an individual's interaction with others influences how people make sense of their world. The participant's engagement with others was an important part of their coping, which included receiving

support from their social networks, SOBS and postvention. While participants had effectively coped with their grief from other deaths, the complexity and intensity of the suicide bereavement strongly motivated many participants to find different ways of coping. This was essential to resolve feelings of guilt, shame, blame, anger, frustration and a sense of failure to prevent the suicide. Notably, over half the participants accessed postvention by health services after the suicide, whereas this was not the case with any other types of death. At the point of data collection, a minority of participants still accessed counselling, cognitive behaviour therapy and five participants were taking prescribed medication to cope with the suicide. However, exploring participant's use of postvention uncovered insights regarding what was considered effective or ineffective in addressing their needs.

Eleven participants utilised counselling to varying degrees of success. Six participants found counselling ineffective, because it was a short-term intervention, lasting between six to 10 sessions. Two participants, found the counsellor focused on their childhood rather than exploring the impact of the suicide. Critically, counselling was needed immediately after the suicide, however, in many cases, participants had to wait a long time for referral into NHS counselling services. Only two participants received immediate access to counselling, because they accessed non-NHS services or paid for it.

The findings uncovered important insights as to why four participants did not fully complete the counselling sessions. They felt their needs and expectations of counselling were unmet, or that they had a poor relationship with the counsellor.

I thought she might have known something about this illness, which clearly she didn't you know. I could have talked or she could have interacted with me but did she do it? No! [...] Waste of time, it was more upsetting actually than anything. (Cath)

To meet the needs of participants, I explored why only five participants found counselling helpful. It was suggested that as a counsellor was an 'outsider', objective and neutral, they provided a safe place for the participants. Participants felt listened to and able to disclose their innermost thoughts without the fear of being judged or distressing others. Moreover, they found it helpful to talk through the complexity of the suicide by sharing their thoughts, worries and anxieties. This was beneficial, especially when the counsellor reassured participants that their experience was 'normal', because there was an assumption that a counsellor was an 'expert'. Receiving professional support helped these participants to cope and deal with their grief. These experiences of counselling highlight the importance of meeting the expectations and needs of suicide survivors in order for effective postvention.

Drawing on social support was a commonly reported coping strategy for participants and beneficial, since the ramifications of the suicide extended to others affected by it. The suicide of a family member altered the dynamics of relationships in the family unit for participants as they reconstructed their social world. Most participants strengthened the bond within their family unit and also valued and appreciated each other because of the shared loss. Thomas talked about his changed relationship with his surviving child after his son's suicide:

I think in fact we have a deeper relationship really because of Adrian leaving us too early and I think that we have a shared understanding of that situation and more. [...] Things are said that have a significance that other people outside the family won't recognise, but we do have a shared deeper understanding of what each other has been through.

Peter's relationship with his mother-in-law became closer after the suicide, due to a mutual commitment to maintaining a bond with the deceased. The advantage of joint interviews became apparent when interviewed participants shared how the dynamics of their relationships changed after the suicide. Connie often experienced anxiety and concern about her daughter Charlotte's grief, which at times led to a difficult relationship. However, supporting each other eventually strengthened their relationship. The suicide of partners altered the family unit and dynamics, for Jonathan and Helen, because they took on the role of both 'mother' and 'father' to their remaining children.

The suicide also intensified the closeness of participant's relationships with friends and work colleagues. They provided support to participants by spending time together, socialising and helping participants find support services. Some participants spoke about their need to return to work and 'get back to normality'. Funeral directors were also a source of support for three participants who developed a positive relationship with them. Participants showed different aspects of themselves in public, depending on the closeness of their relationships with others. Many participants corroborated Charlotte's view of 'masking her grief' to show she was coping in public and as she found in her experience, not everyone's experiences of seeking support from others was positive. Charlotte said,

I did feel like people were watching me in a way and seeing how I was reacting and things like that and I think that I felt a bit trapped, a bit caged in. I felt a bit suffocated by everybody, all my friends, but I felt sometimes a bit suffocated, they were texting me every day, all day just to make sure I'm okay, which was lovely and most of the time I got it as that, but sometimes I just felt like wow!

As previously stated, many participants preferred not to share their feelings with wider family and social networks to prevent any distress or avoid the perceived stigma of the suicide. Therefore, three participants accessed general bereavement support groups that were helpful but did not meet their needs, because the suicide was distinctive compared with other deaths. Thus, an important finding is the need for suicide survivors to meet others who have had a similar lived experience. Since the participants were not provided with information on support organisations, the majority of participants found SOBS from their own searches on the internet, but also via a GP, friends and a funeral director. Most attended SOBS immediately after the suicide, although a few participants took longer when they recognised a need for peer support. Elizabeth shared her reasons for attending SOBS,

it was actually meeting with other people who'd had a similar bereavement. This was what was important to me because I lost my son in the August and the following spring I desperately needed to speak to somebody who'd had such a bereavement, because I knew nobody in my family, my social circle, my work circle, my acquaintances, my casual acquaintances. It's just a complex bereavement that I felt I just needed to discuss all sorts of things with other people and see how they coped and that kind of thing, so I was really glad that I'd eventually found the group

As verified by empirical studies (Pietilä, 2002; Toller, 2011), a positive outcome of peer support was being able to reveal their inner feelings that, outside the group, would challenge the accepted norms of grief and coping. Approximately a third of the participants regularly attended the group and the others visited the group on an irregular basis. Fundamentally, a peer group was more beneficial than one-to-one support, such as counselling, for a number of reasons: because participants had a collective identity; formed new relationships with other members; raised their awareness of understanding the suicide and mental illness; heard others' stories; interacted with others and they found inspirational role models which raised feelings of hope from seeing how longer term bereaved members adapted to their loss. Furthermore, a minority of participants described how hearing others' traumatic suicide experiences put their own experiences into perspective.

Exploring why participants accessed SOBS on an ad hoc basis highlighted different insights. Witnessing the distress of others was difficult for a few participants when dealing with their own loss. Some participants found their own social support beneficial, so did not feel the need to continue to access SOBS. Two participants found the group members were mostly parents who had lost children, whereas they had a different kinship relationship with the deceased and had a strong need to meet others with a similar kinship relationship. The practicalities of visiting the group because of other commitments and the geographical distance was also cited as problematic.

Elizabeth and Violet, both SOBS telephone helpline workers, described the logistical and practical difficulties of accessing groups, the unavailability of a local group and the challenges of disclosing personal experiences in a group with strangers. Nonetheless, the helpline service is practical, anonymous, and enables suicide survivors to immediately access a helpline worker at times of crises. This was important to those recently bereaved who required immediate information or support. Another finding was in relation to suicide survivors' disengagement with health services. Violet cited that from her experiences, health professionals were not appropriately trained for supporting suicide survivors, which was corroborated by some participants who had previously accessed postvention. Moreover, GPs had a tendency to prescribe medication to treat suicide survivors, rather than allowing patients to talk and feel listened to.

5.6.6 'Dealing with grief'

The findings clearly evidenced that understanding the context of the family member's life pre-suicide, provided an in-depth knowledge of what they considered 'normal' grief. The data identified commonalities and differences in participant's grief experiences following a suicide compared with other types of death (See Section 4.1.1, Table 4.1). Re-conceptualising Diagram 5.1, I emphasise the multifaceted ways used by participants in 'dealing with grief' through the private and public self.

5.6.6.1 *The private self*

The participants concealed some aspects of how they dealt with the suicide from others, including their closest family and friends, to minimise distress and personalise grief to help with participant's coping (see Section 5.6.5). Additionally, grief expressions were hidden from others because they could be misconstrued as not 'normal' by others. As with other types of deaths, the suicide elicited common emotional and psychological grief reactions in participants. Grief symptoms included crying, despair, hopelessness, loneliness, self-isolation, sadness, distress, poor sleeping patterns and loss of appetite. A few participants used self-help resources based on traditional stage-based grief theories that shaped how they and others were expected to grieve, regardless of the type of death.

As found with other types of death, a participant's kinship and closeness of their relationship with the deceased strongly impacted their grief. There were normative assumptions of the order of death and those deaths that challenged these norms were difficult. Participants whose

decedents were young, perceived their life was wasted or had ended prematurely before they had had a chance to live a full life. Iris stated, *"it's not the normal thing to bury your children"*. Understandably, losing a child to any type of death could result in a similar experience as found with Beth whose baby died to 'cot death' over 20 years ago. At the time, she was unable to fulfil her wishes to hold her baby, spend time together, take responsibility for the funeral arrangements and say goodbye. In comparison, Beth recalled a different grief experience with her mother who died from a terminal illness, as this death was anticipated. Beth spent time with her mother discussing her death, making funeral arrangements in order to fulfil her wishes. This process helped Beth grieve and cope with her mother's loss by saying goodbye, finding closure and knowing her mother was at peace. Drawing on empirical literature, this type of death is considered a "good death" (Cottrell & Duggleby, 2015, p.687), because the dying person makes decisions about their care, quality of life and death.

Participants whose partners died, expected them to live for many more years and share life experiences, but all the participants felt a sense of loss of future hopes, dreams and aspirations. Although Hannah's father died in older age, she still thought he would live for a longer time and die a natural death, but she felt *"a lot of anger, because I'm an only child"*. Hannah felt a sense of abandonment and a failure by her father to protect her from the trauma of dealing with his suicide. A different perspective was given by Gemma who had accepted her brother's death, but acknowledged that losing a son was different for her parents, *"I could deal with it, but my mum and dad, it was their son and you can't just walk away."* Christine felt her grief for her husband's death and son's suicide were similar, but *"what obviously is different is losing a son to losing a husband."*

Analysing the kinship of non-biological participants and the deceased identified significant differences in their grief experiences. Victoria talked about losing her stepson to suicide, *"the grief for me was losing a family member rather than a son, so it was different, but personal."* Connie and Emma were not biologically related to the deceased and also felt they did not have the right to grieve. I also noted that these two participants did not have a close bond with the deceased, which may have influenced this perception.

Although the suicide resulted in similar grief reactions from other types of death, there were also differences. Nearly all of the participants reported that the suicide was incomparable with other types of death and experienced varying degrees of intensity in their grief, more so in those recently bereaved. They believed that the suicide was an avoidable death and the majority of participants felt strong feelings of guilt by failing to prevent it. A few participants felt guilty for being alive and continuing with their life. Furthermore, participants expressed feelings of abandonment, shame, frustration, anger, low confidence, helplessness, and hopelessness. Self-blame for failing to prevent the suicide emerged for participants, but also

blaming the mental illness, the decedent, and/or mental health services. Again, as highlighted numerous times in this chapter, participants experienced more complicated grief reactions if the deceased had concealed facts regarding their mental illness and treatment, and/or health services had failed to involve or communicate with families about the deceased's care or a possible risk of suicide. Participants expressed anger, confusion and experienced greater difficulties in making sense of the suicide and finding effective ways of coping with the death. Notably, two biologically related participants, and one non-biologically related, had an estranged relationship with the deceased and had not cried. This led to difficulties in expressing their grief, resulting in feelings of guilt. Gemma stated,

what I've gone through is not something I should be sobbing my eyes out about, because I knew he was going to do it anyway and he was doing my head in you know, so therefore, I have no right to be upset in any way

Over time, the grief symptoms became less intense, as shared by Violet whose husband died 19 years ago, "grief to me has resonances of extreme and raw, this is just an ongoing sense of loss which occasionally becomes stronger and bites a bit."

The majority of participants reported that the suicide detrimentally affected their mental and physical wellbeing and some participants shared their diagnoses of depression and anxiety. One participant was diagnosed with a lifelong chronic illness after the suicide, which she firmly believed was caused by the trauma of this event. A few participants also shared the somatic symptoms of their grief or the physical manifestation of the psychological trauma from the suicide.

I can feel my stomach going, I can feel it churning, put my hands on it and I was told to hold, I was told to hold my stomach like this when it comes, I know what is causing it so it's not bothering me. I know why I feel like that, it's me inside having a sob. (Emma)

Witnessing the struggle of the deceased dealing with a severe mental illness, suicide attempts, self-harm and expressions of suicidal intent, took a toll on some participants. Subsequently, a minority of participants reported momentary feelings of relief after the suicide, followed by immense guilt and self-blame. Participants ruminated about changes they could have made to prevent the suicide and 'what if?' They deliberated whether they had missed 'warning signs' of a suicide or if they should have been more involved with mental health services to ensure the deceased received appropriate treatment. This myriad of feelings is widely supported and congruent with suicide bereavement research, as discussed in Chapter Two (see Section 2.2).

Empirical evidence proposes that those affected by suicide are at an increased risk of suicide (DH, 2012a) yet, in this study, the suicide prevented participants from seriously considering taking their own life.

I thought there wasn't much for me to be around for, because who I wanted had gone. It's also the thought came into my mind that I couldn't do the same as what wife had done, because I've seen the consequences, whilst I suppose in wife's case she hadn't seen the consequences. (Peter)

The findings highlighted positive change and growth in many participants, which is described in literature as post-traumatic growth (Gerrish et al., 2009; Smith et al., 2011). Violet reported similar views to other participants by saying, "you know that there is some sort of purpose that you have been able to extract from this dreadful loss, something that is a positive and I think that helps with the grief". Jonathan said, "my own self, my personality's coming out now more, I said that to my daughter and she said what do you mean? Oh, I said you know before your mum was a very strong person, it was difficult". Jonathan's wife had experienced a severe deterioration in her mental illness that caused a considerable strain in their relationship. Jonathan prioritised his wife and children, resulting in a loss of identity. Although the suicide was still immensely distressing, he recently began noticing a positive change in his sense of self after immediately accessing long-term counselling and regularly engaging with SOBS.

Positive growth and change from the suicide for many participants involved the need to help other suicide survivors, including taking part in this study. Having a positive outlook on life also developed resilience in participants to deal with life stressors, because any challenges were incomparable to the suicide. Participants prioritised their own wellbeing and focused on their closest family, friends and others. A few participants also shared how the suicide enabled them to take opportunities they were unable to do when the deceased was still alive, such as travelling, joining social activities and pursuing careers.

The 'new normal' is a code that perfectly encapsulates life now for participants as their lives have irreversibly changed. Christine stated, "it's having to sort of start again, because the way your life was is altered so you have to start doing something else and get a new type of normal". There was an acceptance that each suicide experience was individual, as they reconstructed their social reality. Participants had an implicit understanding that their grief was not bound by time limits, but was dynamic and ever changing. Often, participants recounted the pressure of conforming to 'normal' bereavement and 'moving on', which was unacceptable to them. A suicide was a unique death and did not conform to perceived societal norms and attitudes to grief and loss. All the participants strongly vocalised that they could

not return to the person they were before the suicide, but those longer bereaved had adapted to the suicide.

At the time of interviewing participants, the suicide occurred between three months to 19 years ago, and all the participants fluctuated between struggling with the suicide and trying to find a positive from it. One of the fundamental changes after the suicide reported by all participants, was the uncertainty of their future without the deceased.

I think that's the most scariest bit of it all because you think to yourself where am I going to be in three years' time from now and you think what's the future for me? And it's very, I would say it's very negative to a degree, because you can't see a future. It doesn't mean you all of a sudden want to end anything, but you can't see a future. I say you're just living; you're not enjoying life or enjoying being alive. (Peter)

5.6.6.2 The public self

The participant's shared aspects of their grief with others depending on the closeness of their relationship with others. Public expressions of grief were positive if others shared similar grief reactions, but there were difficulties for participants to meet societal assumptions of 'normal' grief. Thus, participants 'masked' how they truly experienced the suicide, generally to avoid distressing others. When interacting with others, participants struggled to find a balance in their grief expressions. Displaying too much distress would lead others to assume that they were not coping, whereas, not showing any emotion would give the impression that they did not care for the deceased. Hannah stated, "*they probably think I'm over it I suppose, but people don't understand suicide so people don't know how to deal with it. I don't know how to deal with it so how can anybody else?*"

Differences in grief reactions for some family members was a source of conflict and negatively impacted their wellbeing. This was especially evident when the deceased was the common link between their biological families and extended families. For example, Beth wanted to lay her son to rest, but struggled with her son's extended family over the ownership of the ashes and the funeral rites. This resulted in breaking ties with her grandchildren. Summarising the negative consequences of the suicide within families, Violet said:

With a suicide all that anger and blaming and extreme guilt swirls around inside the family unit and that's where you get this sort of toxic, it can, well it can completely destroy the whole family and you can have children who'll never again have contact with one half of the family, the parent who's died.

On the other hand, a number of participants developed new relationships post-suicide with the deceased's extended family members. Hannah had an estranged relationship with her father at times and little contact with his family. However, at her father's funeral, Hannah developed new relationships with her father's family, which she believed was a positive outcome of the suicide.

Comparatively analysing the data identified little differences in grief experiences between genders, but rather more commonalities. As stated in Chapter Two (see Section 2.2.2s), assumptions have been made about stereotypical gender responses to grief, such as 'feminine' and 'masculine' grief (Versalle & McDowell, 2005). Feminine grief describes how females prefer to share their feelings with others and half of the female participants felt talking to people in their family, social networks or others was beneficial in their grieving. However, the remaining female interviewees found it difficult to talk to others and to an extent, internalised their feelings or distracted themselves by fulfilling other tasks, often referred to as 'masculine' grief (Versalle & McDowell, 2005). In terms of the male participants, two of the four male participants found it therapeutic to speak to others, especially their counsellors. On the contrary, the remaining two male participants internalised their feelings, thereby, displaying 'masculine grief' by distracting themselves and avoiding talking about the suicide. The findings therefore challenged the notion of stereotypical gendered responses to grief and supported the emergence of personalised, individualised way of coping with the suicide.

Evidence of positive personal growth (see Section 5.6.6.1) emerged in participants when interacting with others. Challenging the negative societal attitudes to suicide and mental illness motivated participants to become advocates in suicide prevention to dispel the stigma of suicide and mental illness. The motivation for all the participants in the study was for others to learn from their experiences and prevent unnecessary deaths. Elizabeth, a SOBS helpline worker said,

I sometimes come off the helpline mentally exhausted, but I feel that if they respond to me at the other end of the line or they thank me for the time I spent with them [...] that is enough reward for me.

Participants often felt others were uncomfortable with them, therefore, some participants discussed the suicide first to share a personal insight into their subjective experiences, which also helped their grief. Additionally, two participants set up a suicide awareness charity in the deceased's name to prevent other families from experiencing a suicide.

Chapter Six: Discussion

This chapter will discuss the key findings of the thesis, particularly in relation to the importance of 'life before the suicide' and the 'impact on life after suicide', in the context of previous literature. Moreover, I will share my challenges of seeking approval from ethics committees, and how my experiences may be able to help other researchers when conducting future qualitative research with suicide survivors. The implications and recommendations for policy, practice and research will also be discussed, and this chapter finishes with the limitations and strengths of this research.

6.1 Summary of finding and contribution to knowledge

The descriptive model developed in this thesis is the first model looking at the impact of a suicide of someone in receipt of mental health services, so it adds to empirical knowledge in the area. It reflects the importance of recognising the family member's and the decedent's personal, situational, relationship factors and social context of the suicide in order to understand how they may be affected by the death over time. It also clearly demonstrates how the mental health context adds another level of complexity to how the suicide affects suicide survivors. The findings offer insights into this group of suicide survivors that have theoretical and practical implications for clinicians, researchers, policy makers, and service providers.

Understanding the bereaved and the decedents' lives before the suicide enables a deeper understanding of how family members are affected by a suicide (Barrett & Scott, 1990; Berman, 2011; Gaffney & Hannigan, 2010; Jordan, 2008; Sugrue et al., 2014). Therefore, this thesis develops a model which provides a more coherent overall picture as it illustrates a timeline including elements of 'life before the suicide', the 'act of suicide', and the 'impact on life after suicide'. Importantly, the model is not linear, but dynamic, because as found in previous studies, suicide survivors draw on their past experiences with the deceased in how they make sense of the suicide and this affects their grief experiences (Begley & Quayle, 2007; Murray, 2003; Neimeyer, 2006; Wertheimer, 2001). The model does not suggest a 'normal' grief process and acknowledges many different factors influence how family members are affected by a suicide. In 'life after the suicide' (Section 6.2), the distinctiveness of the mental health context of the deceased is most strongly highlighted in 'dealing with the stigma of the mental illness and suicide', as well as 'changing perceptions of the suicide'. However, the model does identify themes across all the participants, such as: 'creating symbolic ties

with the deceased'; 'personal ways of coping', and 'dealing with the grief', which are more common to other types of death. These themes will be discussed further in Section 6.3.

The model sits within a social constructivist framework, because multi-dimensional personal and situational factors affect suicide survivors when they reconstruct their social world (Hall, 2014; Gillies & Neimeyer, 2006; Neimeyer, 2006). The importance of this theoretical approach is that the impact of a suicide is best understood from the perspective of how the bereaved reconstruct their social realities based on their interpretations of social interactions and construction of symbolic elements (Roseblatt, 1988). Therefore, the components of the model illustrate the structures, processes, meanings, behaviours and actions of participants from before to after the suicide.

Within the elements of the model, the changes in the participants are identified as expressed through the 'private' or 'public' self. The self is an important concept in symbolic interactionism and grounded theory because the individual's interaction with others and the world shapes their own multiple social realities (Chamberlain-Salaun et al., 2013). There are important implications of recognising the distinction between private and public ways of dealing with the suicide. Private ways of expressing rituals, grief, coping strategies, and maintaining a relationship with the deceased may be construed as deviant activities because they fail to meet western societal norms according to the literature (Goffman, 1971; Romanoff & Terenzio, 1998). The hidden ways of dealing with the suicide in private partly stemmed from the self-isolation of participants because of the negative perceptions of the suicide by others. Participants experienced perceived stigma, avoidance by others, lack of understanding of the individuality of grief and distinctiveness of suicide bereavement. From a sociological perspective, Goffman (1971) discusses the different guises or roles individuals perform in society when interacting (face-to-face) with others. An individual is expected to conform to stereotypical expectations of an established role, for example, in this study, the participants often talked about 'masking' their grief or finding a balance to show acceptable grieving when interacting with others. More recently, Onja, Dyregrov and Dyregrov (2004) suggest that cultural and generational changes in society have fostered an environment where expressions of grief are made more public and open because of how death is perceived. To some extent, many participants disclosed the need to openly share their experiences in public to challenge some of the misconceptions of suicide and mental illness. There was a sense of collective identity among survivors and Goffman's view is that individuals work together in a team to fulfil a common performance or an activity in the presence of a set of observers. For example, in this study, participants had a strong need to raise awareness of suicide and its impact on suicide survivors in the public arena so they can honestly share how they are affected by the death with others and how they deal with it. This will help others understand how the death

impacts on them and recognise that grief is individual. Moreover, challenging the misconceptions of the suicide in society can enable the breaking down of the barriers that prevent individuals to seek help from health professionals or engage with support groups. Consequently, suicide survivors would be more likely to receive appropriate information and support to prevent the increased risk of negative health outcomes, including suicide or suicidal ideation compared with people bereaved by other types of death (Andriessen & Krysinska, 2011; DH, 2012a; Dyregrov & Dyregrov, 2005; Samaritans, 2016).

6.2 'Life before the suicide'

It is now clear that when someone in receipt of mental health services dies by suicide, the impact on family members is distinctive in a number of ways. Diagram 5.1 (first column) highlights the impact of the varying levels of family member's involvement in mental health services and the support family members provided to the deceased. Unlike previous research, this study explored these differences and how these factors affected the participants when they were supporting the decedent, the impact of the suicide and how they made sense of the death. As highlighted in previous literature (Grad, 2011; Peters et al., 2013; Wertheimer, 2001), past experiences with the deceased are drawn upon by the bereaved in making sense of a suicide and this study clearly demonstrates how influential 'life before the suicide' is in understanding how the suicide impacted on the participants.

A significant number of participants, especially those caring for the decedents, raised criticisms of the support and actions of the mental health services and health professionals, and this is reported elsewhere (Broady & Stone, 2015; Clearly et al., 2014; CQC, 2016; Lindgren et al., 2010). A concern in the present study and shared by Raphael et al. (2006), was that health professionals lacked appropriate skills and knowledge to support some participants, especially after suicide attempts by the decedents. Moreover, in line with the findings from previous research (Champlin, 2009; CQC; 2016; McLaughlin et al., 2016), participants identified that the lack of continuity of care provided by health professionals was problematic, leading to feelings of mistrust and a lack of confidence. The failure of health professionals to act on participants' concerns regarding the decedents was a serious worry prior to the suicide and resulted in them feeling resentment, anger, blame and frustration. This is consistently raised in the literature as an issue for service providers (CQC, 2016: Copeland & Heilemann, 2011; Shah et al., 2010). Consequently, many participants and decedents experienced feelings of powerlessness and disempowerment in relation to health services, which added to their distress and difficulties in providing care. This finding is consistently raised in previous studies (Champlin, 2009; Copeland & Heilemann, 2011;

Weimand et al., 2013), especially if carers oppose decisions made by clinicians regarding their care-recipient's treatment and are ignored (McNeil, 2013).

One factor that was found in many cases and rarely mentioned in the literature is the concealment by decedents of the facts about their mental illness and their engagement with the mental health services. This concealment partly explained why some family members had varying levels of involvement and awareness. Substantial research has shown that society's negative perceptions of a mental illness and the stigma can cause embarrassment or shame for an individual and lead them to conceal their illness and in some cases, prevent them from seeking help from health services (Clement et al., 2015; DH, 2012b; Ferrey et al., 2016; Samaritans, 2016). This was true to some extent in the current study as participants speculated that the perceived stigma, shame and embarrassment led the decedents to conceal the facts to protect themselves or to avoid distressing others. Another reason why some participants had limited or no knowledge, was because the decedent lived with significant others, alone or they had an estranged relationship. Many individuals in receipt of mental health services live alone, although their family members or significant others may still be involved in their care (Cole-King & Platt, 2017) as shown in this study.

A key finding of this study was the impact that disclosure, openness and involvement with mental health services, or conversely, non-disclosure, secrecy and lack of involvement with services, had on the bereaved. It affected how they made sense of the suicide, how they accepted the death, and subsequently on their grief experience and in some cases their willingness to seek help for themselves. Lack of involvement seemed to be associated with more confusion, anger and guilt, more complicated grief reactions and mental health problems. This supports the argument that a suicide can have a profound impact on family members/carers, especially if clinicians failed to disclose the patient's suicide risk due to confidentiality issues or ignore families' concerns regarding a possible suicide (DH, 2014b). This was further compounded by anger and blame mostly directed at health services and staff, because as stated earlier, and found in empirical research, most participants felt the suicide could have been prevented if their deceased had received effective support (CQC, 2016; Copeland & Heilemann, 2011; Shah et al., 2010). In addition, many participants who were involved in supporting or caring for the deceased also expressed negative views or experiences of health services after the suicide.

Studies have identified several reasons for the negative health outcomes for family members and carers. One is dealing with the changeability in someone with a severe mental illness and the burden of care this entails (Buus et al., 2014; Grad, 2011; Raphael et al., 2006; Shah et al., 2010), which strongly emerged in the current study. This in turn was influenced by whether or not they lived with the deceased. Participants who lived with the deceased had

more frequent contact and experienced a greater responsibility of care that negatively affected their wellbeing. This is unsurprising as studies consistently report that carers/families can experience feelings of loneliness, isolation, exhaustion, fear, anxiety, stress and helplessness (Klevan et al., 2016; Lindgren et al., 2010). In addition, suicide survivors who had lived with the decedents have been shown to experience higher post-traumatic psychological distress, compared with those not living with the deceased (Dyregrov & Dyregrov, 2005; Feigelman & Feigelman, 2011; Shah et al., 2010). When family members had not lived with the deceased but played a supportive role along with others, not only is care and responsibility shared before the suicide, but also in the aftermath.

Dealing with self-harm and suicide attempts also contributed to an adverse effect on the participant's well-being and this is often reported in the literature on carers (Maple et al., 2014; Trondsen, 2012). According to a number of studies, incidents of self-harm, suicidal ideation and suicide attempts by the care-recipient can lead to hyper-vigilance by families, which can add to their anxiety and responsibilities of care (Bolton et al., 2013; Shah et al., 2010). This was clearly evident from the participants in this study, moreover, a few participants reported fear, panic and powerlessness from failing to prevent the suicide attempts. Buus et al. (2014) identified similar feelings in parents whose children also made suicide attempts and the ramifications extend wider into the family unit by causing conflict or raising feelings of anger and blame towards the suicidal person (Canvin et al; 2014; Raphael et al., 2006). To an extent, this was exemplified in this study, especially when participants had to prioritise decedents over other family members such as their children and a few participants who witnessed suicidal intent or attempts experienced intensified feelings of blame and anger in towards the deceased. However, McAndrew and Garrison (2007) suggest that people display more sympathy towards individuals who disclose a suicidal intent if they have a chronic physical illness or suffer from severe psychological problems, and this certainly reflected the views of the majority of participants in this study.

The findings that participants' health and wellbeing were negatively affected by caring for or supporting the deceased with a mental illness has been previously reported (Cormac & Tihanyi, 2006; Crowe & Lyness, 2014; Maple et al., 2007; Shah et al., 2010). According to Clearly et al. (2014), family members have to reconstruct a different social world when caring for or supporting a relative with a mental illness and this was certainly apparent in the current study as participants struggled to balance life, work, family, and their needs. Copeland and Heilemann (2011) suggests that carers' personal sacrifices are overlooked by the care-recipient and health services. This was true to an extent in this study, because none of the participants received any acknowledgement from mental health services for the care they

provided, although a minority of decedents had expressed their appreciation for the care they had provided.

6.3. Impact on life after suicide

This section will discuss how the findings addressed one objective of the study; to identify the individual needs and experiences of suicide survivors.

'Personal ways of coping' in the model highlighted how participants who had not accessed health services intervention after other types of death were motivated to seek support or postvention following the suicide. This emphasises the distinctiveness of suicide and the greater difficulties experienced by participants. According to Ward-Ciesielski et al. (2015), suicide survivors can be reluctant to engage with health services if they blame clinicians for failing to prevent the suicide of the decedent. However, most participants in this study were not discouraged from accessing postvention, although their experiences were far from satisfactory because a generic response by health professionals did not meet their individual needs. This is unsurprising given that the literature and most recent grief theories have argued for a tailor-made approach to addressing the needs of the bereaved (McLaughlin, et al., 2014; Rando, 2000).

Consistent with previous studies on suicide survivors, criticisms of postvention included long waiting times, short-term counselling, health professionals lacking any knowledge of suicide bereavement and how to appropriately treat suicide survivors (Dyregrov, 2002; Jordan et al., 2011; Peters et al., 2013). These negative experiences of postvention are often stated by suicide survivors and can further add to their distress (Andriessen & Krynska, 2011; Jordan et al., 2011; McKinnon & Chonody, 2014). It was suggested by participants in this study that long-term postvention such as counselling would have been more effective for at least one year, although a few participants had been accessing health services for many years. A significant number of suicide survivors in Dyregrov's (2002) study would have preferred support from health professionals for at least two years. Another barrier to seeking support or postvention for suicide survivors can be the perceived stigma they experience (Feigelman et al., 2009b; Harwood et al., 2002; Peters et al., 2016; Pitman et al., 2016b; Young et al., 2012). However, in the current study, stigma did not deter any of the participants from seeking postvention, because they recognised that they needed professional support and their GP was most often the first point of contact who were in most cases responsive to meeting their needs.

A small number of participants had positive experiences of postvention services that they felt were effective as their needs were being met. They accessed long-term postvention, for

example counselling where they were able to express their private feelings without being judged and received validation by the 'experts' that people grieved in their own way. Psychological interventions such as counselling and cognitive behavioural therapy can be effective for individuals who experience complicated or intense grief reactions, especially if the counsellor has understanding and flexibility to accommodate the needs of the bereaved (Raphael et al., 1993; Spillane et al., 2017). Some participants in this study also used medication, which, according to Klein and Alexander (2003) can be helpful for the bereaved to cope with such reactions.

There was a strong need for participants to seek support from others who had a shared experience of losing a significant other to suicide, especially if they had accessed postvention but felt it did not meet their needs. Much has been written in the literature about the importance of suicide bereavement support groups and in general the study produced very similar findings. SOBS was appropriate for most participants because they felt others outside the group would not understand their experiences and the difficulties they encountered in making sense of a suicide. This finding is often reported in studies in peer suicide bereavement support (Feigelman & Feigelman, 2011; Pietilä, 2010; Toller, 2011), especially if suicide survivors' social networks did not provide the support they needed as identified in the current study. SOBS also enabled participants to develop new friendships or seek inspirational role models and studies have suggested that this is one strength of suicide bereavement peer support groups (Aguirre & Slater, 2010; Begley & Quayle, 2007; Jordan & McMenemy, 2004; Feigelman et al., 2009a).

Examining why some participants only attended the group on a few occasions provided important insights into limitations with support groups. A few participants felt distressed at hearing others' stories and felt uncomfortable speaking in public and these findings reflect those of a phenomenological study by McKinnon & Chonody (2014). A few participants felt their different kinships with the deceased, such as siblings, parents or partners were not reflected in SOBS, because the majority of group members were parents whose child died by suicide and this has been previously reported (Barlow et al., 2010; Maple et al., 2007; Rando, 2000). Other studies have suggested that suicide survivors may be influenced to construct their grief in a socially acceptable way and conform to traditional grief models, which can be problematic considering the diversity in their experiences (Buglass, 2010; Grad, 2011; Hall, 2011; Larson, 2013; Rothaupt & Becker, 2007; Valentine 2006). However, none of the participants in the present study disclosed such experiences.

A small number of participants found comfort from their religious and spiritual beliefs in coping and making sense of the suicide. They believed that the deceased was at peace and they would be reunited in the afterlife. Previous studies of individuals bereaved by other types of

death have found that they draw on support from co-religionists in their networks in a way that was beneficial to their wellbeing (Holloway et al., 2010; Klein & Alexander, 2003; Matthews & Marwit, 2006). Notably, a few participants in the present study experienced immense turmoil in reconciling their religious beliefs with the act of suicide. Burke and Neimeyer (2014) describe this as maladaptive religious coping and find that in these cases, suicide survivors' grief is more intense as they struggle to accommodate the emotional and spiritual conflict arising from their loss. Moreover, the authors add that suicide survivors can feel abandoned or punished by God or feel blame and anger towards God, but none of the participants in the present study expressed such feelings. In fact, some participants found a way of making sense of the death because they believed the decedents' mental illness and poor mental capacity caused the suicide and it was therefore, not a rational act.

Most suicide survivors or the bereaved in general, may be less inclined to engage in postvention or different sources of support, but rather may prefer to draw on their personal ways of coping (Smith et al., 2011). A few participants reported coping strategies which may be considered risky, such as over-working and an over-reliance on alcohol or having no regard for their own health and personal safety. It is possible that the risky coping strategies used by a few participants were ways of distracting or avoiding dealing with their grief. However, it has been suggested that these types of risky coping strategies are predominately used by males as a way of hiding or redirecting their feelings, because they are unable to cry or grieve in public (Pettersen et al., 2015; Versalle & McDowell, 2005). The current study did not identify any stereotypical gendered responses to grief, and both males and female participants displayed risky coping mechanisms. Hoffmann (2010) also found that adolescent female suicide survivors reported using similar coping strategies to deal with their loss. Moreover, individuals bereaved by different types of death may also use risky coping styles to deal with a death (Grad, 2005; Spillane et al., 2017; SUGRUE et al., 2014).

It was evident in this study that an important part of grief recovery is the reconstruction of a 'new' sense of self and reconstruction of a different social world that is commonly addressed in grief literature (Clarke & Goldney, 1995; Gillies & Neimeyer, 2016; Stroebe & Schut, 2000). Therefore, 'dealing with grief' in the model reflects how the participants' personal and situational context affected their grief experiences as reflected in their private and public self. Unsurprisingly, some of the findings are broadly similar or share common themes with suicide survivors or the bereaved in general. What becomes clear in this study is that understanding what constitutes healthy grieving for the bereaved has to take into account their personal and social context and supports a growing body of literature that opposes traditional grief theories (Buglass, 2010; Chapple et al., 2015; Gillies & Neimeyer, 2006; Stroebe et al., 2005; Valentine, 2006). Furthermore, studies have shown that these factors shape the intensity and

variability of their grief experiences and how the bereaved adapt to their loss (Breen & O'Connor, 2007; Callahan, 2000; Mitchell et al., 2009; Pitman et al., 2016b; Zisook & Shear, 2009).

The suicide was distinctive for participants compared with their experiences of other types of death. Most participants experienced the suicide as sudden and this subsequently led to a stronger need to search for an explanation for the cause of the death by "piecing the puzzle", which many studies report is a key feature of a sudden death (Bailey et al., 1999; Chapple et al., 2015; Grad, 2011; Lindqvist, et al., 2008; Maple et al., 2014; Pitman et al., 2016b). Additionally, this study ascertained that participants' grief experiences were affected when they found it difficult to make sense of the death, because they were unable to find answers or understand why the deceased died by suicide. This failure to find answers can result in a more complicated grief process (Lindqvist et al., 2008; Young et al., 2012), and to an extent reflected many participants' experiences in making sense of the suicide.

Another reason why the suicide was perceived as distinctive was because participants experienced stigma and this was experienced in the realm of the private self as perceived stigma, but also felt in the public self through their interaction with others. Compared with other types of death, they expressed feeling isolated, judged, avoided, blamed or shamed. These findings are commonly reported in many studies with suicide survivors, and are also comparable with other types of death that are stigmatising (Feigelman et al., 2009b; Harwood et al., 2002; Murray et al., 2005; Peters et al., 2016; Pitman et al., 2016b). Moreover, many studies have established that suicide survivors are at a greater risk of suicide and suicidal ideation (e.g., Andriessen & Krysiniska, 2011; DH, 2012a; Dyregrov & Dyregrov, 2005; Samaritans, 2016). However, none of the participants in this study disclosed such thoughts, in fact one participant reported that losing the deceased to suicide prevented him from considering suicide to avoid distressing others.

Unsurprisingly, nearly all the participants expressed how the suicide caused stronger feelings of grief in comparison with other types of death they had experienced, resulting in poorer mental and physical health. Regarding kinship relationships, most participants who were first-degree relatives experienced more intensity in their grief, which is not surprising, given research in grief strongly suggests that immediate family members who had a closer relationship with the deceased are more adversely affected by the death and have greater support needs (Cerel et al., 2017; Mitchell et al., 2009; Wilson & Marshall, 2010). However, Callahan (2000) argues that most studies focus on the kinship relationship and overlook the closeness of the emotional relationship of suicide survivors and decedents. This was indeed found in this study. The closeness of the relationship between the deceased and participant more strongly contributed to their negative health outcomes compared with the kinship

relationship alone. This finding has been acknowledged as an important factor in very few previous studies (Barrett & Scott, 1990; Berman, 2011; McIntosh, 1993; Mitchell et al., 2009).

Differences in grief reactions were also noted in participants who had been bereaved for a longer period as they had come to an acceptance that they would never fully have the answers and, consequently, had accommodated their grief. Time is certainly an important factor in how the bereaved make sense of a death and adjust to their grief (Feigelman et al., 2009a; Murphy et al., 2003b), but Neimeyer et al. (2006) suggests that finding a positive meaning from the death is more beneficial to coping with loss than time. The current study identified many examples of personal growth as a way of taking a positive from the tragedy of the suicide, which helped participant's grieving process and supports previous studies (Berzoff, 2011; Gillies & Neimeyer, 2006). Acknowledging these findings is important, because there are gaps in knowledge in this area as previous studies have tended to focus on the negative effects on suicide survivors (Bonanno & Kaltman, 2001; Feigelman & Feigelman, 2011; Gerrish et al., 2009; Zisook & Shear, 2009).

The present study makes several noteworthy contributions based on the different grief experiences which result from the participants' perceptions of an anticipated but unexpected suicide or an anticipated suicide. A possible explanation for the changing perception of a sudden or anticipated suicide is the deceased's fluctuation between their 'normal' self, expressing future plans and announcing suicidal intent or making suicide attempts. Owens et al. (2011) also found conflicting and inconsistent cues from the suicidal person resulted in mixed messages that confused others. As reported by a few participants in the present study, and established by Grad (2011), a suicide can be perceived as unexpected regardless of suicide attempts or expressions of suicidal intent by the decedent. On the contrary, some participants in the current study anticipated the suicide because of their awareness and involvement in caring for or supporting the deceased and felt relief, peace, and described less intensity in their grief. Although there has been very little discussion of this in the literature, one of the few qualitative studies available is by Maple et al. (2007). They conceptualised the 'preparedness' of the suicide by some parents because their child had made suicide attempts, expressed suicidal intent or had been living with a severe mental illness. Due to these experiences, after the suicide, a few parents felt relief and peace and this was reported by a few participants in the present study. This is an important finding because there remains a gap in knowledge on how and why a suicide is anticipated and its impact on suicide survivors (Maple et al., 2014; McIntosh, 1993; Wojtkowiak et al., 2012). The same reduction in the intensity of grief was found in the few quantitative studies which found that suicide survivors scored lower on grief reactions if the death was anticipated (Bailey et al., 1999; Barrett &

Scott, 1990; Wojtkowiak et al., 2012). Suicide survivors who express feelings of peace or relief may be misconstrued by others who are unaware of the difficult experiences they had when caring for or supporting the deceased with a mental illness. Therefore, the current study adds to the limited number studies that have shared these differences in grief experiences (Clarke & Goldney, 1995; Maple et al., 2007; Sveen & Walby, 2008).

Differences in grief reactions were found also in participants who had an estranged relationship with the deceased. This is an important finding, because, as stated earlier, scant attention has been paid to the closeness of the relationship between the bereaved and the deceased in empirical research (Berman, 2011; Callahan, 2000; Maple et al., 2016; Mitchell et al., 2009; Neimeyer & Cerel, 2015). This study showed that these participants felt anger, rejection, abandonment, blame, frustration, guilt and subsequently were unable to cry or grieve or draw on symbolic ties with the deceased. These findings are confirmed by Stroebe et al. (2005) who suggest that individuals are more likely to experience poorer and more complicated bereavement outcomes if they had a conflicting relationship with the deceased.

The study has demonstrated for the first time, in an integrated fashion, that the mental health context of the deceased and their involvement with mental health services greatly contributed to the changing perceptions of the suicide by participants. By taking a social constructivist perspective to understanding grief and bereavement as well as suicide survivors' experiences, this study has established that a suicide is the type of death that challenges participants' assumptive world or social realities and leads to the reconstruction of meaning about their loss. Gillies and Neimeyer (2006) explain that a death may challenge the bereaved's outlook on life to an extent that they have to reconstruct new meaning structures that are drawn from their religion, spirituality, relationship, and a different sense of self or identity. This was clearly illustrated in this study and the mental health context had a key impact on participants in this reconstructive process. For example, when "piecing the puzzle", some participants learned about the deceased's contact with mental health services, or they discovered undisclosed suicide attempts, non-compliance with medication and missed appointments with clinicians. These facts as well as drawing on their 'life before the suicide' shaped participants' differing views of a suicide as a selfless, rational or an irrational act and in a few cases, as a choice. According to Grad (2011), suicide survivors may have a strong need to know if the death was deliberate, personal or influenced by specific issues such as the mental illness for example. In contrast, some participants who knew about the deceased's contact with mental health services had a lesser need to search for answers, because they felt the mental illness may have made a large contribution to the suicide. This finding is supported by Powell and Matthys (2013), who also identified that suicide survivors who were aware of the decedent's negative life stressors experienced less uncertainty regarding the cause of the death.

The current study highlighted how some participants' perceived an altruistic suicide, which Mayo (1986) suggests alludes to self-sacrifice by the deceased. Some participants in the current study believed that the deceased wanted to take away the perceived burden of care from others or release their own pain from living with a life-long severe mental illness. Joiner (2005) coined the term perceived burdensomeness to capture how an individual at risk of suicide considered themselves as helpless and a burden on their family or significant others. In this study, a few participants heard the deceased express how they felt a burden on them, but many participants speculated that the deceased may have perceived themselves to be a burden. However, regardless of their awareness of the decedent's engagement with mental health services, some participants perceived the suicide as a rational act and a choice. This is an important finding, because only very few researchers have argued that a suicide can be a rational act even if the deceased had an underlying mental illness (Beattie & Devitt, 2015; Bhavsar, 2013; Callaghan et al., 2013; Clarke, 1999).

The findings showed that the participants' kinship and their closeness in relationship to the deceased led to differences in the ways in which participants' created symbolic ties with them. To a large extent the literature presents a similar picture. This thesis takes a similar stance to those grief theories that propose that continuing bonds with the deceased are beneficial for the suicide survivor's recovery and also the bereaved in general (Murray, 2003; Gillies & Neimeyer, 2006; Root & Exline, 2014). Overall, the findings are in agreement with Berzoff's (2011) view that continuing a bond with the deceased can be transformative. This process enables the bereaved to take a positive outlook on life and reconstruct a different sense of self and identity, for example, participants claiming to be survivors rather than victims.

Participants who had a closer relationship with the deceased described how they were most affected by the suicide, which somewhat challenges the assumptions that first-degree relatives are more detrimentally affected by a death (Callahan, 2000). Neimeyer et al. (2006) suggest that the bereaved experience higher levels of separation distress if they had a higher level of intimacy and frequent contact with the deceased, therefore they have a stronger need to continue bonds with the deceased. This was as found in the present study in participants who had a closer relationship, which somewhat challenges the assumptions that first-degree relatives are always the most affected by a death. Unsurprisingly, most participants developed a common use of rituals and objects to continue a bond with the deceased for the same reason found by Neimeyer, Klass and Dennis (2014). These practices offer the bereaved a sense of security, which over time, helps them to heal however, this study identified slight differences in a few participants; those who avoided creating symbolic ties with the deceased and those who had an intense preoccupation with the symbolic ties that negatively affected their mental well-being. Cerel et al. (2009) proposed that the bereaved's avoidance of reminders of the

deceased is a symptom of trauma and while this may seem plausible, the few participants in this study who claimed they did not want reminders of the deceased had an estranged relationship and perceived the suicide as selfish. They had a great deal of anger and blame towards the deceased and one way of ending their bond was disposing of and/or removing their belongings.

This study identified two participants who had had a close relationship with the deceased, but described how, two years after the suicide, their preoccupation with continuing bonds with the deceased left them feeling unable to 'move on'. This shares similarities with the findings from a study by Field, Nichols, Holen and Horowitz (1999), who established that the bereaved's over-reliance on the deceased's belongings six months after the death has negative consequences. They suggested that this prevented the bereaved person from finding different ways of coping, adjusting to their loss or reconstructing their 'new' social world as expressed by the two participants in this study. Clearly, the present findings offer insights into these differences in the benefits and costs of continued bonds, and share common ground with research by Stroebe et al. (2005). These authors confirm that the bereaved's need to continue or relinquish bonds with the deceased can be helpful or harmful depending on the closeness of the relationship they had prior to the death. In this study, the participants who had an over-reliance on continuing bonds with the decedents were still struggling to deal with their grief. Field et al. (1999) suggested that this is considered a maladaptive coping strategy, therefore the bereaved may find therapeutic interventions helpful which support them to adjust to the reality of their loss by exploring alternative ways of continuing a relationship with the deceased. Therefore, there are implications for clinicians and researchers to have a better understanding of how to support suicide survivors who expressed difficulties in 'moving on' in order to minimise negative health outcomes. Stroebe et al. (2005) recommend further research is necessary on how continued bonds with the deceased can aid the bereaved's recovery or indicate unhelpful grief reactions.

6.4 Challenges of ethical issues and the importance of hearing the voices of suicide survivors

As a researcher conducting a study in a sensitive area, one challenge was gaining ethical approval from various ethics committees before I could begin to recruit participants and this took almost a year. In the light of my experiences, I wish to offer a few salient points regarding ethical considerations for future researchers embarking on studies with suicide survivors.

The lengthy process of gaining ethical approval can be problematic and may deter researchers from conducting empirical studies with suicide survivors (Gemmill et al., 2012; Moore et al.,

2013). Ethics committees can be criticised for being paternalistic in raising obstacles for researchers, especially in qualitative studies (Gemmill et al., 2012; Lakeman & FitzGerald, 2009a, 2009b; van Orden et al., 2010). One concern raised by an ethics committee about my study was how soon after the suicide I would recruit potential participants, as the assumption was that people recently bereaved will experience greater distress during the research process. This is a commonly reported concern by ethics committees for researchers conducting qualitative studies with the bereaved and suicide survivors (Biddle et al., 2013). Undeniably, minimising distress to participants is essential in ethical research, however, I believe that a time limit should not be stipulated in studies with suicide survivors. In order to gain a deeper understanding of the impact of suicide requires investigation and acknowledgment of the diversity in the time since the suicide occurred to the point of data collection. Assumptions by ethics committees regarding studies with the bereaved may be based on traditional ideas about grief, whereas I found that regardless of the time the suicide occurred, the participants were pleased to be able to share their feelings about the suicide. Therefore, my argument is that participants should be able to make an informed decision based on clear information of the study and shared in a language they understand.

Ethics committees may underestimate positive outcomes for individuals who participate in qualitative interviews. Interviews can provide an opportunity for participants to vent their feelings, emotions and gain insights into their experiences (Dyregrov, et al., 2011). Bell, (2013) suggests that in qualitative interviews, some participants describe the process as therapeutic. In this study, all the participants described the interviews as a positive experience and, in a few cases, as therapeutic and/or cathartic. However, providing participants with a list of support organisations was important, should they require further help. Perhaps speaking with an 'outsider' gave participants a platform to disclose their inner-most feelings, without feeling judged or perhaps they felt safe knowing that their data was kept confidential and their anonymity preserved.

Understanding the motivation for suicide survivors to take part in research is often disregarded. I identified two overwhelming reasons why participants became involved in this study. Firstly, a number of participants took part to fulfil their broader agenda; to disseminate their subjective experiences with the wider academic community and, more significantly, with health providers. Therefore, having a collective voice in the study was instrumental for many participants so that their concerns about the decedents' experiences of the mental health services were documented for Trusts. Furthermore, participants were keen to share their experiences of postvention and to suggest ways of addressing the needs of suicide survivors. They believed the findings would substantiate evidence for strengthening policy, service provision and practice to support suicide survivors.

Secondly, there was a strong desire to help other bereaved families who had experienced a similar event and their willingness to participate, and share their experiences facilitated a deeper understanding of their experiences. As reported in other research, respondents felt that it was important to find a positive from the tragedy of suicide (Beck & Konnert, 2007; Dyregrov, 2004; Maple et al., 2014). Corbin & Morse (2003) suggest respondents participate in qualitative studies because they may seek an opportunity to unburden as they have no one to share their story with or seek information. In a sense, participating in qualitative studies can be empowering for suicide survivors. It facilitates self-awareness and provides them with a voice that is lacking in suicidology (Jordan, 2008; Shahtahmasebi & Aupouri-McLean, 2011). Moreover, participants wanted to challenge the stigma of suicide and as advocated by other suicide survivors, advise the health providers and the wider community regarding how they would like to be supported and treated (Grad, Clark, Dyregrov & Andriessen, 2004; McKay & Tighe, 2014).

6.5 Implications for research and practice

This study identified how involvement and communication with mental health services prior to the suicide influenced how the family member was able to make sense of the suicide, which in turn affected their grief and distress. It also highlighted how families often carry out the majority of the caring responsibilities for their relative in receipt of mental health services (CQC, 2016; Copeland & Heileman, 2011; Klevan et al., 2016). This involvement means that families or carers sometimes have greater insights into warning signs of a relative's possible risk of suicide and their involvement in care-planning for the care-recipient is recommended in any suicide prevention strategy (CQC, 2016; DH, 2012b). Moreover, it is recommended that families/carers should receive information on the mental illness of the care-recipient of the care-recipient and understand how to deal with expressions of suicidal intent and attempts, which are well-known factors increasing the risk of suicide. This is supported by a Care Quality Commission report (2015), which stated that almost half of the families/carers who participated in their consultation had little or no knowledge of what to do when the care-recipient experienced a crisis. Better communication and information sharing may therefore result in the care-recipient receiving timely access to health services, and possibly prevent future suicides (Clearly et al., 2014; Klevan et al., 2016; McLaughlin et al., 2016), as well as helping the family member make sense of a future suicide.

Caring for a relative with a mental illness is clearly stressful and demanding, therefore, support for carers is important to ensure they can effectively continue supporting their relative (DH, 2012b). This study recommends that Trusts providing mental health services or

clinicians treating the patient should be proactive in offering information on services or sources of support to family members to reduce the negative impact on their health and well-being. Critically none of the participants requested or sought help, because they expected health professionals to proactively inform them of what support was available. However, it was unclear from this study what type of support participants required and it will vary at different times. A few participants alluded to respite care to take a 'break' from the responsibilities of care, but this support should be flexible to meet their different needs at different times. This was especially noticeable in participants who lived with the care-recipient, were the primary carers or when the care-recipient had a severe mental illness over many years. Copeland and Heilemann (2011) also found that respite care was requested by carers of people with a severe mental illness in their study, but Jeon et al. (2005) suggests that the unpredictability of the mental illness causes difficulties for caregivers to plan respite care in advance, leaving them feeling unsupported.

One of the study objectives was to generate recommendations for improving health services for suicide survivors. Critically, none of the participants received any information on support from health services after the suicide, which is a concern that is consistently raised in a number of reports (CQC, 2016; PHE, 2016). Thus, based on the present findings, it is recommended that service providers and clinicians should proactively implement local strategies for suicide survivors to provide them with information and support immediately after a suicide (Cole-King & Platt, 2017; DH, 2015a; Shah et al., 2010). This is to ensure that they know of, and have access to, timely and early interventions to reduce negative health outcomes when dealing with a suicide (DH, 2012a). The findings show that although many participants managed to access health services, postvention was often ineffective and in some cases these interventions further intensified participant's grief experiences or resulted in their disengagement. This shows the importance of researchers, clinicians and policy makers in understanding, identifying and addressing the needs of suicide survivors. Onja et al. (2004) argue that postvention services should not be prescriptive, but rather empower suicide survivors by supporting them to find their own ways of dealing and coping with the death. Furthermore, Cerel et al. (2009) propose that service providers should recognise the use of bereavement support groups as part of a suicide prevention strategy. One way to do this is for Trusts to work closely with suicide bereavement support groups to gain a deeper understanding of suicide survivors' experiences and share information on the groups with family members immediately after a suicide.

As discussed earlier in Section 6.2, the issue of maintaining patient confidentiality can be a barrier to information sharing which is limited if patients choose not to disclose information with their families/carers or staff are unable to inform families/carers about a patient's risk of

suicide. However, what is clear from the DH (2014b), and recommended by participants in this study, is that health professionals should encourage patients to involve families/carers in their care and if a patient is at risk of suicide. Additionally, the treating clinicians should encourage patients to accept the importance of sharing information with family members/carers. Health professionals should also be open to listening to the concerns of family members, even if they do not have the patient's consent to share information on their care. The DH (2014b) suggest practitioners use their professional judgement to minimise the suicide risk of a patient by disclosing information without consent to the carers/family members. Clearly, the present study established that the suicide of someone who concealed their mental illness and/or engagement or disengagement with mental health services contributed to complicated grief reactions for the participants. They experienced feelings of shock, resentment and confusion that negatively affected their physical and mental wellbeing. Nevertheless, despite legitimate and important considerations regarding patient confidentiality, there is room for closer collaborative working between mental health professionals, the patient and their carers/families (DH, 2012b). In addition, the DH (2014b) states that good practice includes health professionals listening to families' concerns, sharing information without consent of a patient who is at risk of a possible suicide and providing carers/families with information on support and services they can access in a crisis.

The finding that involvement and communication with mental health services prior to the suicide influenced how the family member made sense of the suicide, and their grief and distress, has implications for future research. It may be possible to evaluate the impact of a pilot project in which health services proactively involve families/carers and the care-recipients in communicating and sharing information regarding the treatment. It is difficult to see how this could be evaluated in terms of improving outcomes for suicide survivors, but it could evaluate the impact on the well-being and strain on carers. Additionally, this study found participants' health and wellbeing was detrimentally affected by caring for someone in receipt of mental health services, so such a pilot study could evaluate the impact of enhanced support for carers/families. It would be important to involve families/carers and patients in the development of the enhanced service, taking a co-production approach and drawing on their expertise to highlight areas that may have been missed by health services (Breen & O'Connor, 2007). Other outcome measures could include patient satisfaction to capture their attitudes and perceptions of health services, staff and quality of care, aspects of communication with health professionals, coping, impact on their physical and mental health, the positive and negative effects of caregiving, sense of burdensomeness and attitudes and perceptions of the treating clinicians and health services. The findings from this pilot project would offer a better understanding of families/carers and patients' perspectives and assess whether the intervention prevents adverse outcomes on families/carers and patients,

increases their satisfaction with health services and improves the quality and effectiveness of health care.

Another recommendation from this study is that before an individual is labelled by health professionals as having a 'pathological' grief reaction, it is important to consider the complexities and idiosyncratic ways in which individuals are affected by and cope with a suicide. Clearly, the present study strengthens the argument that clinicians should consider the bereaved's personal and situational factors, including the closeness of their relationship with the deceased, and the private and public ways in which they grieve and cope. Feigelman et al. (2009a) suggests clinicians should have an awareness of the bereaved's relationship with the deceased, especially if they had an estranged relationship, because this knowledge can be used to identify individuals who may be at a greater risk of grief difficulties. Therefore, this research will serve as a base for future studies that emphasises the heterogeneity of this group, because many studies have proposed that suicide survivors are researched as a homogenous group (Bailey et al., 1999; Bolton et al., 2013; Mitchell et al., 2009; Parkes, 2002; Stroebe et al., 2006). Subsequently, the findings will enable a deeper understanding of the diversity of suicide survivors' grief experiences and supports Rosenblatt's (1988) argument that an individual's grief or expressions of loss are better understood by taking into account their cultural context. Moreover, there is a continued need for qualitative research with suicide survivors in order to allow a thorough exploration of their subjective experiences to draw out subtle insights (Andriessen, 2009; Hardiman, 2004; Shahtahmasebi & Aupouri-Mclean, 2011). As clearly apparent in this study, applying a qualitative approach proved to be valuable in gaining a deeper understanding of the impact of suicide on participants and capturing their experiences.

A further recommendation from this study is for the conceptual model to be used in research and practice, because it demonstrates the impact of suicide on family members whose relative died whilst in receipt of mental health services. The findings have concisely consolidated many different aspects of participants' experiences that are often found in fragmented pieces of empirical research. Subsequently, the findings can be used by health professionals or academics to understand how suicide survivors' experiences may be different and challenge the normative assumptions that suicide is similar to other types of death or that a suicide is sudden. Health professionals can use the model to initiate dialogue with suicide survivors and facilitate a process of reconstructing their social reality. Subsequently, the individual needs of suicide survivors can be identified and health professionals can help them to develop constructive strategies to deal with their loss (Gillies & Neimeyer, 2006). As found in this thesis tailor-made interventions and person-centred care and support will be more effective to meet the needs of suicide survivors.

A qualitative approach in this study proved to be valuable in gaining a deeper understanding of participants' experiences, but there are still gaps remaining in knowledge on how a suicide impacts on suicide survivors and what their needs are to minimise negative health outcomes (Cerel, Jordan & Duberstein, 2008; Cvinar, 2005; Grad, 2011; Feigelman et al., 2009a; Jordan, 2008). It is recommended that there is a continued need for qualitative research with suicide survivors in order to allow a thorough exploration of subjective experiences and give suicide survivors a voice through meaningful research (Andriessen, 2009; Hardiman, 2004; Shahtahmasebi & Aupouri-Mclean, 2011). As stated earlier, this approach encourages suicide survivors' experiences and views being taken into account and hopefully this will lead to a co-production to research and service design (Breen & O'Connor, 2007).

Finally, the findings from this study will be disseminated in the wider academic arena with service providers, especially health services as well as VCS organisations who support suicide survivors. Outputs from this study include the publication of papers in journals (see disseminated findings), as well as a summary of the research in raising awareness of the impact of suicide. The findings will also be presented at a learning and sharing event for the Trust, including participants who registered their interest in attending, people affected by suicide and key staff members from SWYPFT and SOBS.

6.6. Limitations and strengths of the study

Although the study has successfully demonstrated that the impact of suicide on families of people in receipt of mental health services is distinctive, there are a number of limitations and strengths of this study.

Most of the participants in the study were recruited via SOBS and empirical studies have been criticised for recruiting participants from support groups or those who are already accessing postvention (Barlow, et al., 2010; Jordan & McMenemy, 2004). Consequently, research has to some extent disregarded the majority of suicide survivors who do not access any type of intervention from health services or VCS organisations, thereby leading to gaps in knowledge regarding experiences (Cerel et al., 2009). These critiques were taken on board in the early research design and the original recruitment strategy for participants was via the NHS PST. There was a lengthy process of negotiation with the PST and after numerous discussions with the staff, it was clear that many families were possibly willing to participate in the study. Unfortunately, only two participants were recruited via the PST, and it was tentatively suggested by the PST staff that the distress of the suicide prevented families from participating. However, due to the time constraints and practicalities of completing the study, it became necessary to broaden the recruitment of participants via SOBS while still recruiting

participants via the PST. Although recruiting from SOBS deviated from the original sampling strategy, it did address identified gaps in knowledge regarding how specialist peer suicide bereavement support groups can be effective or ineffective (Cerel et al., 2009; Groos & Shakespeare-Finch, 2013). Consequently, the study makes several noteworthy contributions to understanding why suicide survivors access peer suicide bereavement support and captures the diverse experiences of many participants' engagement with SOBS. However, it is acknowledged that the study did not manage to focus on suicide survivors who are not engaged in bereavement support groups to the extent that was intended, so further qualitative research with this group will enable a deeper understanding of the commonalities or differences in their experiences.

The sample was nationally representative of the majority of suicide survivors who were; White, British, mostly females who had lost male decedents to suicide, and mostly parents who had lost their child to suicide. Many researchers contend that this composition of sample is found in many studies with suicide survivors and can be considered a limitation (Kato & Mann, 1999; Maple et al., 2014; McIntosh, 1993; Moore et al., 2013). However, the participants in the study reflected variability and diversity in their age, gender, time since the suicide, and kinship and closeness of their relationship with the deceased. As a result, this study has gone some way towards enhancing our understanding of the personal and situational context of suicide survivors. Moreover, the study also offered insights into the suicide of female decedents, and the impact of their death on male suicide survivors, which Mallon, Galway, Hughes, Rondón-Sulbarán and Leavey (2016) suggested is still an area that is neglected in research.

A key strength of this qualitative study and its methods is that it offered flexibility to pursue different areas of inquiry by including participants who had been bereaved for a greater length of time than those more recently bereaved. This led to a deeper understanding of the role of time on the impact of suicide and how a person adapts. The participants' keenness to share their stories also added to the depth of the study and insights. However, the retrospective nature of the study as well as the considerable time differences between the suicide and the point of data collection can be considered a limitation because of the participants' recollection of events (Maple, Cerel, Sanford, Pearce & Jordan, 2016). Nevertheless, Owens et al. (2011) point out that retrospective accounts by suicide survivors do not diminish the quality of the findings from this type of study. Most often in qualitative studies, participants' stories, interpretations and views are likely to change and their accounts are fluid rather than static (Chapple et al., 2015). Moreover, to strengthen the quality of the data and to develop theoretical sensitivity on the emergent findings, I conducted a focus group that included some

of the interviewed and non-interviewed participants. Their feedback on the emergent findings was beneficial to the development of the final conceptual model.

As stated in the Introduction Chapter, preventing suicide is a public health concern and involving families in the care and treatment of the deceased by mental health services is strongly advocated (DH, 2014a). Considering the current economic difficulties, suicide rates are expected to increase, especially in males (DH, 2014a; Samaritans, 2016). Notably, there has been an increase in suicides by people receiving care from crisis resolution teams in England, especially in the first two weeks after hospital discharge (NCISH, 2016). Consequently, a larger number of individuals will be affected by suicide. Unfortunately, a suicide irrevocably changes the lives of people and as demonstrated in this study, there is a large amount of variability in their experiences. Understanding these variations and in particular, the experience of families and carers of those who were in receipt of mental health services before their suicide, will enable appropriate and individualised support. It also raises the possibility of preventing suicides if some of the misgivings respondents articulated regarding the mental health services the decedents received, could be addressed.

Chapter Seven: Conclusion

The study has contributed to our understanding of the impact of suicide by someone in receipt of mental health services on their family members. To address the aim of the study, there were three objectives: to investigate suicide survivors' perceptions of the health service support which they and the deceased received before the suicide; to identify the individual needs and experiences of suicide survivors and finally, to generate recommendations for improving health services for suicide survivors.

A key finding was the importance of the experiences of family members of those in receipt of mental health services before the suicide. Focusing on the mental health context of the decedents in this study has produced a number of significant insights that highlight the different levels of awareness or involvement participants had of the deceased's mental illness and engagement in mental health services. These factors greatly affected how the suicide impacted participants and reflected the diversity in their experiences, which strengthens the argument that service providers, policy-makers and clinicians should focus more on the individual needs of suicide survivors. An important finding was that greater involvement and better communication with mental health services prior to the suicide tended to help the bereaved person to accept the death and protected them from a complicated grief reaction.

A significant contribution from this study is the conceptual model that is developed within a social constructivist framework that now incorporates the personal context of participants to gain a deeper understanding of how they reconstruct their social world. Exploring their social reality before the suicide is important because family members ruminate on their past experiences with the decedents and it recognises the importance of exploring the nature of their relationship rather than just the kinship relationship. Previous studies on suicide survivors have focused on the closeness of their relationship with the deceased because strong evidence suggests they are detrimentally affected by the death. However, the study highlighted how those who had an estranged relationship with the deceased were also negatively affected. These experiences strongly influence the intensity and variability of suicide survivors' grief reactions and the impact of the suicide (Begley & Quayle, 2007; Murray, 2003; Neimeyer et al., 2006; Wertheimer, 2001).

The model clearly emphasises the significance of the 'private' and 'public' self of participants, which has been key to identifying how they conceal or share aspects of themselves with others. In the model, differences between the self are shown in the context of: 'dealing with stigma of the suicide and the mental illness'; 'changing perceptions of the suicide'; 'creating symbolic ties with the deceased'; 'personal ways of coping', and 'dealing with the grief'.

Therefore, the model is dynamic because it reflects the multi-faceted structures, processes, learning and interactions of the participants as they deal with the impact of the suicide. This model can be used by health professionals, academics, policy-makers and researchers to understand the individuality and diversity of suicide survivors' experiences, their needs and how to better support them after a suicide.

This thesis has highlighted that health professionals failed to act on the concerns of participants when the mental health of the deceased deteriorated. This is worrying considering this issue is raised in literature with carers (Cormac & Tihanyi, 2006; DH, 2014a) and is problematic if there is an increased risk of suicide by a care-recipient. The Governmental suicide prevention policy strongly suggests that health professionals should act upon families' concerns and where possible involve them in the care planning of the patient (DH, 2012b). The implications of not involving families/carers is that after the suicide, participants' feelings of anger towards health services and clinicians intensified, because they considered there to have been missed opportunities to prevent the suicide. This in turn leads to more complicated grief reactions. It has been argued that these negative experiences can be considered a barrier to suicide survivors fully engaging in future postvention (Ward-Ciesielski et al., 2014), however, this was not found in the present study.

Many studies with carers/families report that they are fully involved in supporting the care-recipient, however this study showed the different levels of awareness or involvement participants had with mental health services. Some of the decedents concealed their mental illness because of the perceived stigma, embarrassment and shame, and also to avoid distressing others. However, most participants who were caring for or supporting the deceased reported how their own health and mental wellbeing was negatively affected. Critically, none of the participants received any information or support from health services to help them cope with the demands of care and this was consistently raised as a concern (Cormac & Tihanyi, 2006; Crowe & Lyness, 2014; Shah et al., 2010). Therefore, Mental Health Trusts or clinicians can use this study to support families/carers of care-recipients to minimise negative health outcomes, especially during these challenging times.

Another significant finding from this study is that, more so than with other types of death, the suicide adversely affected the health of participants and the mental health context of the deceased was an influential factor in contributing to these negative outcomes. There were clear differences in participants' perceptions of the suicide, such as a sudden death, which resulted in participants having a stronger need for "piecing the puzzle", more complex grief reactions and a greater risk of mental health problems. This process was important because some participants uncovered facts about the decedents such as non-compliance with medication, missed appointments with health services, expressions of suicidal intent to the

clinicians treating them and undisclosed suicide attempts. Consequently, a sudden suicide negatively affected these participants' grief experiences and caused difficulties in making sense of the suicide. On the other hand, a few participants anticipated the suicide because they had an in-depth understanding of the severity of the deceased's mental illness and their long-term engagement with mental health services. Relatively few studies have focused on anticipated suicide (Maple et al., 2007; Wojtkowiak et al., 2012) and therefore, the findings from this study contribute to empirical knowledge in understanding how and why this type of death is different compared to participants who experience a sudden or sudden but expected suicide.

Critically, none of the suicide survivors were offered any support by mental health services after the suicide. Most participants struggled to cope with the suicide and this a serious concern, because governmental guidelines (DH, 2017) recommend local NHS health services provide suicide survivors with information on bereavement services and offer them timely, appropriate and effective support. This is especially recommended if the deceased was a patient prior to their suicide (Pitman et al., 2016a).

There were some participants who accessed health services after the suicide and found postvention to be effective, because it met their needs. Counselling for example was long term, participants were able to express their feelings in a safe place without the fear of being judged and the 'experts' confirmed that grief was distinctive to each individual. However, most of them found postvention ineffective, because health professionals did not understand the distinctiveness of suicide bereavement or the interventions did not meet their needs. Therefore, these participants explored different avenues such as support groups like SOBS that met their needs because they wanted to find others who had experienced the suicide of a significant other. The literature on death identifies stereotypical grief reactions such as 'masculine' or 'feminine' grief (Versalle & McDowell, 2005), but none of the participants felt their gender influenced how they dealt with or coped with the suicide. As found in the study, a generic response by health services did not address most participants' needs and this strengthens the body of research that suggests clinicians and services providers should meet the individual needs of suicide survivors (Iglewicz et al., 2013; Bonanno & Boerner, 2007; Cerel et al., 2009; McMenemy et al., 2008).

The importance of involving suicide survivors in future research and designing service provision is consistent with taking a co-production approach to research and service design. This is essential to enable commissioners, policy-makers and health professionals to identify and implement more effective preventative interventions to reduce negative health outcomes for suicide survivors (Breen & O'Connor, 2007). This study would have been impossible without the contribution of the participants and has been key in capturing their experiences.

They have offered insights into their personal and often distressing experiences into how the suicide of the deceased impacted on them. Importantly, many respondents felt that participating in the study was a way of keeping the deceased's legacy alive by sharing their story with others. Moreover, all the respondents were clear that taking part in this research and the dissemination of the findings is to help suicide survivors in the future and possibly prevent future suicides.

Appendices

Appendix 1a: Interview schedule for family participants

Appendix 1(a)

Title of study: Understanding the impact of suicide by people who have been in receipt of mental health services on their family

Interview topic guide for family members

A topic guide consisting of the following areas of enquiry will be used during the interview:

1. Can you tell me about yourself?
(Age, occupation, residence, religion, ethnicity and residence, family structure, relationship to the deceased)
2. Can you tell me about what happened when the suicide occurred?
3. How did you feel at the time
-How did the suicide affect you?
4. Why in your opinion did the suicide happen?
5. How do you feel about the care that the patient received?
6. How did you cope at the time?
 - What support, if any, was offered to you and by whom?
 - When was that?
 - How helpful was it?
 - Is there any other help you could have benefited from at the time?
7. How are you coping now?
 - Do you have any support needs?
 - Are they being met?
8. Is there anything else you would like to add?

Appendix 1b: Interview topic guide for health professionals

Understanding the impact of suicide by people who were in receipt of mental health services on their family

Interview topic guide for health professionals

- a) Can you tell me about your role in (organisation)? (Professional background information)
- b) In what capacity & at what point did you come into contact with the (name of patient) & family?
- c) What contact have you had with suicide survivors & family?
- d) What support did you provide to the (name of the patient) & family?
- e) What support (if any) was requested from the suicide survivor?
- f) What were the needs of the suicide survivor and how could they be better supported?
- g) How do you think the suicide affected the suicide survivor?
- h) How did the suicide survivor feel about the services (name of patient) received from the Trust?
- i) What training and support (if any) did you receive on communicating with suicide survivors?
- j) What additional training and support would be useful to you when dealing with suicide survivors?

Appendix 2: Study research leaflet



With all of us in mind



University of
Huddersfield
Leading in learning, research and innovation

South West Yorkshire Partnership 
NHS Foundation Trust

Understanding the impact of suicide (or apparent suicide) by people who have been in receipt of mental health services on their family

WHY THIS STUDY IS IMPORTANT

The purpose of this study is to interview family members who have lost someone to suicide, and to learn about their experiences. I am also interested in finding out if the family has any particular needs which should be acknowledged and acted upon.

I would like to include health professionals in the study who have had contact with these families. Families will first be asked for their consent before I approach a health professional.

Involving health professionals will offer a further perspective and insight about experiences of people such as yourself. If you would not like a health professional to be involved, I would like to speak with you.

WHAT ARE THE BENEFITS OF TAKING PART?

Research in this area is very limited. The views of the family are valuable, and a summary of the research findings will be made available. This information will be passed on to service providers and should help them to improve the support they offer.

Who is eligible to take part?

With regards to family members, I am interested in talking with people who:

- Are 18 years of age or over
- Have lost a family member through suicide who was in receipt of mental health services within 12 months of them taking their own life
- Have received a report from the Patient Safety Team of South West Yorkshire Partnership Foundation Trust

With regards to health professionals, I am interested in talking with people who:

- Are a health professional who has had contact with the family of someone who has committed suicide
- Have been approached by the Patient Safety Team in the Trust following consent from the family of someone who has committed suicide

University of Huddersfield, room HHR1/12, School of Human and Health Sciences, Queensgate, HUDDERSFIELD, HD1 3DH

Leaflet on research for participants (v6) 09/06/14STAGE 1Appendix 2

I would really appreciate your participation in this research as your contribution is very valuable. If you would like to discuss participating in the study or have any questions or concerns about this study, you can contact me directly:
Farzana Ali, mobile number: 07936 201938 or office tel number 01484 472581.
Email: farzana.ali@hud.ac.uk.

Appendix 3a: Participant information sheet for PST family members

Appendix 3(a)



South West Yorkshire Partnership 
NHS Foundation Trust



Participant information sheet for family members

Understanding the impact of suicide by people who were in receipt of mental health services on their family

Introduction: My name is Farzana Ali. I would like to invite you to meet me to talk about taking part in a research study conducted for my PhD at the University of Huddersfield. The study is supported by South West Yorkshire Partnership NHS Foundation Trust. Before you decide whether you wish to take part, please take time to read the information below carefully. This is now yours to keep. If you have any questions, then please feel free to get in touch with me, using my contact details, which are given at the end of this information sheet. £20 will be given to family members who are interviewed in recognition of their participation in the research.

Why this study is important: The purpose of this study is to understand the impact of suicide by people who were in receipt of mental health services on family members. It is important to learn about their experiences in order to determine how best to help and support people.

I am also interested in finding out if these families have any particular needs, which should be acknowledged and acted upon. Passing on such findings should help to ensure that organisations who provide services could improve their services as necessary.

Who is eligible to take part:

I am interested in talking with people who:

- Are 18 years of age or over
- Have lost a family member through suicide who was in receipt of mental health services
- Have received a report from the Patient Safety Team of South West Yorkshire Partnership Foundation Trust, who investigate cases of suicide, within the last 3 years

With your permission, I would also like to interview a health professional known to the family. If possible, this health professional will be identified by you. Interviewing health professionals will offer an insight into how they think people experience the suicide of someone they know, and what they feel are the needs of the family. If you do not want me to speak to a professional, then I will not do so. But I would still like to interview you regardless of the involvement of a health professional.

What are the benefits of you taking part: Research in this area is very limited, so I am particularly interested in hearing and learning about how family members deal with suicide. You will have an opportunity to voice your experiences, and identify any needs

you may have. The results of this study will be published for health professionals and organisations, which will lead to an increased understanding of how family members deal with suicide. This information will be passed on to service providers, including the Mental Health Trust, and should help them to provide better support for others who have lost a family member through suicide. You will be asked if you would like to receive a copy of the research findings and/or invited to attend an event where it will be shared. You will be asked about both when completing the consent form.

Any travelling expenses or reasonable expenses such as childcare expenses incurred as a result of taking part in interviews will be reimbursed. As a token of our appreciation and your valuable contribution to the research, £20 will be offered to family members who are interviewed.

What will happen during the study:

You have received this information because you have agreed for your details to be passed to me by the Patient Safety Team in the Trust. Initially, I will contact you by telephone or email to discuss whether you are still interested in finding out more about the research study. I will ask you whether you would be willing to meet me to discuss the research. Having an initial meeting will give me an opportunity to introduce myself, to talk about the research study, and will allow you to ask any questions. However, if you do not wish to meet up for now, but still might be interested in participating in the study, then we can communicate via email or telephone to discuss the research and answer any questions you may have.

After our meeting or discussion, I will give you time to think about whether you wish to take part. After about a week I will contact you, and if you are happy to proceed, we will arrange a mutually convenient date and time for the interview. Before the interview starts, I will ask you to complete a consent form if you are still happy to take part. I will ask you a few questions about your background and circumstances.

The interview may take up to one hour, and, with your permission, it will be audio-recorded. There will always be an option of stopping the interview at any time if you wish. I will ask you to discuss your experience of losing a family member through suicide and your views about service support.

Protecting your privacy:

I will make every effort to protect your privacy and identity. I will not use your name in any of the information that I get from this study or in any of the research reports. Any identifiable information will be omitted from the research reports, such as the area where you live, the name of anyone you mention in the interview, or any other information which may reveal your identity or the person you lost to suicide. Your information will be kept in a locked area and will be destroyed after 5 years. Any information kept on my computer or laptop will be password protected and only accessible to me.

I may use quotes from your interview in the research, but will ensure these are kept anonymous, and will not include any information in the research, which will identify you.

Risks and discomforts: It may be possible that you will feel upset, during or after the interview. If so, please tell me and we can terminate or take a break. Information

regarding support services and helpline numbers will be made available to you on a separate sheet before the start of the interview.

In the highly unlikely event that you tell me something, which makes me concerned that you or someone else may be at risk, I may have to speak to a supervisor. However, I will speak to you first before I do so.

Your rights: It is up to you to decide whether or not to take part in the study, but if you do wish to take part, you will be asked to sign a consent form. During the interview, you do not have to answer all of the questions and can stop the audio recording at any time, have a break or terminate the interview.

Your role in this research project is voluntary, so you also have the right to withdraw from the study at any time without giving a reason. If you wish, your data will be erased.

If you want to take part in the study or you have any questions:

I would really appreciate talking to you about your participation in this research, as your contribution will be very valuable. If you would like to participate in the study or you have any questions or concerns about this study at any time, you can contact me, Farzana Ali, on my mobile on xxxxxxxxxxxx or farzana.ali@hud.ac.uk.

My office address is room HHR1/12, School of Human and Health Sciences, University of Huddersfield, Queensgate, HUDDERSFIELD, HD1 3DH.

Alternatively, if you have any concerns you can contact my research supervisors, Professor Mike Lucock on 01924 327560

Thank you for taking the time to read this information sheet.

Appendix 3b: Participant information sheet for NHS health professionals

Appendix 3(b)



South West Yorkshire Partnership 
NHS Foundation Trust



Participant information sheet for health professionals

Understanding the impact of suicide by people who were in receipt of mental health services on their family

Introduction to the study: My name is Farzana Ali. I would like to invite you to meet me to talk about taking part in a research study conducted for my PhD at the University of Huddersfield. The study is supported by South West Yorkshire Partnership NHS Foundation Trust. Before you decide whether you wish to take part, please take time to read the information below carefully. This is now yours to keep. If you have any questions, then please feel free to contact me on my details which are given at the end of the information

Why this study is important: The purpose of this study is to understand the impact of suicide by people who were in receipt of mental health services on family members. It is important to learn about their experiences in order to determine how best to help and support people.

Research in this area is very limited, so I am particularly interested in hearing about how family members deal with suicide.

Including health professionals in the study can offer a further perspective and insight into peoples' experiences of losing someone through suicide. Understanding the needs of these families is important in this study, in order to ensure that the findings from this research study generate new information, build on existing knowledge which will inform and influence policy makers, service providers and service provision.

Who is eligible to take part:

I am interested in talking with people who:

- Are a health professional who has had contact with the family of someone who has committed suicide
- Have been approached by the Patient Safety Team in the Trust following consent from the family of someone who has committed suicide

What will happen during the study?

You have received this information because you have agreed for your details to be passed to me by the Patient Safety Team in the Trust. Initially, I will contact you by telephone or email to discuss whether you are still interested in finding out more about the research study. I will give you time to think about whether you wish to take part. After one week I will contact you and if you still happy to proceed we will arrange a mutually convenient date and time for the interview at an agreed location. I will meet with you individually in person, and again before the interview starts I will ask you to complete a consent form if you agree to take part. I will ask you a few questions about

your background, circumstances and some questions on your experiences of supporting people who have lost someone to suicide.

The interview may take about half an hour, and, with your permission, the interview will be audio recorded. If at any time you want to stop, then the audio recording will be stopped.

Protecting your privacy:

I will make every effort to protect your privacy and identity. I will not use your name in any of the information that I get from this study or in any of the research reports. Any identifiable information will be omitted from the research, such as where you work, the name of anyone you mention in the interview, or any other information which may reveal your identity. Your personal information including your typed up interview will be kept in a locked area and will be destroyed after 5 years. Any information kept on my computer or laptop will be password protected and only accessible to me.

I may use quotes from your interview in the research, but will ensure your details are kept confidential, and will not include any information in the research which will identify you.

Risks and discomforts: It may be possible that you may feel upset before, during or after the interview. If so, please tell me and we can terminate the interview or take a break. Information regarding local support services and helpline numbers will be made available to you on a separate sheet, including staff support services such as staff counselling before the start of the interview.

In the highly unlikely event that you tell me something which makes me concerned that you or someone else may be at risk, I may have to speak to a supervisor. However, I will speak to you first before I do so.

Your rights: It is up to you to decide whether or not to take part, but if you do wish to take part, you will be asked to sign a consent form. During the interview, you don't have to answer all of the questions and can stop the audio recording at any time, have a break or terminate the interview.

Your role in this research project is voluntary, so you also have the right to withdraw from the study at any time without giving a reason. If you wish your data will be erased.

If you want to be a part of the study or you have any questions:

I would really appreciate talking to you about your participation in this research as your contribution will be very valuable. If you would like to participate in the study or you have any questions or concerns about this study at any time, you can contact me, Farzana Ali, on xxxxxxxxxxxx or farzana.ali@hud.ac.uk.

My office address is room HHR1/12, School of Human and Health Sciences, University of Huddersfield, Queensgate, HUDDERSFIELD, HD1 3DH.

Alternatively, if you have any concerns you can contact my research supervisors, Professor Bob Heyman 01484 471124 or Professor Mike Lucock 01924 327560.

Thank you for taking the time to read this information sheet.

Appendix 4: PST family member contact details form for researcher

ID Number

CONFIDENTIAL

Appendix 4



South West Yorkshire Partnership **NHS**
NHS Foundation Trust



Understanding the impact of suicide by people who were in receipt of mental health services on their family

I agree for my details to be passed to the researcher carrying out this study to contact me. I also understand that I am only agreeing to discuss the study with the researcher at this stage.

Name:

Address:

.....

Postcode: Telephone number:

Email address:

Best method of contact: (please tick a box)

Post

Email

Telephone

Preferred day(s) and time(s) of contact

.....

.....

Signature: _____ Date: _____

Please return completed form to:

Farzana Ali
University of Huddersfield
Room HHR1/12, School of Human and Health Sciences
Queensgate, HUDDERSFIELD, HD1 3DH
Email: farzana.ali@hud.ac.uk

Office telephone number: 01422 472581

Contact details form (v1) 03/10/13

STAGE 2 (family) & STAGE 7 (health professionals)

Appendix 5a: PST family members consent form

ID Number



Appendix 5a

South West Yorkshire Partnership 
NHS Foundation Trust



Participant consent form for family members

Understanding the impact of suicide (or apparent suicide) by people who have been in receipt of mental health services on their family

It is important that you read, understand and sign the consent form. Your contribution to this research is voluntary and you are not obliged in any way to participate.

Please initial each box

- I have read and understood the information sheet and have had the opportunity to ask questions
- I understand I am entering the study voluntarily and I am free to withdraw at any time without giving any reason
- I understand that I may withdraw my interview from the study if I no longer wish to be part of the research
- I give permission for my words to be quoted (by use of pseudonym)
- I would / would not like a summary of the research once completed
- I would / would not like to attend a learning and sharing event
- I consent to take part in the study
- I understand that the information collected will be kept in secure conditions for a period of 5 years in line with University guidelines
- I understand that my identity will be protected by the use of pseudonym in the report and that no written information could lead to me being identified will be included in any report
- I consent to the interview being audio-recorded

Participant Name: _____ Signature: _____

Date: _____

Researcher Name: _____ Signature: _____

Date: _____

Both researcher & participant to initial each box (One to be retained by the participant and one copy to be retained by the researcher)

Family consent form (v7) 09/06/14

STAGE 6

Appendix 5b: Participant consent form for NHS health professionals

ID Number

Appendix 5b



Participant consent form for health professionals

Understanding the impact of suicide by people who were in receipt of mental health services on their family

It is important that you read, understand and sign the consent form. Your contribution to this research is voluntary and you are not obliged in any way to participate.

Please initial each box

- I have read and understood the information sheet and have had the opportunity to ask questions.
- I understand I am entering the study voluntarily and I am free to withdraw at any time without giving any reason
- I understand that I may withdraw my interview from the study if I no longer wish to be part of the research.
- I give permission for my words to be quoted (by use of pseudonym)
- I would/would not like a summary of the research once completed
- I would / would not like to attend a learning and sharing event
- I understand permission has been received from the patient's family
- I consent to take part in the study
- I understand that the information collected will be kept in secure conditions for a period of 5 years in line with NHS guidelines
- I understand that my identity will be protected by the use of pseudonym in the report and that no written information could lead to me being identified will be included in any report

Participant Name: _____ Signature: _____ Date: _____

Researcher Name: _____ Signature: _____ Date: _____

Both researcher & participant to initial each box
(One to be retained by the participant and one copy to be retained by the researcher)

Health professional consent form (v 5) 03/10/13

STAGE 9 (health professionals)

Appendix 6a: PST family members letter of invitation

Appendix 6(a)



South West Yorkshire Partnership 
NHS Foundation Trust



School of Human and Health Sciences
Room HHR1/12
University of Huddersfield
Queensgate
HUDDERSFIELD HD1 3DH

(INSERT DATE)

Dear (INSERT NAME)

Understanding the impact of suicide by people who were in receipt of mental health services on their family

Letter of invitation for family members to take part in a research study

My name is Farzana Ali. I am a PhD research student at the University of Huddersfield. You have been sent this letter and attached information because you have agreed for your details to be passed on to me by the Patient Safety Team of South West Yorkshire Partnership NHS Foundation Trust, with your consent, so that I can discuss your possible participation in the research study with you.

The purpose of this study is to learn about the experiences of people who have lost a family member through suicide, and to find out how support for them might be improved. I would also like to talk confidentially to a health professional who has been involved with you. But I would only do this with your consent and it will be fine for you to participate in the study, if you agree, but not consent to me talking to a health professional.

Please read the attached information sheet for more details on the research. I will be contacting you in one week's time to find out if you are willing to meet to discuss possible participation or if you would like to take part in the research. In the meantime, if you have any further questions or concerns, please do not hesitate to contact me.

Email address: farzana.ali@hud.ac.uk
Telephone numbers: Office (01484) 472581 or mobile xxxxxxxxxxxx

Thank you for your time.

Yours sincerely,

Farzana Ali

Covering letter for family (V4) 03/10/13

STAGE 4 (family)

Appendix 6b: Letter of invitation for NHS health professionals to take part in the study



South West Yorkshire Partnership **NHS**
NHS Foundation Trust



School of Human and Health Sciences
Room HHR1/12
University of Huddersfield
Queensgate
HUDDERSFIELD HD1 3DH

Appendix 6(b)

(INSERT DATE)

Dear (INSERT NAME)

Understanding the impact of suicide by people who were in receipt of mental health services on their family

Letter of invitation for health professionals to take part in a research study

My name is Farzana Ali. I am a PhD research student at the University of Huddersfield. You have been sent this letter and attached information because your details have been passed on to me by the Patient Safety Team of South West Yorkshire Partnership NHS Foundation Trust, with your consent, so that I can discuss your possible participation in the research study with you.

The purpose of this study is to learn about the experiences of people who have lost a family member through suicide, and to find out how support for them might be improved. Including health professionals in the study can offer a further perspective and insight into peoples' experiences of losing someone to suicide.

I would like to invite you to participate in the research as a health professional who has been involved with a family whose relative has commit suicide. The family member involved in this research has already consented to a health professional who has been in contact with them being approached.

Please read the attached information for more details on the research. I have also included a contact details form. If you are willing to meet me to discuss possible participation, please complete the enclosed form and return to me in the self-addressed envelope. In the meantime, if you have any further questions or concerns, please do not hesitate to contact me.

Email address: farzana.ali@hud.ac.uk
Telephone numbers: Office (01484) 472581 or mobile xxxxxxxxxxxx

Thank you for your time.

Yours sincerely,

Farzana Ali

Appendix 7: Support organisations list for PST participants

Appendix 7

SUPPORT ORGANISATIONS LIST FOR PEOPLE WHO HAVE EXPERIENCED THE LOSS OF A FAMILY MEMBER THROUGH SUICIDE

Please note this list is not exhaustive but offers suggestions for organisations which you may find useful.

CRUSE Bereavement Care	<ul style="list-style-type: none">• Helpline 0844 477 9400• Young People's Helpline 0808 808 1677• www.crusebereavementcare.org.uk
CRUSE local branches	<ul style="list-style-type: none">• Kirklees Area telephone number: 0844 800 3309• Leeds Branch telephone number: 0113 234 4150• Pontefract and Wakefield Branch telephone number: 01977 708335
Bereavement Advice Centre	<ul style="list-style-type: none">• Freephone number 0800 634 9494 (<i>a charge may be made by some mobile networks</i>)• www.bereavementadvice.org
Survivors of Bereavement by Suicide	<ul style="list-style-type: none">• National Helpline - 08445616855 (9am to 9pm every day)• Local branch at Leeds Bereavement Forum• Helps people express grief and come to terms with loss• 0113 225 3975• www.lbforum.org.uk
The Samaritans	<ul style="list-style-type: none">• Helpline, 24 hours a day, 7 days a week.• 08457 909090• www.samaritans.org.uk
South West Yorkshire Partnership NHS Foundation Trust Customer Services	<ul style="list-style-type: none">• For comments, compliments, concerns and complaints• 0800 587 2108• Email: customer.services@swyt.nhs.uk

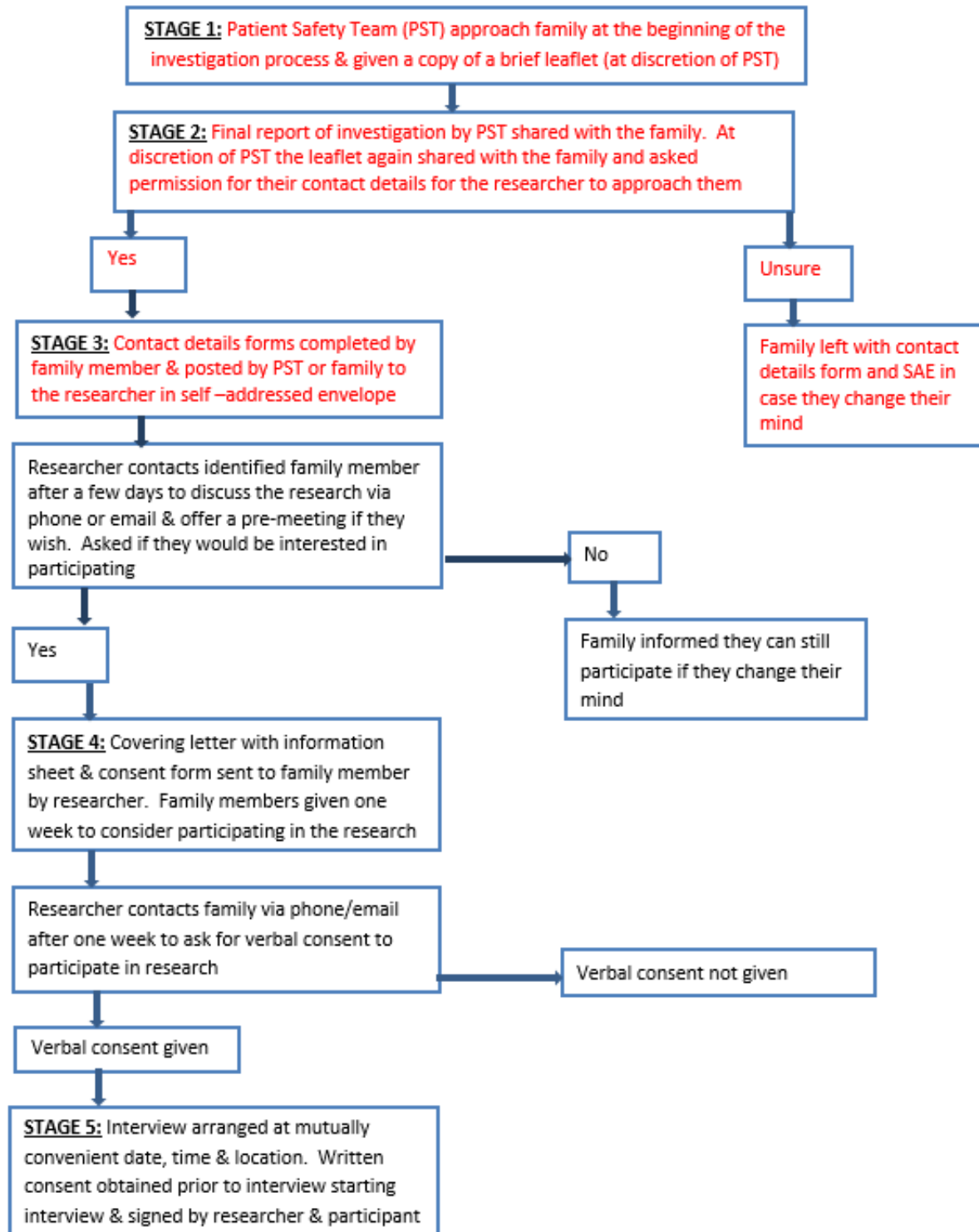
If you feel that you need more information or support from health services then it may be beneficial to speak to your GP first.

List of helpline numbers for participants v1 (03/10/13)

STAGE 5 (family) & STAGE 9 (health professionals)

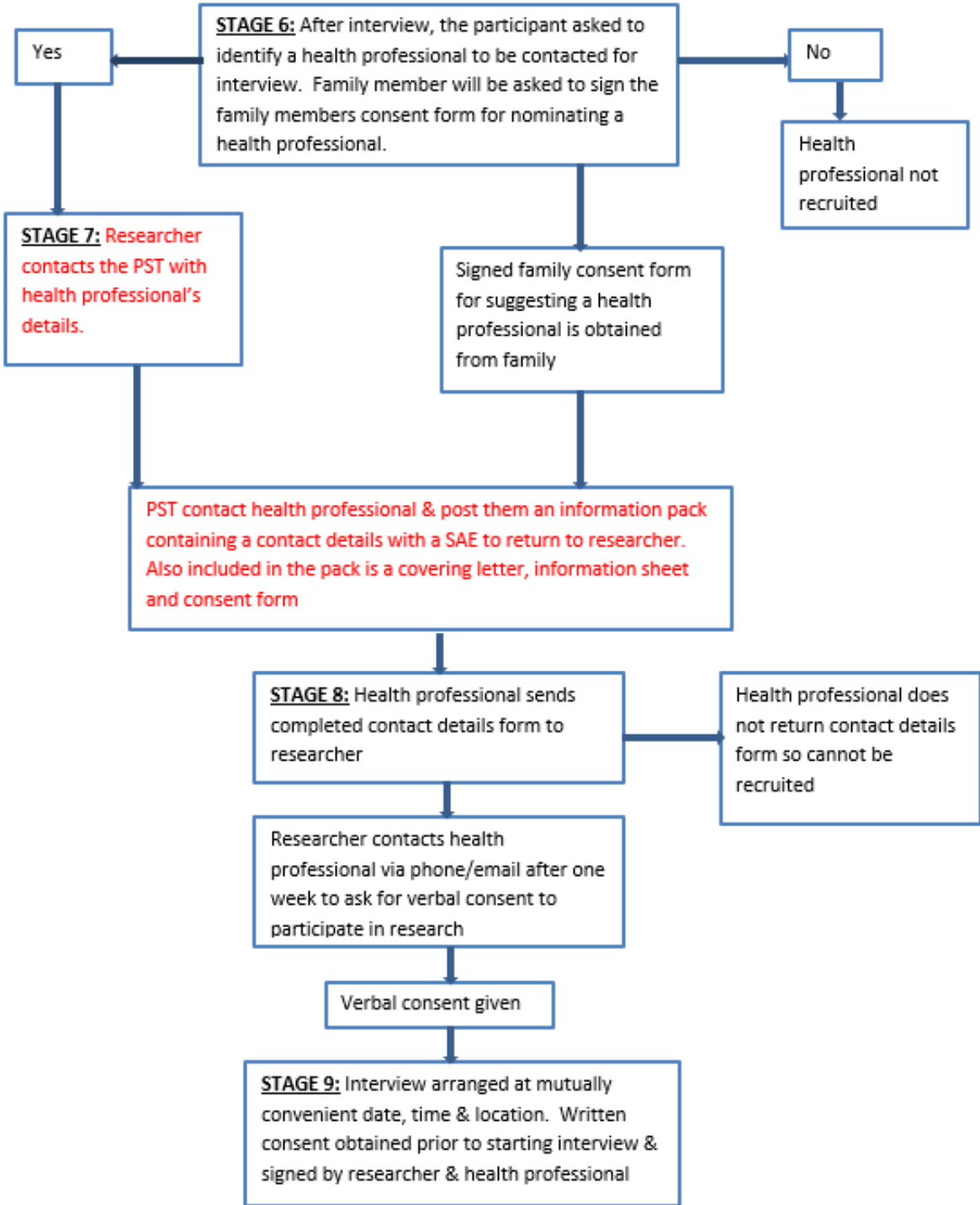
Appendix 8: PST process of recruiting participants

Please note: Stages 1 – 5 refer to recruitment of family members



Appendix 8: PST process of recruiting participants

Please note: Stages 6 – 9 refer to recruitment of health professionals



Appendix 9: PST family participant nomination form for health professional

ID Number

CONFIDENTIAL Appendix 9



South West Yorkshire Partnership 
NHS Foundation Trust



Understanding the impact of suicide (or apparent suicide) by people who have been in receipt of mental health services on their family

I agree for (NAME OF HEALTH PROFESSIONAL) to be approached to ask their views on understanding the impact of suicide on the family and their views on the needs of the family.

Signature: _____ Date: _____
(Family Member)

Signature: _____ Date: _____
(Researcher)

Appendix 10: SOBS research leaflet

Understanding the impact of suicide by people who have been in receipt of mental health services on their family


WHY THIS STUDY IS IMPORTANT

The purpose of this study is to interview family members who have lost someone to suicide, and to learn about their experiences. I am also interested in finding out if the family has any particular needs which should be acknowledged and acted upon.

WHAT ARE THE BENEFITS OF TAKING PART?

Research in this area is very limited. The views of the family are valuable, and a summary of the research findings will be made available. This information will be passed on to service providers and should help them to improve the support they offer.

In recognition of your valuable contribution to the research, a £20 voucher will be offered to family members who are interviewed.



University of
HUDDERSFIELD
Inspiring tomorrow's professionals

Who is eligible to take part?

I am interested in talking with people who:

- Are 18 years of age or over
- Have lost a family member through suicide who was in receipt of mental health services within 12 months of them taking their own life
- Would be agreeable in sharing their experience with me

I would really appreciate your participation in this research as your contribution is very valuable. If you would like to discuss participating in the study or have any questions or concerns about this study, you can contact me directly:

Farzana Ali, PhD Researcher
Mobile number: 07936 201938
or office telephone number: 01484 472581
Email: Farzana.ali@hud.ac.uk

If you would like me to contact you, please complete this slip and return it to:
Farzana Ali, PhD Researcher, University of Huddersfield, room HHR1/12, School of Human and Health Sciences, Queensgate, HUDDERSFIELD, HD1 3DH

Name:

Address:

..... Postcode:

Telephone or mobile number:

Email address:

SOBS research leaflet for family participants (v1) 28/02/14 Appendix 11

Leaflet on research for participants (v1)18/02/14

Appendix

Appendix 11: Participant information sheet for SOBS family members



Participant information sheet for family members

Understanding the impact of suicide by people who have been in receipt of mental health services on their family

Introduction: My name is Farzana Ali. I would like to invite you to meet me to talk about taking part in a research study conducted for my PhD at the University of Huddersfield. The study is supported by South West Yorkshire Partnership NHS Foundation Trust. Before you decide whether you wish to take part, please take time to read the information below carefully. This is now yours to keep. If you have any questions, then please feel free to get in touch with me, using my contact details which are given at the end of this information sheet.

Why this study is important: The purpose of this study is to understand the impact of suicide by people who were receiving mental health services on family members. It is important to learn about your experiences in order to determine how best to help and support people.

I am also interested in finding out if you have any particular needs which should be acknowledged and acted upon. Passing on such findings should help to ensure that organisations who provide services can improve their services as necessary.

Who is eligible to take part:

I am interested in talking with people who:

- Are 18 years of age or over
- Have lost a family member through suicide who was in receipt of mental health services
- Are prepared to share their experience with me

What are the benefits of you taking part: Research in this area is very limited, so I am particularly interested in hearing about how family members deal with suicide. You will have an opportunity to voice your experiences, and identify any needs you may have. The results of this study will be published for health professionals and organisations, which will lead to an increased understanding of how you deal with suicide. The findings from the study will be passed on to the Trust, and should help them to provide better support for others who have lost a family member through suicide. You will be asked if you would like to receive a copy of the research findings and/or invited to attend an event where it will be shared. You will be asked about both when completing the consent form.

As a token of our appreciation and your valuable contribution to the research, a £20 voucher will be offered to each family member who is interviewed.

What will happen during the study:

After you have contacted me or given me permission to contact you, I will discuss the research study with you and answer any questions you may have. After our discussion, I will give you time to think about whether you wish to take part. After about a week I will contact you, and if you are happy to proceed, we will arrange a mutually convenient date and time for the interview. Before the interview starts, I will ask you to complete a consent form if you are still happy to take part. You may also wish to have a joint interview with you and another family member. In the case of joint interviews, I will ask you both to read through the participant information sheet and read and sign your own consent forms.

The interview may take up to one hour, and, with your permission, the will be audio-recorded. There will always be an option of stopping the interview at any time if you wish. I will ask you to discuss your experience of losing a family member through suicide and your views about service support.

Protecting your privacy:

I will make every effort to protect your privacy and identity. I will not use your name in any of the research reports. Any identifiable information will be omitted from the research reports, such as the area where you live, the name of anyone you mention in the interview, or any other information which may reveal your identity or the person you lost to suicide. Your information will be kept in a locked area and will be destroyed after 5 years. Any information kept on my computer or laptop will be password protected and only accessible to me. I may use quotes from your interview in the research, but will ensure these are kept anonymous.

Risks and discomforts:

It may be possible that you will feel upset, during or after the interview. If so, please tell me and we can terminate or take a break. Information regarding support services and helpline numbers will be made available to you on a separate sheet.

Every effort will be made to keep your involvement in the research confidential. Although it is unlikely, if anything you tell me leads me to believe that you or someone else is at risk of immediate or future harm, I may have to break confidentiality by speaking with my supervisor to decide upon the most appropriate course of action. This may then involve contacting the relevant authorities in interest of protecting you or others. If this is necessary I would hope to discuss it with you first.

Your rights:

It is up to you to decide whether or not to take part in the study, but if you do wish to take part, you will be asked to sign a consent form. During the interview, you don't have to answer all of the questions and can stop the audio recording at any time, have a break or terminate the interview.

Your role in this research project is voluntary, so you also have the right to withdraw from the study at any time without a reason. If you wish your data will be erased.

If you want to take part in the study or you have any questions:

I would really appreciate talking to you about your participation in this research as your contribution will be very valuable. If you have any questions or concerns about this study at any time, you can contact me, Farzana Ali, on my mobile on 07936 201938 or farzana.ali@hud.ac.uk.

My office address is room HHR1/12, School of Human and Health Sciences, University of Huddersfield, Queensgate, HUDDERSFIELD, HD1 3DH. My office telephone number is 01484 472581.

Alternatively, if you have any concerns you can contact my research supervisor, Professor Mike Lucock, on 01924 327560

Thank you for taking the time to read this information sheet.

Appendix 12: Letter of invitation for PST family members to take part in the study

School of Human and Health Sciences
Room HHR1/12
University of Huddersfield
Queensgate
HUDDERSFIELD HD1 3DH

(INSERT DATE)

Dear (INSERT NAME)

Understanding the impact of suicide by people who have been in receipt of mental health services on their family

Letter of invitation for family members to take part in a research study

My name is Farzana Ali. I am a PhD research student at the University of Huddersfield. You have been sent this letter and attached information because you have expressed an interest in finding out more about the research study.

The purpose of this study is to learn about the experiences of people who have lost a family member through suicide, and to find out how support for them might be improved.

Please read the attached information sheet for more details on the research. I will be contacting you in one week's time to find out if you are willing to meet to discuss possible participation or if you would like to take part in the research. In the meantime, if you have any further questions or concerns, please do not hesitate to contact me.

Email address: farzana.ali@hud.ac.uk
Telephone numbers: Office (01484) 472581 or mobile 07936 201938

Thank you for your time.

Yours sincerely,

Farzana Ali

Appendix 13: SOBS family member's helpline list

HELPLINE NUMBERS

FOR PEOPLE WHO HAVE EXPERIENCED THE LOSS OF A FAMILY MEMBER THROUGH SUICIDE

Please note this list is not exhaustive but offers suggestions for organisations which you may find useful.

CRUSE Bereavement Care

- Helpline 0844 477 9400
- Young People's Helpline 0808 808 1677
- Website: www.crusebereavementcare.org.uk

CRUSE local branches

- Kirklees Area telephone number: 0844 800 3309
- Leeds Branch telephone number: 0113 234 4150
- Pontefract and Wakefield Branch telephone number: 01977 708335

Bereavement Advice Centre

- Freephone number 0800 634 9494 (*a charge may be made by some mobile networks*)
- www.bereavementadvice.org

Survivors of Bereavement by Suicide

- National Helpline - 0300 111 5065 (9am to 9pm every day)
- Email support available: sobs.support@hotmail.com
- Website: www.uk-sobs.org.uk
- Have locality based bereavement support groups

The Samaritans

- Helpline, 24 hours a day, 7 days a week. 08457 909090
- www.samaritans.org.uk

Leeds Bereavement Forum

- Local branch at Leeds Bereavement Forum
- Helps people express grief and come to terms with loss
- Telephone: 0113 225 3975
- Website: www.lbforum.org.uk

If you feel that you need more information or support from health services then it may be beneficial to speak to your GP first.

Appendix 14: PST retrospective cases invitation letter for family participants

School of Human and Health Sciences
Room HHR1/12
University of Huddersfield
Queensgate
HUDDERSFIELD HD1 3DH

(INSERT DATE)

Dear (INSERT NAME)

Understanding the impact of suicide by people who have been in receipt of mental health services on their family

Letter of invitation for family members to take part in a research study

My name is Farzana Ali. I am a PhD research student at the University of Huddersfield. You have been sent this letter and attached information because you have expressed an interest in finding out more about the research study.

The purpose of this study is to learn about the experiences of people who have lost a family member through suicide, and to find out how support for them might be improved.

Please read the attached information sheet for more details on the research. I will be contacting you in one week's time to find out if you are willing to meet to discuss possible participation or if you would like to take part in the research. In the meantime, if you have any further questions or concerns, please do not hesitate to contact me.

Email address: farzana.ali@hud.ac.uk
Telephone numbers: Office (01484) 472581 or mobile 07936 201938

Thank you for your time.

Yours sincerely,

Farzana Ali

Appendix 15: PST retrospective cases summary to Lead Investigators

Project title:

Understanding the impact of suicide on families where the deceased was in receipt of mental health services

Retrospective cases

I am also interested in approaching families who lead investigators may have already been in contact with and shared the investigation report with from 2011 until now. If you feel any of these families would welcome the opportunity to share their experiences with me, I would be grateful if you would send them a copy of the contacts details form (appendix 4), the leaflet on research for participants (appendix 2) and a self-addressed envelope.

Sample:

Inclusion criteria:

Family members who:

- Are 18 years of age or over
- Have lost a family member through suicide who was in receipt of mental health services. Immediate family includes partner, parent, child or equivalent
- Have received an investigation report from the Patient Safety of South West Yorkshire Partnership Foundation Trust (SWYPFT) within the last 12 months
- To the knowledge of the Patient Safety Team, do not pose any risks to the researcher

Appendix 16: Covering letter to SOBS helpline workers

School of Human and Health Sciences
Room HHR1/12
University of Huddersfield
Queensgate
HUDDERSFIELD HD1 3DH

(INSERT DATE)

Dear (INSERT NAME)

Understanding the impact of suicide by people who have been in receipt of mental health services on their family

Letter of invitation for SOBS helpline workers to take part in a research study

My name is Farzana Ali and I am a PhD research student at the University of Huddersfield. The purpose of this study is to learn about the experiences of people who have lost a family member through suicide, and to find out how support for them might be improved.

I am in the process of interviewing family members for my research and many participants have discussed how they benefit from sharing their suicide bereavement experiences with others who have lost a loved one to suicide. In order to explore this further, I would like to interview SOBS helpline workers who have experienced the suicide of a loved one and who have a minimum of 2 years experience in offering peer support through their role as helpline workers. I would like to interview you over the telephone to ask you some questions such as your motivation for becoming a helpline worker, why you feel families would prefer to speak with you rather than health professionals, and your general experiences in supporting people who are bereaved by suicide through the helpline.

Please find attached an information sheet which gives you more details of the study and a consent form which outlines your rights if you agree to take part in the telephone interview.

If you are willing to discuss your possible participation in a telephone interview, or have any questions or concerns, please do not hesitate to contact me.

Email address: farzana.ali@hud.ac.uk
Telephone numbers: Office (01484) 472581 or mobile 07936 201938

Thank you for your time.

Yours sincerely,

Farzana Ali

Appendix 17: Participant information sheet for SOBS helpline workers



Participant information sheet for SOBS helpline workers

Understanding the impact of suicide by people who have been in receipt of mental health services on their family

Introduction: My name is Farzana Ali. I would like to invite you to meet me to talk about taking part in a research study conducted for my PhD at the University of Huddersfield. The study is supported by South West Yorkshire Partnership NHS Foundation Trust. Survivors of Suicide Bereavement have also supported this study. Before you decide whether you wish to take part, please take time to read the information below carefully. This is now yours to keep. If you have any questions, then please feel free to get in touch with me, using my contact details which are given at the end of this information sheet.

Why this study is important: The purpose of this study is to understand the impact of suicide by people who were receiving mental health services on family members. I am in the process of interviewing family members for my research and many participants have discussed how they benefit from sharing their suicide bereavement experiences with others who have lost a loved one to suicide. In order to explore this further, I would like to interview SOBS helpline workers who have experienced the suicide of a loved one and who have a minimum of 2 years experience in offering peer support through their role as helpline workers. I would like to interview you over the telephone to ask you some questions, such as your motivation for becoming a helpline worker, why you feel families would prefer to speak with you rather than health professionals, and your general experiences in supporting people who are bereaved through suicide. I would also like to ask you how your role as a helpline worker has impacted on your suicide bereavement experience. It is important to learn about your experiences in order to determine how best to help and support people who are bereaved through suicide.

I am also interested in finding out if you have any particular needs which should be acknowledged and acted upon. Passing on such findings should help to ensure that organisations who provide services can improve their services as necessary.

Who is eligible to take part:

I am interested in talking with people who:

- Are 18 years of age or over
- Have lost a family member through suicide who was in receipt of mental health services
- Volunteer for SOBS as a helpline worker for at least 2 years or more

What are the benefits of you taking part: Research in this area is very limited, so I am particularly interested in hearing about how SOBS helpline workers support people who have lost a loved one to suicide. You will have an opportunity to voice your experiences, and identify any needs you may have. The results of this study will be published for health professionals and organisations, which will lead to an increased understanding of how

you deal with suicide. The findings from the study will be passed on to South West Yorkshire Partnership NHS Foundation Trust, and should help them to provide better support for others who have lost a family member through suicide. These findings will be anonymised, so participants in the study will not be identifiable in the information shared with the Trust or any organisation. You will be asked if you would like to receive a copy of the research findings and/or invited to attend an event where it will be shared. You will be asked about both when completing the consent form.

How will you agree to be interviewed:

After you have contacted me or given me permission to contact you, I will discuss the research study with you and answer any questions you may have. After our discussion, I will give you time to think about whether you wish to take part. After about a week I will contact you, and if you are happy to proceed, and I will arrange a mutually convenient date and time for the telephone interview. When I ring you for the telephone interview, you will have an opportunity to share any concerns or ask any questions. I will then talk through the consent form which outlines your rights in taking part in the study and how your information will be anonymised, kept confidential and if you consent to the telephone interview being audio-recorded. Your verbal consent to be interviewed will be audio recorded to ensure I have a record of what you have given me permission for. The telephone interview should take no longer than one hour.

Protecting your privacy:

I will make every effort to protect your privacy and identity. I will not use your name in any of the research reports. Any identifiable information will be omitted from the research reports, such as the area where you live, or any other information which may reveal your identity or the person you lost to suicide. Your information will be kept in a locked area and will be destroyed after 5 years. Any information kept on my computer or laptop will be password protected and only accessible to me. I may use quotes from the telephone interview in the research, but will ensure these are kept anonymous.

Risks and discomforts:

It may be possible that you will feel upset, during or after the telephone interview. If so, please tell me and we can stop or take a break. Information regarding helpline numbers is also attached should you wish to access other support services.

Every effort will be made to keep your involvement in the research confidential. Although it is unlikely, if anything you tell me leads me to believe that you or someone else is at risk of immediate or future harm, I may have to break confidentiality by speaking with my supervisor to decide upon the most appropriate course of action. This may then involve contacting the relevant authorities in the interest of protecting you or others. If this is necessary I would hope to discuss it with you first.

Your rights:

It is up to you to decide whether or not to take part in the study, and your decision will not be disclosed to anyone outside the research team and will not impact on the support you receive

from SOBS. However, if you do wish to take part, you will be asked to sign a consent form. During the telephone interview, you don't have to answer all of the questions and can ask me to pause or stop the audio recording at any time.

Your role in this research project is voluntary, so you also have the right to withdraw from the study at any time without a reason. If you wish your data will be erased.

If you want to take part in the study or you have any questions:

I would really appreciate talking to you about your participation in this research as your contribution will be very valuable. If you have any questions or concerns about this study at any time, you can contact me, Farzana Ali, on my mobile on **07936 201938** or farzana.ali@hud.ac.uk.

My office address is room HHR1/12, School of Human and Health Sciences, University of Huddersfield, Queensgate, HUDDERSFIELD, HD1 3DH. My office telephone number is 01484 472581.

Alternatively, if you have any concerns you can contact my research supervisor, Professor Mike Lucock, on 01924 327560

Thank you for taking the time to read this information sheet.

Appendix 18: Participant consent form for SOBS helpline workers



Participant consent form for helpline workers

Understanding the impact of suicide by people who have been in receipt of mental health services on their family

It is important that you read and understand the consent form before the telephone interview. Before I start the telephone interview, I will read through the points and ask for your verbal consent which will be audio-recorded as a record of what you are giving me permission for.

Your contribution to this research is voluntary and you are not obliged in any way to participate.

Please initial each box

- I have read and understood the information sheet and have had the opportunity to ask questions
- I understand I am entering the study voluntarily and I am free to withdraw at any time without giving any reason
- I understand that I may withdraw my interview from the study if I no longer wish to be part of the research
- I give permission for my words to be quoted (by use of pseudonym)
- I would / would not like a summary of the research once completed
- I would / would not like to attend a learning and sharing event
- I consent to take part in the study
- I understand that the information collected will be kept in secure conditions for a period of 5 years in line with University guidelines
- I understand that my identity will be protected by the use of pseudonym in the report and that no written information could lead to me being identified will be included in any report
- I consent to the telephone interview being audio-recorded

Participant Name: _____ Date: _____

Appendix 19: Interview schedule for SOBS helpline workers

Interview questions for SOBS helpline workers

- a) What motivated you to become a volunteer for the helpline?
 - How long have you been doing this role?
 - Has it changed over time?

- b) What do you gain as a helpline worker from talking to people?
 - Does it help with your grief?
 - How? In what ways?
 - Benefits?
 - Difficulties?

- c) What do you bring to the role as a helpline worker?

- d) What do you think people who ring the helpline gain from talking to a helpline worker rather than a health professionals? Or family members?

- e) What support do people who ring the helpline ask for?
 - Can you give examples

- f) Do people who ring the helpline find it more appealing than going for counselling for example or attending a group?
 - Why do you think this is the case?

- g) What support do you receive as helpline workers from SOBS?

- h) Are there times when you're unable to help people?

Appendix 20: Study leaflet for the focus group

Understanding the impact of suicide by people who have been in receipt of mental health services on their family



INVITATION TO A FOCUS GROUP DISCUSSION

WHY THIS STUDY IS IMPORTANT

The purpose of this study is to understand how family members experience the suicide of a loved one and to learn about their experiences.

I am in the process of exploring the findings which are emerging from the interviews I have completed with some family members. Therefore, I would like to invite you to a focus group where I can share some of my findings with you and would welcome an opportunity to hear your views.

WHAT ARE THE BENEFITS OF TAKING PART?

Research in this area is very limited. The views of the family are valuable, and a summary of the research findings will be made available. This information will be passed on to service providers and should help them to improve the support they offer.

Who is eligible to take part?

I am interested in talking with people who:

- Are 18 years of age or over
- Have lost a family member through suicide who was in receipt of mental health services within 12 months of them taking their own life

I would really appreciate your participation in this research as your contribution is very valuable. If you would like to discuss participating in the study or have any questions or concerns about this study, you can contact me directly:

Farzana Ali, PhD Researcher
Mobile number: 07936 201938
Or office telephone number: 01484 472581
Email: Farzana.ali@hud.ac.uk

If you would like me to contact you, please complete this slip and return it to:
Farzana Ali, PhD Researcher, University of Huddersfield, room HHR1/12, School of Human and Health Sciences, Queensgate, HUDDERSFIELD, HD1 3DH

Name:

Address:

Postcode:

Telephone or mobile number:

Email address:

Appendix 21: Participant information sheet for focus group



Participant information sheet for focus group

Understanding the impact of suicide by people who have been in receipt of mental health services on their family

Introduction: My name is Farzana Ali. I would like to invite you to meet me to talk about taking part in a research study conducted for my PhD at the University of Huddersfield. The study is supported by South West Yorkshire Partnership NHS Foundation Trust. Survivors of Suicide Bereavement have also supported this study. Before you decide whether you wish to take part, please take time to read the information below carefully. This is now yours to keep. If you have any questions, then please feel free to get in touch with me, using my contact details which are given at the end of this information sheet.

Why this study is important: The purpose of this study is to understand the impact of suicide by people who were receiving mental health services on family members. It is important to learn about your experiences in order to determine how best to help and support people who are bereaved through suicide. I am in the process of exploring the findings which are emerging from the interviews I have completed so far with some family members. I would now like to share some of my findings with you and would welcome an opportunity to hear your views.

Who is eligible to take part:

I am interested in talking with people who:

- Are 18 years of age or over
- Have lost a family member through suicide who was in receipt of mental health services
- Are prepared to share their experience with me

What are the benefits of you taking part: Research in this area is very limited, so I am particularly interested in hearing about how family members deal with suicide. You will have an opportunity to share your experiences. The results of this study will be published for health professionals and organisations, which will lead to an increased understanding of how you deal with suicide. The findings from the study will be passed on to South West Yorkshire Partnership NHS Foundation Trust, and should help them to provide better support for others who have lost a family member through suicide. You will be asked if you would like to receive a copy of the research findings and/or invited to attend an event where it will be shared. You will be asked about both when completing the consent form.

What will happen during the focus group:

After you have contacted me or given me permission to contact you, I will discuss the research study with you and answer any questions you may have. After our discussion, I will give you time to think about whether you wish to take part. After about a week I will contact you, and if you are happy to proceed, and I will arrange a mutually convenient date, time and venue for the focus group. Once the details of the focus group have been finalised, I will then send you a confirmation letter.

The focus group will involve between 6 – 9 people who have accessed SOBS and have consented to take part in the focus group. I will share some of my findings from the study so far, and will be asking a few questions to the group for their views. My supervisor, Professor Mike Lucock, will also be attending with me to help me facilitate the discussion of the group. The focus group may last between one to two hours and with permission from all participants in the focus group, will be audio recorded.

Protecting your privacy:

I will make every effort to protect your privacy and identity. I will not use your name in any of the research reports. Any identifiable information will be omitted from the research reports, such as the area where you live, or any other information which may reveal your identity or the person you lost to suicide. Your information will be kept in a locked area and will be destroyed after 5 years. Any information kept on my computer or laptop will be password protected and only accessible to me. I may use quotes from the group discussion in the research, but will ensure these are kept anonymous.

Risks and discomforts:

It may be possible that you will feel upset, during or after the focus group. If so, please tell me and we can stop or take a break. Information regarding support services and helpline numbers will be given to you before the focus group starts.

Every effort will be made to keep your involvement in the research confidential. Although it is unlikely, if anything you tell me leads me to believe that you or someone else is at risk of immediate or future harm, I may have to break confidentiality by speaking with my supervisor to decide upon the most appropriate course of action. This may then involve contacting the relevant authorities in the interest of protecting you or others. If this is necessary I would hope to discuss it with you first.

Your rights:

It is up to you to decide whether or not to take part in the study, and your decision will not be disclosed to anyone outside the research team and will not impact on the support you receive from SOBS. However, if you do wish to take part, you will be asked to read and sign a consent form. During the focus group, you don't have to answer all of the questions and can pause, take a break, or stop the audio recording at any time. You can also take a break or leave the focus group if you feel distressed.

Your role in this research project is voluntary, so you also have the right to withdraw from the study at any time without a reason. If you wish your data will be erased.

If you want to take part in the study or you have any questions:

I would really appreciate talking to you about your participation in this research as your contribution will be very valuable. If you have any questions or concerns about this study at any time, you can contact me, Farzana Ali, on my mobile on **07936 201938** or farzana.ali@hud.ac.uk.

My office address is room HHR1/12, School of Human and Health Sciences, University of Huddersfield, Queensgate, HUDDERSFIELD, HD1 3DH. My office telephone number is 01484 472581.

Alternatively, if you have any concerns you can contact my research supervisor, Professor Mike Lucock, on 01924 327560

Thank you for taking the time to read this information sheet.

Appendix 22: Letter of invitation for focus group participants

14 January 2016

Dear

Understanding the impact of suicide by people who were in receipt of mental health services on their family

Letter of invitation to take part in a focus group

I am writing to you as you have shown interest in taking part in a focus group where I can discuss some of my findings so far from the study. The purpose of this study is to learn about the experiences of people who have lost a family member through suicide in order to determine how best to support them.

I have recently been interviewing family members who have lost a loved one to suicide, and have identified some emerging findings on how family members might experience the suicide of a loved one. I am, therefore, writing this letter to invite you to take part in a focus group where I will share these findings and welcome your views.

I am inviting people who have accessed SOBS, therefore, you will be part of a focus group with between 6 to 9 people who have also been to SOBS. Every effort will be made to maintain confidentiality and your responses to the questions will be kept anonymous.

The date, time and venue of the focus group is **Tuesday 26 January at 1.00pm at the University of Huddersfield, Research hub, room RH2/09. However, I will meet everyone at 1pm at the main reception of Harold Wilson building and take you to the room where the focus group will be held.**

If you would like to attend the focus group, please contact me to confirm your attendance. I have attached some documents with this letter including an information sheet which gives more details about the focus group. A consent form, which I would be grateful if you would bring with you on the day after you have read and signed it to agree to take part in the focus group. Finally, I am also attaching a map of the campus where I have highlighted the meeting point, which is the main entrance of Harold Wilson building. In the meantime, if you have any further questions or concerns, please do not hesitate to contact me.

Email address: farzana.ali@hud.ac.uk
Telephone numbers: Office (01484) 472581 or mobile 07936 201938

Yours sincerely,

Farzana Ali

Appendix 23: Participant consent for focus group



Participant consent form for focus group

Understanding the impact of suicide by people who have been in receipt of mental health services on their family

It is important that you read, understand and sign the consent form. Your contribution to this research is voluntary and you are not obliged in any way to participate.

Please initial each box

- I have read and understood the information sheet and have had the opportunity to ask questions
- I understand I am entering the study voluntarily and I am free to withdraw at any time without giving any reason
- I understand that I will respect the confidentiality of the group & discussion
- I give permission for my words to be quoted (by use of pseudonym)
- I would / would not like a summary of the research once completed
- I would / would not like to attend a learning and sharing event
- I consent to take part in the study
- I understand that the information collected will be kept in secure conditions for a period of 5 years in line with University guidelines
- I understand that my identity will be protected by the use of pseudonym in the report and that no written information could lead to me being identified will be included in any report
- I consent to the focus group being audio-recorded

Participant Name: _____ Signature: _____

Date: _____

Researcher Name: _____ Signature: _____

Date: _____

Both researcher & participant to initial each box (One to be retained by the participant and one copy to be retained by the researcher)

SOBS focus group consent form (v2) Appendix 23

Appendix 24: Interview schedule for focus group

Appendix 24

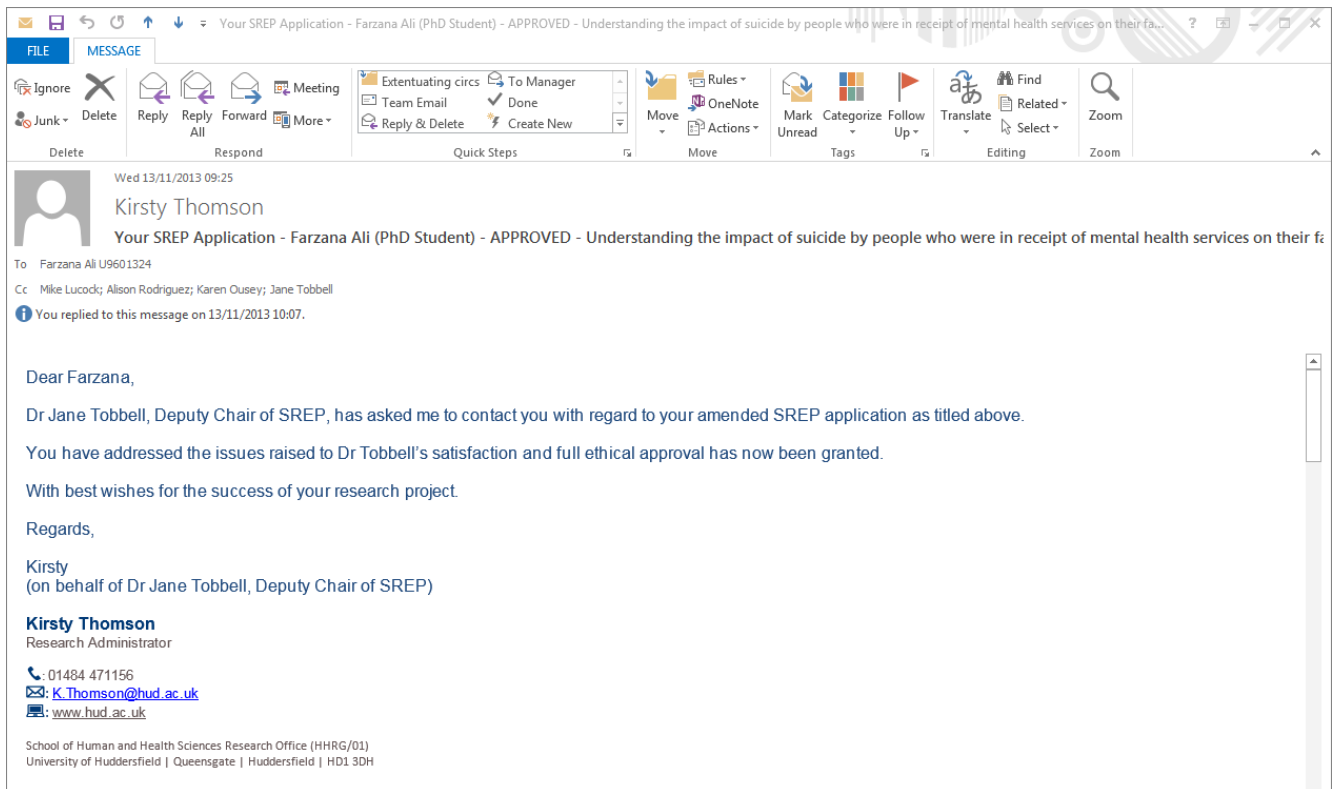
Understanding the impact of suicide by people who were in receipt of mental health services on their family

Interview topic guide for focus group

Discussion on a theory or explanation from my analysis on how family members experience the suicide of a loved one

- a) How do you feel this explanation describes how you have experienced the suicide of your loved one?
- b) Is there anything that you wish to add these findings?
- c) Is there anything which needs to be taken out?

Appendix A: University of Huddersfield SREP Ethics Approval



FILE MESSAGE

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Wed 13/11/2013 09:25

Kirsty Thomson
Your SREP Application - Farzana Ali (PhD Student) - APPROVED - Understanding the impact of suicide by people who were in receipt of mental health services on their fa

To Farzana Ali U9601324
Cc Mike Lucock; Alison Rodriguez; Karen Ousey; Jane Tobbell
You replied to this message on 13/11/2013 10:07.

Dear Farzana,

Dr Jane Tobbell, Deputy Chair of SREP, has asked me to contact you with regard to your amended SREP application as titled above.

You have addressed the issues raised to Dr Tobbell's satisfaction and full ethical approval has now been granted.

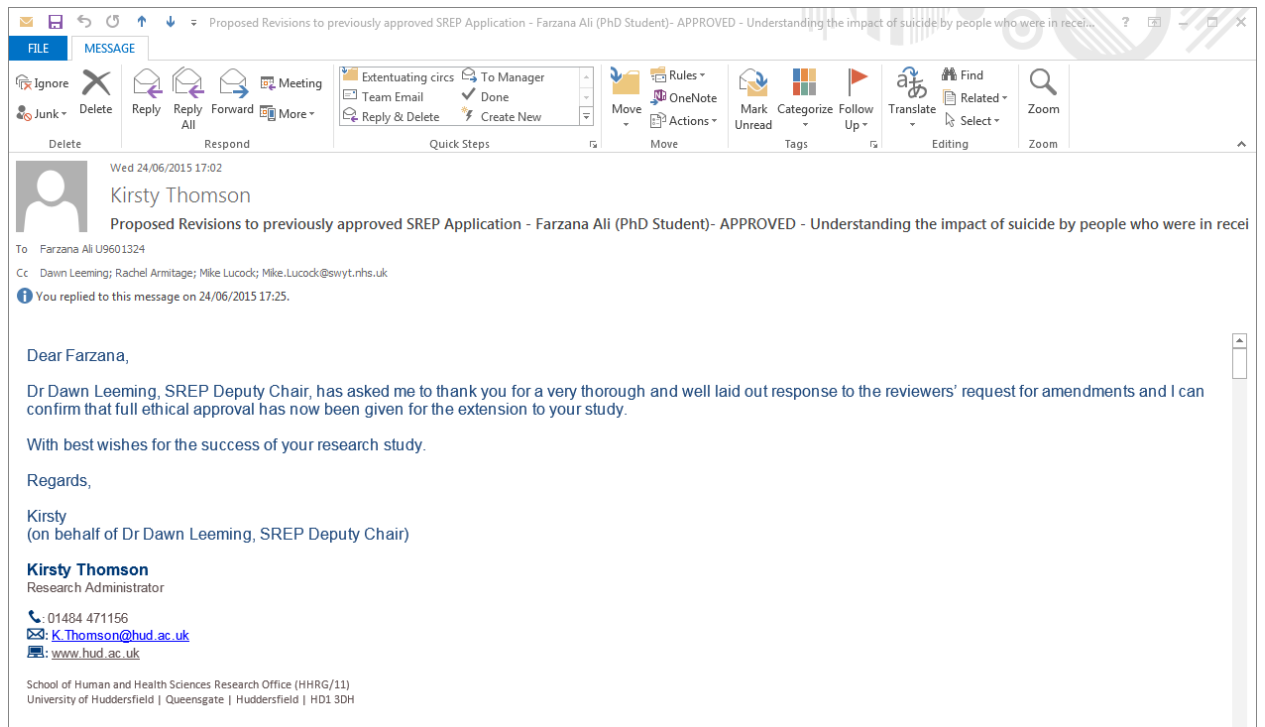
With best wishes for the success of your research project.

Regards,

Kirsty
(on behalf of Dr Jane Tobbell, Deputy Chair of SREP)

Kirsty Thomson
Research Administrator
01484 471156
K.Thomson@hud.ac.uk
www.hud.ac.uk

School of Human and Health Sciences Research Office (HHRG/01)
University of Huddersfield | Queensgate | Huddersfield | HD1 3DH



FILE MESSAGE

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Wed 24/06/2015 17:02

Kirsty Thomson
Proposed Revisions to previously approved SREP Application - Farzana Ali (PhD Student)- APPROVED - Understanding the impact of suicide by people who were in recei

To Farzana Ali U9601324
Cc Dawn Leeming; Rachel Armitage; Mike Lucock; Mike.Lucock@swyt.nhs.uk
You replied to this message on 24/06/2015 17:25.

Dear Farzana,

Dr Dawn Leeming, SREP Deputy Chair, has asked me to thank you for a very thorough and well laid out response to the reviewers' request for amendments and I can confirm that full ethical approval has now been given for the extension to your study.

With best wishes for the success of your research study.

Regards,

Kirsty
(on behalf of Dr Dawn Leeming, SREP Deputy Chair)

Kirsty Thomson
Research Administrator
01484 471156
K.Thomson@hud.ac.uk
www.hud.ac.uk

School of Human and Health Sciences Research Office (HHRG/11)
University of Huddersfield | Queensgate | Huddersfield | HD1 3DH

Appendix B: Ethics approval from NRES Committee Yorkshire & The Humber



Health Research Authority

NRES Committee Yorkshire & The Humber - Bradford Leeds
North East REC Centre
Room 002
TEDCO Business Centre
Viking Industrial Park
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0191 428 3444

13 February 2014

Miss Farzana Ali
PhD Research Student
The University of Huddersfield
Room HHR1/12, School of Human and Health Sciences
Queensgate
HUDDERSFIELD
HD1 3DH

Dear Miss Ali

Study title: Understanding the impact of suicide on families where the deceased was in receipt of mental health services.
REC reference: 14/YH/0015
Protocol number: HUFA1
IRAS project ID: 132118

Thank you for your letter of 05 February 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 28 January 2014

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		05 February 2014
Other: Interview Topic Guide for Family Members	v4	30 January 2014
Other: Interview Topic Guide for Health Professionals	v5	30 January 2014
Other: Contact Details Form for Participants	v2	30 January 2014
Other: Covering Letter for Family	v5	30 January 2014
Other: Covering Letter for Health Professional	v3	30 January 2014
Participant Consent Form: Consent Form for Family Members	v6	30 January 2014
Participant Consent Form: Consent Form for Health Professionals	v6	30 January 2014
Participant Consent Form: Family Consent Form for Nominating Health Professional	v2	30 January 2014

A Research Ethics Committee established by the Health Research Authority

Participant Information Sheet: Family Participants Information Sheet	v8	30 January 2014
Participant Information Sheet: Leaflet on Research for participants	v5	30 January 2014
Participant Information Sheet: Health Professionals Participants Information Sheet	v7	30 January 2014

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Advertisement	4	11 November 2013
Covering Letter		05 February 2014
Evidence of insurance or indemnity		03 January 2014
Investigator CV	CI	03 January 2014
Letter of invitation to participant	Family, V4	03 October 2013
Other: CV (Supervisor)	student	03 January 2014
Other: Letter of invitation to participant	Health professionals ; V2	03 October 2013
Other: Interview Topic Guide for Family Members	v4	30 January 2014
Other: Interview Topic Guide for Health Professionals	v5	30 January 2014
Other: Contact Details Form for Participants	v2	30 January 2014
Other: Covering Letter for Family	v5	30 January 2014
Other: Covering Letter for Health Professional	v3	30 January 2014
Participant Consent Form: Consent Form for Family Members	v6	30 January 2014
Participant Consent Form: Consent Form for Health Professionals	v6	30 January 2014
Participant Consent Form: Family Consent Form for Nominating Health Professional	v2	30 January 2014
Participant Information Sheet: Family Participants Information Sheet	v8	30 January 2014
Participant Information Sheet: Leaflet on Research for participants	v5	30 January 2014
Participant Information Sheet: Health Professionals Participants Information Sheet	v7	30 January 2014
Protocol	2	07 January 2014
REC application	3.5	07 January 2014
Summary/Synopsis	2	03 October 2013

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/YH/0015	Please quote this number on all correspondence
-------------------	---

Yours sincerely



Ms. Kirstie Penman
REC Administrative Assistant

E-mail: nrescommittee.yorkandhumber-bradfordleeds@nhs.net

Copy to: *Ms Rebecca Spencer, South West Yorkshire Partnership NHS Foundation Trust*

Appendix C: Ethics approval from South West Yorkshire NHS Partnership



With all of us in mind

South West Yorkshire Partnership 
NHS Foundation Trust

18th June 2014

Miss Farzana All
PhD Research Student
The University of Huddersfield
Room HHR1/12
School of Human & Health Sciences
Queensgate
Huddersfield
HD1 3DH

Research Department
Ward 2
Castleford & Normanton District Hospital
Lumley Street
Castleford
WF10 5LT

Tel: 01977 605285
Fax: 01977 605298

Email address: research@swyt.nhs.uk

Dear Miss All

Re: Understanding the Impact of suicide on families where the deceased was in receipt of MH services

REC ref: 14/YH/0015

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within South West Yorkshire NHS Foundation Trust.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol	3	27.02.2014
Participant Information Sheet: Family PIS	10	09.06.2014
Covering Letter Health Professionals	5	09.06.2014
Interview Topic Guide: Family Members	4	30.01.2014
Interview Topic Guide: Health Professionals	5	30.01.2014
Covering Letter for Family	6	09.06.2014
Participant Consent Form: Family Members	7	09.06.2014
Participant Consent Form: Health Professionals	7	09.06.2014
Participant Consent Form: for Nominating Health Professional	3	09.06.2014
Participant Information Sheet: Leaflet on Research for Participants	6	09.06.2014
Participant Information Sheet: Health Professionals	8	09.06.2014
Summary/Synopsis	2	03.10.2013
Investigator CV		03.01.2014
Letter of Invitation to Participant: Family	4	03.10.2013
Supervisor CV		03.01.2014

Chair: Ian Black Chief Executive: Steven Michael





With all of us in mind

Document	Version	Date
Letter of Invitation to Participant: health Professionals	2	03.10.2013
Contact Details Form: Participants	3	09.06.2014

This approval is granted subject to the following conditions:

- You must comply with the terms of your approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform us immediately.
- You must comply with the procedures on project monitoring and audit¹.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care²(RGF). Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.
- Research projects will be added to any formal Department of Health research register.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using Trust incident reporting procedures in the first instance and to the chief investigator³.

They should also be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study (if applicable)
- other related regulatory bodies as appropriate.

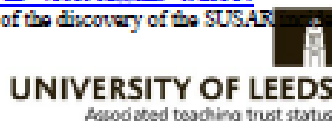
You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved by in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

¹ Details from:

Chair: <http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticleFromContent?ID=4108962&chk=WideITv>

² SUSARs – this must be within 24 hours of the discovery of the SUSAR at





With all of us in mind

Projects sponsored by organisations other than the Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

Note that NHS Indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time.

May I take this opportunity to wish you well with the project.

Yours sincerely

Dr Nisreen Booya
Medical Director

Chair: Ian Black Chief Executive: Steven Michael



Appendix D: South West Yorkshire Partnership NHS Foundation Trust letter of access for research



South West Yorkshire Partnership **NHS**
NHS Foundation Trust

29th July 2014

Miss Farzana Ali
University of Huddersfield
Human & Health Sciences
Room HHRB1/12
Queensgate
Huddersfield
HD1 3DH

Research Department
Ward 2
Castleford & Normanton District Hospital
Lumley Street
Castleford
WF10 5LT

Tel: 01977 605285
Fax: 01977 605298
Ref: LOA

Email address: research@swyt.nhs.uk

Dear Miss Ali

Letter of access for research

STUDY: Understanding the Impact of Suicide on Families where the Deceased was in Receipt of Mental Health Services

This letter should be presented to each participating organisation before you commence your research at that site. The participating organisation is: **South West Yorkshire Partnership NHS Foundation Trust.**

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 29th July 2014 and ends on 30th September 2015 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from South West Yorkshire Partnership NHS Foundation Trust. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from the individual organisation of their agreement to conduct the research.

The information supplied about your role in research at the organisation has been reviewed and you do not require an honorary research contract with the organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to the organisation.

You are considered to be a legal visitor to the organisations premises. You are not entitled to any form of payment or access to other benefits provided by the organisation or this organisation to employees and this letter does not give rise to any other relationship between you and the organisation, in particular that of an employee.

While undertaking research through the organisation you will remain accountable to your substantive employer The University of Huddersfield but you are required to follow the reasonable instructions of Professor Mike Lucock in the organisation or those instructions given on their behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any

Chair: Ian Black Chief Executive: Steven Michael





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investigation by the organisation(s) in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the organisations policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the organisation(s) in discharging its/their duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisations premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each organisation prior to commencing your research role at that organisation.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the organisations premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation do not accept responsibility for damage to or loss of personal property.

This organisation may revoke this letter and any organisation may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

No organisation will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

Chair: Ian Black Chief Executive: Steven Michael





With all of us in mind

South West Yorkshire Partnership 
NHS Foundation Trust

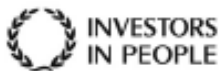
If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in each participating organisation and the R&D office in this organisation.

Yours sincerely

Rebecca Spencer
Research Management & Governance Manager

cc: University of Huddersfield

Chair: Ian Black Chief Executive: Steven Michael



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