Portfolio 1: Major Research Project

Unspoken Stories: Exploring the Narratives of Self-defined Family Members who have Experienced Suicide Bereavement.

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Abstract

Aims: This study explores the unspoken narratives experienced by individuals who have been bereaved by suicide.

Method: Nineteen semi-structured interviews were carried out with individuals who classified themselves as self-defined family members to individuals who had died by suicide. The interviews were transcribed verbatim and analysed using Reflexive Thematic Analysis.

Findings: Six themes, with eight subthemes, were identified within this data: 1) ‘explicitly unspoken’; 2) ‘never ending tasks for the survivor’; 3) ‘them and us- the act of othering’ (which included the subthemes, ‘experienced othering’, ‘perceived othering’, and ‘solidarity’); 4) ‘protection’ (including the following three subthemes: ‘protecting deceased’, ‘protecting others’, and protecting self’); 5) ‘comparisons to physical illness- nobody says ‘oh they’ve committed cancer’’; 6) ‘when and who are ‘allowed’ to grieve?’ (including subthemes ‘there’s an expiry date to grief- Sarah’, and ‘hierarchy of grieving’).

Considerations and Implications: This study offers insight into an area with limited research. The results have been considered in line with existing literature, and clinical, research and wider societal implications have been discussed.

Keywords: suicide, bereavement, chosen family, unspoken narratives, stigma.

1 Introduction

1.1 Overview

This research explores the experiences of self-defined family members who have experienced suicide bereavement, to identify any unspoken narratives that are present. Within this introductory chapter, I outline my relationship to this topic, the epistemological stance taken, and the definitions of key terms that I shall use throughout. I provide an overview of the history of suicide and its prevalence within UK society, explore current research into suicide bereavement and the key policy documents that are currently available, and describe the different theories of understanding suicide. The chapter concludes with the rationale for the systematic literature review, which focuses on the existing research exploring the difficulties, challenges and barriers to conducting suicide-related research.

1.2 Positionality and epistemology

1.2.1 Positionality

Identifying as a White British cis-gender woman, I'm aware that I hold certain privileges and cultural expectations that influence my interpretation of this research, and how the stories of bereaved individuals experiences of unspoken narratives is told.

It was important for me to make explicit my relationship to this topic, and provide reasons why I'm passionate about this area being researched. At the age of 10, I became aware of the possibility that an individual can end their own life, when a family friend died by suicide. Prior to this experience, it had not been a phenomenon I had given thought to. I remember feeling confused, not only due to my age, but due to the stigma attached to this death and the silence that it created with regard to talking about their death. I was professionally exposed to suicide later in life when working in a mental health team prior to starting the Doctorate training. I was informed, whilst working within this service, that a client I was working with had ended their life. At the time of hearing this, I felt sadness and disbelief that an individual I had seen the week before had now died. Working within the team following the individual’s death, I felt disheartened that, even as mental health professionals, it felt like a ‘taboo topic’, as though everyone was aware that the person had died by suicide, but that it was difficult or uncomfortable to talk about, or individuals were not able to talk about suicide directly, using other words instead of ‘suicide’ and ‘skirting around the topic’. I felt driven by my own observations to explore the experiences of individuals bereaved by suicide, specifically focusing on the silences that may be present and the narratives that are unspoken, as a result.

1.2.2 Epistemology

Epistemology is a branch of philosophy that concerns the study of knowledge and how we obtain knowledge (Braten, 2010). For the reader to comprehend how knowledge has been positioned and understood, it’s important to be made aware that I adopt a critical realist epistemological stance.

Critical realism (CR) lies between realism and relativism. A realist approach situates itself in the position of there being truths that can be known, and that within research, data that is extracted reflects reality. In comparison to this, a relativist approach positions knowledge as “fallible, partial and changeable over time” (Albert et al., 2020, p. 358). It assumes that truth is constructed, therefore data derived from research can be interpreted in many different ways (Harper, 2011).

CR considers aspects of both realism and relativism within its stance, it uses the realist aim to gain a better understanding of what is happening within the world, but acknowledges that data obtained within research may not directly reflect reality (Willig, 2008). CR aims to establish causation “to help researchers to explain social events” (Fletcher, 2017, p. 181) to provide recommendations to address social problems identified. This epistemology presumes that there’s socially-located knowledge, but that behind this there’s a real and knowable world, and that this can be discovered via research (Joffe, 2012). As a position, this facilitates that there can be perspectives of truth, and that there can be conflicting truths held at one time.

CR employs that knowledge is fallible, but that it’s also positioned (Albert et al., 2020), and that there is some knowledge that can be closer to reality (Fletcher, 2017). A critical realist contends that the way in which we perceive knowledge, the world, and facts depends on our beliefs, expectations, and experiences (Bunge, 1993), concluding that there is a subjectivity in the production of knowledge (Madill et al., 2000).

The current study aims to situate the experiences of individuals bereaved by suicide within their context, therefore the critical realist position is in-keeping with achieving this. Additionally, the research question aims to identify individuals experiences of unspoken narratives following a suicide bereavement, therefore a critical realist approach is appropriate as it positions knowledge as subjective to experiences had. As the methodology used seeks “to develop causal explanations” (Fryer, 2022, p. 366) a critical realist approach to thematic analysis is appropriate. As a researcher, I recognise that it’s possible to gain an understanding of an individual’s experience of being bereaved by suicide, through their account, but am aware that I, as a researcher, shall play a role in constructing knowledge through my interpretations, which are influenced by my own experiences, views and beliefs (Grogan et al., 2022).

1.3 Reflexivity

When conducting research, it's not unusual for researchers to focus on a topic that they feel passionately about (Burnham et al., 2008). This passion has motivated me to thoroughly explore this topic, but with passion comes apprehension in this being a topic I haven't researched before.

Having experiences of suicide bereavement, I identify as an insider researcher (IR) within this project; a member of the population being researched; sharing a characteristic, role or experience (Dwyer & Buckle, 2009). Although this may provide me with some insight and understanding into the participants experiences (Kanuha, 2000), some argue that being an IR can result in "loss of objectivity and bias" (Saidin, 2016, p. 849). Being an IR holds the risk of assuming the experiences of the participants, and a risk of participants not fully explaining their experiences due to the assumption that the researcher would know and understand already (Dwyer & Buckle, 2009). In contrast, being an IR can support the process of acceptance from participants (Dwyer & Buckle, 2009) and may allow for individuals to express certain aspects of their experience (Talbot, 1999) that they would not be able to with individuals they feel 'won't get it'.

Whilst being an IR, it's important to highlight that I am also an outsider researcher (OR) on the basis that my experiences and identity (e.g., ethnicity, class, race, age, gender, sexuality) differ to those of my participants. Wilkinson & Kitzinger (2013) identified the insider/outsider status within research can shift and change across the course of an interview and between each interview. With this fluidity in status, as a researcher I am acutely aware that the interviews I've completed are influenced by both my insider position, as an individual who has experienced suicide bereavement, and my outsider position, as a White woman who has not experienced suicide bereavement directly within my family.

It’s important to consider the “ethical importance of the feelings that emerge through research encounters” (Boden et al., 2016, p. 1078). In line with the critical realist approach, I have considered and attempted to outline my own beliefs, biases, and assumptions that may influence the research process and findings. To document these and reduce potential bias, I have kept a reflective journal throughout this process and shall be sharing my reflexive thoughts (see Appendix A). Table 1 highlights the additional methods of reflexivity used within this research.

Table 1

Methods of reflexivity

Method	Task
Reflective journal	Reflective journal (See Appendix A) to document the thoughts, reflections, questions and feelings I had throughout this process, as well as the supervisory and research team discussions had and discussions with Experts by Experience that impacted and influenced my understanding, meaning-making and approach to this project.
Consultation	A group of experts by experience were consulted at various times within this project, including: recruitment, interview development, and data collection. (detailed in Chapter 3) Coder-reliability checks with a member of the research group- extracts of transcriptions were shared and coded separately, prior to comparing codes and engaging in discussions to identify areas of differences and similarities.
Research team input	Discussions and spaces for reflection within supervisory research team meetings to acknowledge my own views, beliefs, bias’ and assumptions and how these have influenced this research.

1.4 Key terms

See Table 2 for definitions of the key terms that shall be used throughout this research.

Table 2

Key terms

Key term	Definition	Terms used interchangeably
Suicide	A self-inflicted death (O'Connor, 2021)	'death by suicide', 'died by suicide', 'killed themselves', 'taken their life', 'ended their life'
Death by misadventure	Death that happens by accident (Cambridge University Press, 2023).	
Self-defined family members	A group of people who care about each other because they have a close relationship or shared interests (Cambridge University Press, 2023).	Chosen family members
Suicide survivors	Individuals who have been bereaved by suicide; "people who have lost a significant other to suicide" (Scocco et al., 2017, p. 40); "any and all people, both close and distant, who experience the pain of a suicidal death" (Farberow, 2005, p. 13).	Survivors
Suicide bereavement	"Grief, mourning, and adjustment" (Pitman et al., 2016b, p. 1) following a death by suicide.	
Narratives	A spoken or written description of an event (Cambridge University Press, 2023), which also can be referred to as a story of an experience.	
Unspoken narratives	Stories and experiences that are not told, written, or verbally spoken.	
Postvention	The response to, and care provided for, individuals impacted by suicide, i.e.,	

	suicide bereavement support (Andriessen et al., 2019a). Postvention includes “activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behaviour” (Andriessen, 2009a, p. 43).	
Stigma	Negative, prejudiced beliefs or assumptions that individuals hold about something or someone (Scocco et al., 2017).	
Stigmatisation	A social process that can result in rejection and exclusion (Weiss et al., 2006).	
Research team	Although this work was completed independently, support was provided throughout the process by the supervisory team and a peer completing research within a similar topic area.	Research group Supervisory team

The term ‘committed suicide’, which is often used within society, won’t be used within this study. This is because the term ‘committed suicide’ originates from when suicide was a criminal act, and individuals would be prosecuted. It was not until 1961 that the ‘Suicide Act’ decriminalized suicide.

1.5 History

Suicide as a concept and act has been examined since ancient times, with the famous case of Socrates’ suicide being narrated by the Greek philosopher Plato in his work ‘Phaedo’ (Dinkelaar, 2020). Within this text, suicide is described as morally wrong (Werner, 2018). Similar to Plato’s opposed views of suicide, the Greek philosopher Aristotle also condemned suicide (Tondo, 2014), viewing this as an act of cowardice (Moore, 1790). This view of suicide was evident in how the deceased bodies were treated in Ancient Greece whereby the bodies of individuals who had died by suicide were often abandoned and left for animals (Shandilya, 2018).

Nowadays, the negative and stigmatized view of suicide has deep-rooted associations with “religious and legal connotations” (Peters et al., 2016, p. 251), as suicide was viewed as a sinful and a criminal act. As a result of these associations, individuals bereaved by suicide are often subject to social exclusion, financial burden, and distress (Beaton et al., 2013).

Considering the religious and legal connotations of suicide, the Christian Church legislated against suicide in the sixth century (Alvarez, 2002), creating a ban on suicide. Historically, individuals were “condemned to death for the crime of having condemned himself to death” (Alvarez, 2002, p. 63). It has been reported that during the Middle Ages (500-1300), the Church “sanctioned suicides with the refusal of religious burials” (Marra & Orru, 1991, p. 278). A similar outlook on suicide continued throughout the 1600’s where suicide was viewed as a criminal act that was the lowest of the low (Alvarez, 2002), and degradation of corpses took place if an individual died by suicide. This degradation could take the form of individuals being buried in an intersection of a road rather than a burial site. The last known corpse being buried in this way in England was documented in 1823 (Alvarez, 2002).

In addition to the way in which the deceased were viewed and treated historically, suicide survivors were also implicated in the legal proceedings following the death. For example, in the 14th century it has been reported that personal assets were confiscated from the deceased by the state (Murray, 1998), having financial implications on the living (Tucker, 2015).

As mentioned, suicide was previously a criminal act which resulted in punishment of the deceased and their family members, and was not decriminalised until the 1961 ‘Suicide Act’. The shift in views of suicide and the development of the Suicide Act followed the passing of the Mental Health Act in 1959 (Moore, 2000). This was a time in history whereby individuals began to question how mental health impacted people's decisions to end their own lives, and whether the medical profession would be better suited to intervene in and manage this phenomenon, rather than the judicial system (Moore, 2000). Similarly, the Church of England Information Office (1959) published a booklet called 'Ought Suicide to be a crime?' in which it proposed that it should not. Both government legislations and support from the Church of England therefore played a role in the decriminalisation of suicide.

Although in most Western countries suicide has been decriminalised, it continues to have criminal overtones (Maple et al., 2010), with the involvement of coronial services emphasising the difference between death by suicide and death by other means. Despite decriminalisation within the UK, social perceptions continue to be held of suicide which continue to impact the stigma experienced by suicide survivors (Tait & Carpenter, 2016). These social perceptions of suicide include that suicide shows an "emotional weakness" (Nathan & Nathan, 2020, p. 2) in individuals, it's a selfish act (Sheehan et al., 2016), and that it's a sign of cowardice (Nathan & Nathan, 2020).

These social perceptions may be impacted by historical connotations, religion, and an individual's level of understanding and education, which could be a consequence of the media's response and publications related to suicide. Although suicide is now more openly discussed in the media, and reporting of deaths by suicide has increased (Niederkrotenthaler et al., 2020), the language used to describe death by suicide remains ambiguous. Although it has previously been argued that specifying details of the individual's death may result in negative influence on the reader or audience (Hawton and Williams, 2002), the ambiguity of the language used may further stigmatise suicide.

Having explored the meaning of suicide historically, it's also important to consider different cultural meanings of suicide. Bell (2014) highlighted that there are differing views amongst cultures regarding suicide. Within Muslim cultures suicide continues to be viewed "as an unforgivable act" (Bell, 2014, p. 594), whereas in Japanese cultures suicide can be viewed positively and an "act of honour if one shames one's family" (Bell, 2014, p. 594). This highlights the continued differing views of suicide present today.

1.6 Prevalence of suicide in UK

The World Health Organization (2021) reported that suicide is one of the worldwide leading causes of death, estimating that one person dies by suicide every 40 seconds in the world (WHO, 2018), with an average of 135 people knowing each individual who has died by suicide (Cerel et al., 2019). This highlights not only the vast impact of suicide, but also the high prevalence of suicide throughout the world.

Focusing on the prevalence of suicide in the UK, Samaritans reported that there were 5,219 suicides registered in England in 2021 (Samaritans, 2022), and similar figures were reported in 2022 where 5,284 suicides were registered in England and Wales. Similarly, the Office for National Statistics (ONS) (ONS, 2023a) published information outlining the figures of suicide death registrations in England. These statistics report that in 2022 there were 5,642 suicides registered in England and Wales (10.7 deaths per 100,000 people); this was consistent with figures reported in 2021 where 5,583 deaths were registered as suicide (10.7 per 100,000). Both the Samaritans (2023) and the ONS documented that in 2022 roughly three-quarters of the suicides registered were male (4,179 deaths; 16.4 deaths per 100,0000), and that the rate for female suicides had remained consistent between 2021 and 2022 (2022 data found that the rate for female deaths was 5.4 deaths per 100,000) (ONS, 2023b).

When reviewing the statistics, it's important to be mindful of the date in which the death is registered rather than potentially the date of death itself (ONS, 2023c), as an inquest can take up to a year to be completed. In addition to this it's important to consider that there is the potential for not all deaths by suicide to be included within these statistics as deaths may be registered by the coroner as 'misadventure' or other causes.

Despite these figures, in-depth research on suicide bereavement and suicide postvention is limited. With that said, psychologists within the UK have more recently began research to understand and formulate suicidal behaviour (BPS, 2017).

1.7 Overview of suicide bereavement literature

As highlighted, suicide is a phenomenon that goes beyond individual victims and causes pain for those left behind, with the victims of suicide being seen as both the dead and the living (Pederi, 2022).

Research has previously found that individuals bereaved by suicide are at higher risk of developing "major depression, post-traumatic stress disorder" (Young et al., 2012, p. 177), and attempting suicide themselves. It has been reported that there is a ripple effect (Maple, 2016) of impact when an individual takes their own life, suggesting that for every one individual person who dies by suicide, 6 to 135 people are affected (Cerel et al., 2019; Pompili et al., 2008).

With a vast number of individuals being impacted by one death by suicide, research into suicide bereavement and the experiences of those bereaved is crucial as their experiences can be traumatic, disturbing and challenging (Pederi, 2022). A number of researchers have studied or summarised the experiences of survivors, including the stigma experienced, responses from others, and the support available for those bereaved by suicide.

Studies have highlighted the 'silence' and the 'powerlessness to speak' experienced by those bereaved by suicide (Bowden, 2017; Maple et al., 2010; Pederi, 2022; Peters et al., 2016). Within Bowden's (2017) research, which focused on young men's experiences of losing a close male friend to suicide, it was found that survivors felt ‘voiceless’ about their experience, and felt they needed to suppress their emotions, remain silent, and not publicly grieve their friend. Recent research has explored Psychologists experience of suicide bereavement and how they ‘make sense’ of suicide (Dauhoo et al., 2024). Dauhoo et al. (2024) focused on exploring psychologists experiences of suicide bereavement, whether that were to be a personal experience, or a professional experience of a client taking their own life. The findings of this study highlighted that psychologist’s reported that talk of their experiences of suicide bereavement was inhibited. Talk was identified as inhibited “due to a sense of anticipated discomfort, a fear of invading privacy, and a fear of being judged or misunderstood” (Dauhoo et al., 2024, p.52). Suicide survivors have also reported feeling secluded, isolated, or distanced from society and their community (Bosticco, 2002; Bowden, 2017).

Despite initiatives being in place to raise awareness of suicide and educate individuals (as outlined within the ‘key policy’ section of this chapter), those bereaved by suicide continue to experience stigma attached to the death (Bartik et al., 2015; Schreiber et al., 2017; Sheehan et al., 2018). This stigma is thought to be different and greater than any stigma attached to death through natural causes or illness (Serani, 2013). Although a few studies have suggested that stigma is not a main experience for those bereaved by suicide (Gall et al., 2014; Houck, 2007), the literature highlights the negative impact and repercussions for survivors due to both actual and anticipated stigma, and social prejudice associated with suicide (Michaud-Dumont et al., 2020; Peters et al., 2016). This stigma can result in feelings of shame (Michaud-Dumont et al., 2020; Peters et al., 2016), and bereaved individuals not seeking support (Peters et al., 2016), resulting in prolonged grief (Bailey et al., 2015).

As a result of the stigma associated with suicide, and suicide often being seen as a taboo topic (Michaud-Dumont et al., 2020), survivors have reported experiencing negative responses from others, including being treated differently to those who have been bereaved by different means, and "feeling a sense of responsibility to alleviate the discomfort experienced by others" (Peters et al., 2016, p. 255).

The silence, secrecy (Schreiber et al., 2017), and stigma associated with suicide, can result in survivors feeling guarded and protective about who they share dialogues with, and who they share their stories and experiences with (Maple et al., 2010; Peters et al., 2016). This research project aims to add to the current literature by exploring what is silenced, what is unspoken, and what suicide survivors feel they must keep secret. Having a greater understanding of the effect of suicide on those bereaved can potentially inform the direction of services for suicide bereavement support (Bartik et al., 2013).

1.8 Key policy documents

I shall outline some of the key policies and guidance available within the UK in relation to suicide prevention and postvention support. It's important for the reader to be aware of this, to have an understanding of how services and support for those bereaved are developed, and the aims they follow in relation to the policies outlined. See Table 3 for the aims of each policy and a critique of each one, highlighting how the current study can support the guidance available.

Table 3

Key policy policies and guidance available within the UK

Guidance/policy creators and year	Aims	Critique and rationale for need of current study
The National Institute of Clinical Excellence (NICE, 2019)	-Quality standard document -Five statements with the aim of supporting the reduction of suicides within the UK, and identifying ways of helping those bereaved or affected by suicide.	-Does not specify how this would be done, or how they would ensure that they're reaching individuals who would not be classed as 'first-degree' relatives or next of kin. -Oversight highlights the

	-Highlights the increased risk of suicide for a suicide survivor, and emphasizes the need for those bereaved or affected by suicide to be provided adequate information and offered tailored support (NICE, 2019).	need for the current study as it reaches further than just ‘first-degree’ relatives and next of kin. -Relationship status is not used as a measure for psychological closeness, and rather closeness can be viewed as an indicator for impact of loss (Cerel et al., 2017; Eckerd et al., 2016).
Public Health England (Department of Health) (2023)	-Part of the NHS Long Term Workplace Plan -‘5-year cross-sector strategy’ for suicide prevention in England -Highlights 8 priority action points including: providing effective crisis support when needed, providing effective bereavement support, and making suicide everybody’s business (Public Health England, 2023). - Document identifies that support should be for family members, friends, and acquaintances (Public Health England, 2023), (acknowledging the impact that suicide can have on many individuals).	-Does not identify what the support would entail or how it would be ensured that the support is ‘timely’ or ‘effective’. -Current study aims to gain an understanding of what difficulties are experienced by survivors which will help to outline practical steps that need to be taken to work towards achieving this 5-year strategy.
The British Psychological Society (2017)	-A position statement. -Highlights the importance of considering psychological processes to better understand suicidal thinking and suicidal behaviours. -The statement identified two key aspects to suicide prevention: the need to understand the factors that influence and are associated with suicidal ideation, and reducing the likelihood that an individual engages in suicidal behaviours (BPS, 2017).	-There is no mention of the involvement of suicide survivors, or any use of consultation with Experts by Experience (EbE) when developing suitable interventions. -Current study used EbE’s.
World Health Organisation (WHO)	-2014: ‘Preventing suicide: a global imperative’ (WHO,	-Policy brief states that it was developed using a

(2014, 2023)	2014). -Report aimed to increase awareness of the public health significance of suicide and suicide attempts, encouraging countries to take action in implementing suicide prevention activities (WHO, 2014). -2023: A policy brief on the health aspects of decriminalization of suicide and suicide attempts (WHO, 2023). -Aimed to provide guidance to support decriminalizing suicide and suicide attempts through promoting a shift from 'punishment' to promoting mental health services and other forms of support for individuals, their families, and communities.	rigorous process, including input from 'experts', but there is no confirmation as to whether these 'experts' were suicide survivors themselves (who could provide input and insight from their own lived experiences).

1.9 Theories to understanding suicide

Literature exploring the stigma of suicide experienced by survivors has highlighted the need for members of the public to better understand the act of suicide (Sheehan et al., 2018), to attempt to eradicate misconceptions of suicide and suicidal behaviour. Suicidal behaviour includes suicidal ideation, plans, and attempts, and can be viewed as a result of complex interacting factors, such as an individual's personality, negative and traumatic life events, and aspects of society and their impact (O'Connor & Nock, 2014).

Table 4 highlights models of suicide and suicidal behaviour which aim to conceptualize and provide additional understanding of the act of suicide. This is not an exhaustive list of models, but highlights the factors that can influence these behaviours. Conceptualization of these behaviours, and the complex interacting factors, can help support individual's understanding of suicide and, when applied to those exhibiting suicidal behaviour, can identify suitable support and interventions for suicide prevention. Additionally, it can highlight how survivors may make sense of their chosen family members death.

Table 4

Models of suicide and suicidal behaviour

Model & Author	Premise of model
Cubic model of suicide (Shneidman, 1987)	Suicide risk arises due to a combination of stress, psychological pain and perturbation. Shneidman (1998) identified that when psychological pain becomes intolerable in intensity, this plays a crucial part in increasing suicide risk and initiating suicidal behaviours.
Diathesis-stress-hopelessness model (Schotte & Clum, 1987)	There is an interaction between genetic vulnerability and adverse life events or exposure to trauma, and these are precipitating factors of major depression (Ladd et al., 2000).
Suicide as an escape from self (Baumeister, 1990)	This model reports that the need and desire to escape from painful self-awareness is a main motivation of suicide (O'Connor & Nock, 2014). Baumeister (1990) highlighted that suicide can be seen as an act to escape from the world and the self, following awareness of the "self's inadequacies" (Baumeister, 1990, p. 90).
Arrested flight model (Williams, 2001; Williams 2014)	This model has 3 main components which it identifies as factors that will increase suicide risk: a sense of being unable to escape, a sense that there will be no way out or 'rescue', there is a sensitivity to defeat, entrapment or humiliation (Williams et al., 2005).
Interpersonal-psychological model (Joiner, 2005)	This model proposes that an individual will not die by suicide unless the individual has both the desire to die by suicide, and the ability to do so (Joiner et al., 2009). It highlights that suicidal desire is caused by burdensomeness, and the individuals sense of belonging (O'Connor & Nock, 2014).
Cognitive model of suicidal behaviour (Wenzel & Beck, 2008)	There are 3 main factors that influence suicidal thoughts and behaviours: "dispositional factors, maladaptive cognitive processes associated with psychopathology, and cognitive processes

	more specifically related to suicidal thoughts and acts" (Burke et al., 2016, p. 1146). This model proposes that the development of suicidal thoughts is a result of negative cognitive content and maladaptive information processing biases.
Integrated motivational-volitional model of suicidal behaviour (O'Connor, 2011)	A diathesis-stress model which identifies the "components of the premotivational, motivational and volitional phases of suicidality" (Arensman et al., 2019, p. 2). The model considers the relationship between factors and triggering events, and the development of suicidal thoughts or intent, through to suicidal behaviour (O'Connor, 2011). The premotivational phase includes: life events, diathesis and environment; the motivational phase considers factors such as: defeat, entrapment and other moderators; and the violation phase focuses on the behavioural enaction (O'Connor & Kirtley, 2018).

Conceptualisation of the factors of suicide bereavement are also important in understanding how an individual may experience suicide bereavement and identifying suitable support. The Tripartite Model of Suicide Grief (Sands, 2009; Sands et al., 2011) outlines that there is a process of adaptation within the bereavement process. Within this model metaphors such as "walking in the shoes of the deceased" are used to illustrate the dimensions of the grief process (Sands, 2009). It also highlights the interactions between an individual's relationship to self (including isolation and guilt felt by the survivor), and their relationship with the deceased. This model of suicide bereavement has been highlighted as although there are various models of bereavement, due to the limited, but growing, research into suicide bereavement, there are currently limited evidence-based models. Models of suicide bereavement are important as they allow us to consider how an individual bereaved by suicide may experience this death and how their experiences may impact help-seeking behaviours.

1.10 SLR rationale

As evidenced, suicide has a high prevalence within the UK and, although suicide prevention is a topic of interest within literature, government policies, and social media campaigns, in order to ensure that suicide, suicidal behaviour, and suicide bereavement is researched well and ethically, it’s important to understand why certain topics are not being researched, and whether there are any potential challenges or barriers to conducting this research. Examining the policies outlined previously (Table 3), it’s evident that there are important aspects that have been missed or not included within the guidance written. Within the BPS (2017) and WHO (2023) guidelines, such aspects include the use of consultation to develop appropriate support services for those bereaved. Similarly, Public Health England (2023) emphasise the need for timely and effective suicide bereavement support, but don’t identify what difficulties this support shall need to focus on. It can be questioned whether these aspects are not presented in such policies due to their lack of evidence derived from research. This led me to question whether there are any barriers to this research being conducted, and resulted in me completing a systematic literature review on this topic.

2 Systematic Literature Review (SLR)

2.1 Overview

This chapter presents the SLR that has been completed. It shall include the aims of the review, how the literature search was conducted, the methodology used, and a quality appraisal of the literature. Themes identified within the literature shall be discussed, prior to suggesting recommendations for future research. This chapter shall conclude with a description of the rationale as to how the outcome of the SLR has supported the creation of the current study.

2.2 Aims of the SLR

An SLR is a "systematic way of collecting, critically evaluating, integrating, and presenting findings" (Pati & Lorusso, 2018) from multiple studies on a specific topic, or answering a specific research question. An SLR differs from a traditional literature review as it aims to identify all studies relevant to a topic or question, and the methodology used is developed in a way that should reduce data extraction bias (Nightingale, 2009).

This SLR aims to consider and explore the following question:

What are the potential difficulties, challenges, and barriers to conducting research related to suicide?

The aim of the SLR is to qualitatively understand the experiences of conducting suicide-related research, highlighting the potential difficulties, barriers and challenges. It shall also aim to assess the quality of the current literature, and identify any knowledge gaps. This

SLR is registered with the international prospective register of systematic reviews (PROSPERO; CRD42024513505).

2.3 SLR Methodology

2.3.1 Question Configuration

The Population, Phenomena of Interest and Context (PICo) tool was used to define the important parts of the research question, as it has been proven as a useful tool when research involves analysing human experience (Stern et al., 2014). PICo focuses on the Population, Phenomena of Interest, and Context (See Table 5).

Table 5

PICo for study

P: Population	I: Phenomena of Interest	Co: Context
Researchers Ethical review board Participants, consultants and experts by experience	Challenges to the experiences of conducting suicide-related research	Conducting research related to suicide

2.3.2 Scoping strategy

To ensure that there had been no SLR's completed related to this topic, an initial scoping search was conducted. This scoping search included, but was not limited to searching: PROSPERO, Google Scholar and Cochrane Library.

2.3.3 Literature search strategy

The Sample Phenomenon of Interest Design Evaluation Research (SPIDER; Cooke et al., 2012) tool was used to develop the search strategy for this SLR (See Table 6). This tool was used as it has been reported to be suitable for qualitative research (Cooke et al., 2012).

Table 6

SPIDER tool

S: Sample	PI: Phenomenon of Interest	D: Design	E: Evaluation	R: Research type
Researchers Ethical review board members Participants, consultants and experts by experience	Conducting research related to suicide	Interviews Observations Questionnaire	Experiences Examples Stories	Qualitative Mixed Methods

Qualitative synthesis “draws findings from individual studies together” (Seers, 2012), and can involve summarising or interpreting data (Noblit & Hare, 1988). A systematic search was conducted to review papers relevant to the research question proposed. Searches were conducted in January 2024 and were re-examined in March 2024 to identify if any additional literature had been published. The following databases were used to search for and retrieve articles and research papers:

- Scopus
- PsycINFO
- MEDLINE
- Ethos (grey literature)
- Records from other areas

These databases were chosen as they incorporate literature from different disciplines such as medicine, nursing and applied social science (Schotten et al., 2017). The final search strategy involved conducting pilot searches to identify the commonly used terms and relevant articles. A scoping search was also conducted using Ethos, a database of grey literature. Grey literature is a field of information not controlled by commercial publishers (GreyNet, 2013). As grey literature is not published within formal journals, it's not peer-reviewed and may be seen as less credible than literature published within formal journals following a peer-review process. With that said, it's important to consider and review grey literature as it can represent research that is at the stage of initial development, it's often produced by experts in the specific fields (Pappas & Williams, 2011), and it can minimise the potential of publication bias. "Publication bias refers to the propensity for only studies reporting positive findings to be published" (Paez, 2017, p. 234), therefore potentially skewing results within a SLR. However, the search identified no additional papers in the grey literature.

The terminology for the literature search was discussed and agreed upon with the supervisory team, so that the terms would produce relevant results (see Table 7).

Table 7

Search terms and concepts used

Concepts	Search Terms
Concept 1: Research	researchers OR research OR academics OR scholars OR "undergoing research" OR "completing research"
	AND
Concept 2: Suicide	suicide OR "ended their life" OR "topic of suicide"
	AND
Concept 3: Barriers	barriers OR difficulties OR obstacles OR obstructions OR hurdles OR issues

Search terms were combined using Boolean operators 'AND'/'OR' to yield appropriate papers. Due to the timescale of this project and the resources available, only English language papers were included. Table 8 provides a summary of the inclusion and exclusion criteria.

Table 8

Inclusion and exclusion criteria

Inclusion Criteria	Exclusion criteria
Qualitative research	Quantitative research
Mixed-methods research	Individuals who have only expressed their interest in participating in suicide-related research
Researchers who have conducted suicide-related research.	Articles/studies published in any language other than English
Researchers who have attempted to conduct suicide-related research.	
Individuals working on the ethical review boards who are giving ethical approval for suicide-related studies.	
Articles/studies published in the English language	
Individuals who had participants in suicide-related research	

2.4 Outcome of literature search

The initial search of the named databases identified 2434 papers. The Covidence Systematic Review online software tool was used to screen the papers. Out of the 2434 papers, Covidence detected 1247 duplications, which were removed. Initially, the titles and abstracts were screened by both the researcher, and a peer who was a member of the research group, using the inclusion and exclusion criteria as a guide to identify relevant papers. Although this thesis represents the researchers independent work, a member of the research group provided support during the screening process. Use of the Covidence software allowed both individuals within the screening process to view each other’s decisions and deliberate the outcome.

From this initial screening, 1154 further papers were removed as they were not deemed relevant, resulting in 33 papers remaining for full-text screening. From the remaining 33 papers, 8 were identified to fit the inclusion criteria. A full breakdown of this process is shown within Figure 1, using the Preferred Reporting Items for Systematic Reviews and

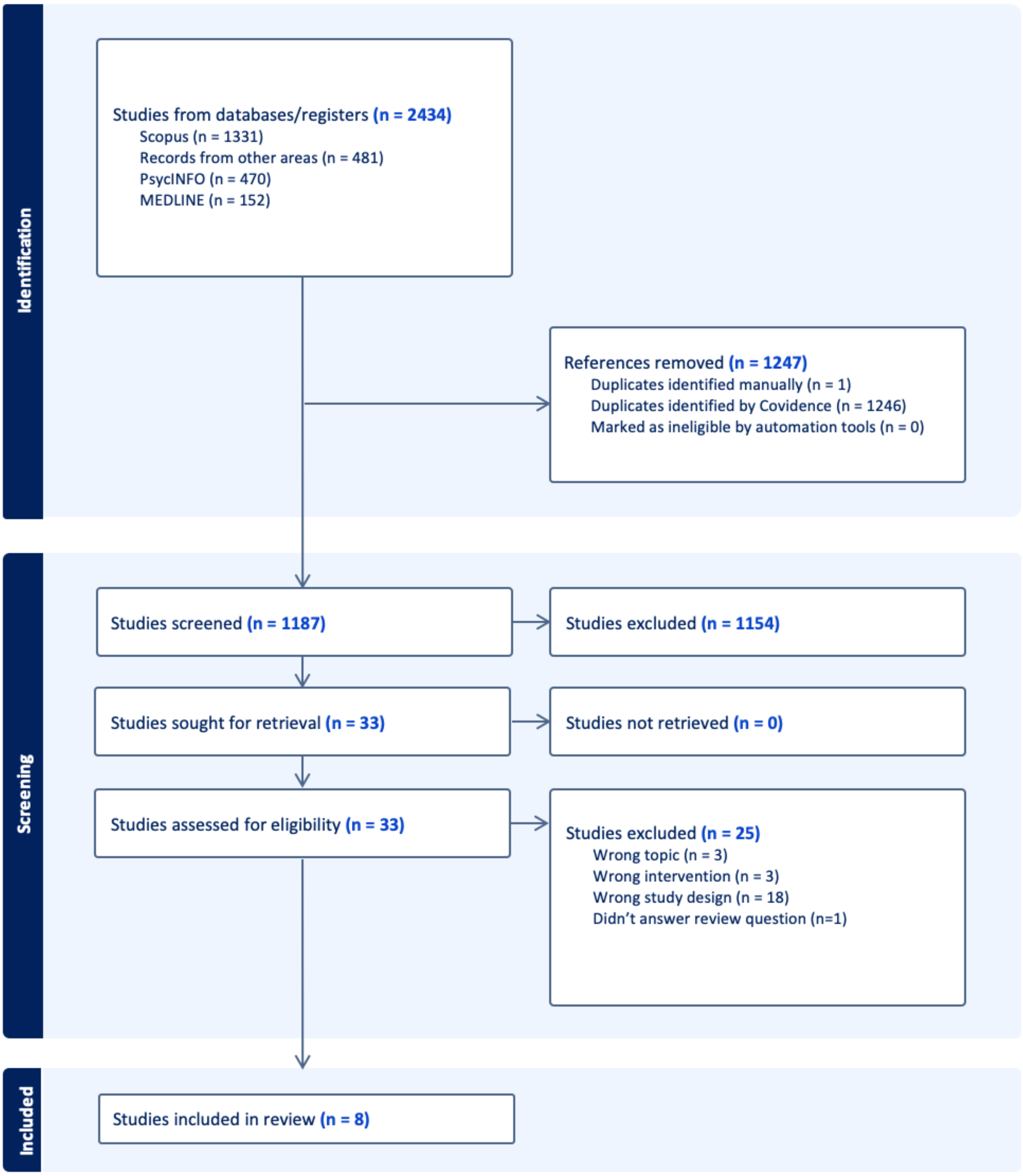
Meta-Analyses (PRISMA) flow chart (2009) (Page et al., 2021). The PRISMA flow chart is an extension of the PRISMA Statement which provides recommendations to “encourage transparent and complete reporting of systematic reviews” (Sarkis-Onofre et al., 2021, p. 1). It is used when conducting systematic literature reviews to highlight what the author has done and found, and to outline the process that was used (Sarkis-Onofre et al., 2021).

As both the researcher, and a member of the research team screened the papers, to gain an understanding of the level of agreeability between the two individuals, inter-rater reliability scores were calculated. Inter-rater reliability assesses and represents the extent to which different raters differentiate between different responses and how consistent this is (Gisev et al., 2013).

It was calculated that there were 64 conflicts when reviewing the titles and abstracts during the screening process. This number of conflicts resulted in a Cohen’s kappa (Cohen, 1960) score of 0.43. When screening the full-texts of the paper, there was 6 conflicts in screening decisions. This number of conflicts resulted in a Cohen’s kappa (Cohen, 1960) score of 0.58. Both of these scores indicate moderate agreement amongst the individuals (McHugh, 2012). To review these conflicts, discussions took place whereby individual decisions and rationales were presented. Disagreements identified related to the screener’s subjective understandings of the papers and their relevance to the review question. Conflicts that were unable to be resolved amongst the screeners were discussed with the wider research group to reach agreement. Following these procedures, full agreement was reached.

Figure 1

PRISMA flow chart



2.5 Data Extraction

Key information from the 8 eligible studies was extracted and inputted into a summary table (Table 9).

Table 9

Summary of studies

Author(s) & Date of Publication	**Aim(s) of study**	**Sample size**	**Participant demographics**	**Country study was conducted**	**Data Collection & Analysis**	**Summary of findings**	**Clinical Implications**	**Strengths and limitations**
Andriessen et al. (2019b)	Investigating what concerns ethics committees have when reviewing research applications (for research related to suicide), and how researchers have then dealt with the concerns raised. To improve understanding in this area, with the aim of supporting researchers and ethics	33	Male: 14 Female: 19 Researchers	Australia	Online survey (forced-choice and open-ended questions). Quantitative data analysed descriptively. Qualitative data analysed using content analysis.	Concerns raised by ethics committees included: -Confidentiality -The responsibilities researchers have to participants -Researcher competency -Participant competency -Harm to researchers -Harm to participants -Access to recruiting population Other: -Potential distress or increased risk of suicide -Appropriate management of distress -Clarifications of definitions and outcome	Provides considerations and advice for what to consider when completing and submitting an ethics application for suicide-related research. Highlighted the need to have vigorous ethics processes to result in improved study designs. Highlighted the need for researchers and ethics	+ Found substantial concerns which was different from previous research (Lakeman & Fitzgerald, 2009). + Correlates to literature (Lakeman & Fitzgerald, 2009) in regard to mirroring the concerns identified + Concerns raised align with the values

	committees to make decisions that can minimise risks and maximise benefits. To ensure safe and ethical research related to suicide, to support suicide prevention.					measures -Project management and data storage -Researchers' responsibilities to participants (e.g. support and resources available to participants). -Participant competency (e.g. participants' mental capacity, young age and ability to provide verbal consent) Indications that most studies could proceed following concerns being addressed. Positive impacts of concerns raised: -Improved clarity -A safer study (e.g., better resourced) -Identifies experiences which can support facilitation of future studies -Opportunities to educate the ethics committee about safe	committees to work together to ensure conduct of safe and high-quality research.	endorsed by the National Statement on Ethical Conduct in Human Research (2007, updated 2018). -Possibility of some relevant researchers not being reached to take part in this study. Cannot determine whether the findings are a representative sample (35% of people emailed completed survey). - Online only- some individuals may have preferred other

						suicide-related research Negative impacts: -Delays in starting research -Limitations to recruitment Advice: -Anticipate possible concerns by providing evidence -Be clear about the study design, potential risks and the procedures which need to be in place to deal with these risks -Researchers should gain better understanding of how ethics committees work, and 'educate' their committee, e.g., by providing relevant information and advice		ways of participating. -Only conducted in Australia.
Gibson et al. (2014)	To identify the impact of taking part in research online.	113	Male: 31 Female: 80 Members of the public: 113	UK	Quantitative (18) and qualitative (7) questions within a	Quantitative: The negative experiences score decreased from 4.5 before the study to 4.0.	Highlights how use of online research can support a change in the power dynamics	+Contribute to a developing body of evidence +Assesses immediate

			Ages: 16-67 97 individuals completed both quantitative and qualitative questions		questionnaire- to be completed before and after taking part in research. Quantitative: The non-parametric within-groups Wilcoxon signed-ranks test was used to test differences before and after taking part in the study. Qualitative: thematic analysis (Braun & Clarke, 2006).	Qualitative: 4 main themes identified- 1. Well-being and distress- sub-themes: ‘judging wellbeing’- making careful judgements regarding their wellbeing and distress before and during the study, encouraged participants to reflect on their recovery process; ‘managing distress’- felt able and willing to cope if they did experience distress, confidence in distress passing; ‘concern for others’- feeling concerned about others experiencing distress in relation to the study, worry of other individuals not being able to make informed decisions about participation. 2. The importance of being heard- provides participants with the opportunity to communicate their	between researcher and participant. Providing the participant with power, and enhances validity by minimizing bias. Allows researchers to continue participant care when undergoing research. Identifies importance of monitoring/ checking in on wellbeing both during and after taking part in research.	impact of research participation +Minimizes bias -No additional data on the longer-term impact -No data on the impact of participation on those who dropped out of the study part way through, and it is possible that the impact of taking part was a reason for non-completion. -Unclear when participants undertook the evaluation -Short or one-word answers to open-ended questions

						feelings.Sub-themes: ‘struggle to be heard’- difficulties verbalizing feelings or giving adequate descriptions to experience; ‘sharing without consequence’- sharing without censure, anonymity of online format; ‘feeling heard, feeling supported’- knowledge that research is underway, participants are listened to, making contact with someone. 3. Therapeutic impact- sub-themes: ‘catharsis’- release, calmness, relief, or positive feelings from sharing experiences; ‘sense-making’- greater self-understanding through participating. 4. Engendering hope- hope for others and hope for self. Sub-theme: ‘hoping to help’- being helpful to others by participating, wanting to be useful; ‘hopes for recovery’- motivation to seek help.		

Dyregrov. (2004)	Phase 3 of a study. To investigate methodological and ethical questions of participating in research- describing parents' experiences and to examine whether there are characteristics of bereaved parents that may explain their experience of participation.	64	Male: 30 Female: 34 Parents from 37 families	Norway	Questionnaire (9 closed-ended items and 3 open-ended questions) Frequency analyses and content analysis (on phase 3 data). Correlation and regression analysis (on phase 1 and 3 data). The qualitative material is analysed after Kvale's (1996) five-stage phenomenological mode of analysis.	Positive experiences were categorized as: (1) telling the story - opportunity for this, no regret of interview participation despite it being "a little" painful and agonizing), (2) the interview format (importance of talking to a person from outside their system, no time-limit), and (3) helping others (telling own strategies of survival could help others- benefit of engaging in research within this topic). Additionally, (4) positive or negative comments about the researchers, or of concerns for future researchers- quantitative analysis used to identify whether negative appraisal of research participation was due to particular characteristics of the bereaved. Predictors of "painful interview experience" at	Encourages researchers to involve bereaved parents within appropriate research. Guidance for researchers to be: caring, understanding, gentle, empathic, humane, interested, and sincere. Recommendations provided for future researchers. Established of LEVE (The Norwegian Organisation for Suicide Survivors). Identified potential need to screen participants for specific vulnerabilities (not to exclude these individuals	+In-depth interviews +Opportunity for multiple family members to be part of the same interview +Provides recommendations for future researchers +Follow-up support offered +Large sample size +Quantitative and qualitative data may help interpret results effectively. -No follow-up was completed -Generalizing the quantitative results.

						the final step were: high GHQ (general health questionnaire) (Goldberg & Williams, 1988) scores and being a woman.	but to take special precautions).	
Lakeman & Fitzgerald. (2009)	To identify what researchers report to be the difficulties associated with suicide-related research, and how these difficulties could, or have previously been resolved.	28	Researchers (suicide researchers) & Ethics Committee members (part of larger project)	Ireland & Australia	Web-based survey with open-ended questions. Descriptive analysis for closed question, content analysis for open questions.	Open-ended question results: - Problems were anticipated related to: accessing the population (unnecessarily pathologizing the person's experience, cultural issues where suicide remains taboo), gaining consent, difficulties or distress that participants might experience during participation, and how to manage this (balance between being a researcher and being a clinician), vulnerability of individuals to exacerbation of suicide and management of risk (what to do if suicidal ideation is expressed), maintaining the validity of the research, and the	Clarifying that researchers don't often have a duty to provide treatment or psychological support, beyond dealing with harm or problems as a result of participating within the research. Making researchers aware of the need for them to disclose how they would respond it was identified that a participant poses an imminent risk of suicide. Teaching that informed consent	+Adds to the understanding of ethical and pragmatic issues that can arise within research involving people who are suicidal or classified as vulnerable. +Represents opinion rather than consensus. -Utilizes a review of recently published research to identify researchers (excludes some

						difficulties that may arise from ethics committees (e.g. overprotective attitudes) - Safety measures provided: recruiting through third party and 'gate-keepers' both an obstacle and a positive, risk management protocols, design and trial study to ensure sensitive and meaningful. Availability, skill, and sensitivity of the researcher were emphasized. - Problems encountered: distress of participants, distinguishing between research and therapy - Ethical review processes: careful to anticipate possible concerns, ethics committee obstructive or resistant, advice provided	shouldn't be a procedure, but a process (that needs to be negotiated and revisited throughout the research). Further research suggestions: building consensus around the principles needed to be considered in suicide research, to inform education and training in how to respond to suicide and make sense of it.	potentially-valuable participants) -28 participants was only 35% of those emailed- snowballing method of recruitment might have supported recruitment -Short answers -Anonymity meant no option to go into greater depth to answers given
Mugisha et al. (2011)	To explore cultural responses and attitudes	28 / 30	28 focus group discussions (FGD), and	Uganda	Focus Groups	Two categories identified: 1. Community access challenges- difficulties	This research has opened up a communication channel in	+Timely study

	toward suicide within the Baganda community in Uganda.		30 key informant interviews (Kis) FGD’s (laypeople), Kis (community leaders) Focus groups conducted with men, woman and youth		Key Informant Interviews Data analysed using grounded theory.	in getting people to talk about issues when the culture demands silence (cultural fears related to death, lack of use of words related to death, culturally related tension); legal challenges (lack of trust in researcher, suicide is a criminal offence, apprehension to talk due to legal connotations, good working relationships with community leaders improved community access for the research); apprehension about consent forms (challenge for those who cannot read or write, may not trust researchers explanation, verbal consent used, double-consent for under 18’s); building rapport (importance of participants feeling relaxed); understanding each other (language competency challenges,	Uganda as the interviewer is a senior government official. This study contributes to the need for integration of suicidology in both the developed and the developing world. Research highlights the need for more qualitative studies in additional countries around the world to facilitate a comparison.	-Use of verbal consent- is this enough? -Small sample size. -Results may not be generalizable to other communities in Uganda or other counties.

						needing to be inducted to meanings of words); logistical issues (limited funds, need to avoid “tarmac bias”) 2. Expectation challenges- community expectations; material expectations (looking at information as goods that can sell); strategic expectations (participants having a strategic vision for their communities, researcher to develop their strategic outlook among the research subjects).		
DeCou et al. (2013)	To understand the perspective and experiences of college students (from rural villages) who have survived the suicide of a loved one, friend, or community members. To explore	25	Male: 7 Female: 18 Age: 18+ (age 18-37). 25 students	United States	Semi-structured interviews Grounded Theory	Conceptual model developed illustrating the experience of completing an interview (through participants’ responses to questions asked within the debriefing part of the interview (tree metaphor emerged)). Themes: 1. Foundation- difficult yet beneficial experience	Identify that discussing suicide may support survivors of suicide. Identifies the importance of conducting future research exploring the therapeutic effect of discussing suicide. Future research:	+Findings consistent with existing literature. +Study aim achieved +Snowball sampling- indicates the benefits experienced of the interview +Opportunity to conduct an

	suicide prevention strategies and identify ways to meet the needs of survivors. To explore experiences and benefits or consequences of discussing suicide during an interview.					2. Exposure to suicide- history of exposure to suicide had an impact on how the participants experienced the interview, and potential benefits found from discussing suicide. 3. Previous therapy or counselling- benefit of counselling to be allowed to discuss past experiences. 4. Talked or thought about before- benefit of being able to talk about experiences 5. Process- previous life experiences impacted how the individual experienced the interview process (e.g. beliefs about discussing suicide) 6. Talking about suicide- importance of interviewer being thoughtful, and the experience of active listening 7. Barriers to communication-	-include other methods to understand the effects of discussing suicide - Developing appropriate interventions to meet the needs of those affected.	interview with someone with different ethnic and cultural difference (between interviewer and participants) +Anonymity -Specific population. -Self-selection bias to take part -Snowball sampling may have resulted in selection bias. -Generalizability. -Unknown long-term effect

						difficulties of western and traditional cultures and languages, particularly when suicide is culturally bound to silence. 8. Outcomes- Benefits from interview experiences. 9. Focus and clarification- personal and professional goals, self-realization (purpose and motivation to achieve goals) 10. Perceived affective benefit- increase in positive affect 11. Helping and giving back- motivation to take action to address suicide prevention 12. Realization of insight- Participants realising that their voices can contribute to discussions of suicide and supporting suicide prevention		
Moore et al. (2013)	To explore the challenges of ethical approval,	25	Male: 7 Female: 18	Worldwide (US, Australia	Online pilot survey (the Survey of	Research proposals have been challenged, with individuals reporting	Findings offer novice researchers	+Identification of real-life

	and the lessons learned from prior experiences of the ethical approval process when conducting suicide bereavement research. To explore experiences of navigating ethical review boards.		Researchers	, Europe, Asia)	Post-vention Researchers) No clear data analysis identified- a description of subjective experiences	they were required to make major changes to their proposals as a result. Concerns researchers received include: - Participants being traumatized by discussing their experiences – 'Discussing suicide could lead to contagion' – Insufficient support for participants who did become upset – Research self-identification as survivor may be coercive – How to ensure confidentiality and data security – Recruitment processes Impact: -Delays to start of research Ways to navigate review board: -To educate the ethical board committee members about suicide	guidance regarding how to approach ethical review boards in order to provide a timely approval. Recommendation for guidelines for novice/new researchers to be developed. Further research needed: -To determine suicide bereaved participants' opinions about research -To determine the role of ethical boards in protecting participants -To find ways of supporting ethical board members through the re- view of proposed suicide bereavement	difficulties encountered **-**No analysis of the data clarified, just a descriptive explanation provided

						research (e.g. sharing existing literature) -Provide guidance to use researchers' clinical skills to manage distress of participants	research -To include qualitative and quantitative research -To explore the potential benefits and challenges of research (qualitative and quantitative) in suicide bereavement	
Wadman et al. (2019)	To explore the perceptions and experiences of Early Career Researchers (ECR's) involved in youth and/or adult involvement work in the field of mental health (e.g. self-harm and suicide research). To explore ECR's perspectives as to whether work	41	Early Career Researchers (ECR's) ECR's undertaking research in mental health, self-harm and/or suicide in the UK	UK	Survey (closed and open-ended questions) Self-report questionnaire (administered online) Quantitative descriptive statistics provided. Qualitative data thematically analysed using	Value of involvement had a significant difference between youth involvement and adult involvement. Themes identified describing challenges/what can support facilitation: 1. Ethical approval and access to young people/specific groups- safeguarding concerns, ethical approval and ethical considerations needed to be taken 2. Perceptions of risk involved- potential of affecting well-being,	Can lead to the development of future research that is accessible and relevant to these populations. Highlights both barriers and factors that can support the facilitation of undergoing involvement work, providing guidance for future ECR's who wish to	+Highlights both barriers and factors that can support facilitation +Recruitment benefit through use of social media +Diversity- participants had different and unique experiences of undergoing involvement work research -Small sample.

	in youth and adult involvement is valued, to describe how ECRs involve young people and adults in research, and identify barriers in completing youth and adult involvement in their research.				inductive coding.	perceptions influenced involvement in research (e.g. supervisors) 3. Real costs (time/money) vs. perceived value- lack of funding was a barrier, lack of benefit for involvement identified as a barrier 4. Challenge of recruitment- difficulties working with certain populations, difficulties in 'finding' participants and having connections to recruit 5. Expert examples, expertise & guidelines- felt learning from others experience supported involvement work, professional resources supported this (e.g. guidelines, training schemes) 6. Practical resources (e.g. money)- costs were a barrier, increased resources promoted practice of involvement work	progress in this field of work.	-Unclear how many individuals chose not to participate due to recruitment method (social media) -Terminology used to describe involvement work is confusing and used interchangeably (impacting recruitment uptake)

						7. Wider community support- forming relationships between community groups and researchers was a facilitative factor 8. A supportive culture within institutions- need for greater support from organizations, a shift in culture needed.		

2.6 Study Characteristics

Studies within the review were published between 2004 and 2019. The sample featured both studies using qualitative methods (DeCou et al., 2013; Moore et al., 2013; Mugisha et al., 2011), and mixed methods (Andriessen et al., 2019b; Dyregrov, 2004; Gibson et al., 2014; Lakeman & Fitzgerald, 2009; Wadman et al., 2019). Only qualitative data within the mixed methods papers were synthesised as it supported the purpose and question proposed for the review. This process of considering specific aspects of the data provided is often referred to as 'tagging data' (Baptiste, 2001).

2.6.1 Included study aims

The studies each had specific aims including: exploring experiences of engaging in suicide-related research and engaging in dialogues about suicide (DeCou et al., 2013; Dyregrov, 2004; Gibson et al., 2014; Mugisha et al., 2011), experiences of ethical approval processes when aiming to or conducting suicide-related research (Andriessen et al., 2019b; Moore at al., 2013), researchers overall experiences of conducting suicide-related research (Lakeman & Fitzgerald, 2009), and researchers experiences of involvement work in the field of mental health (Wadman et al., 2019).

2.6.2 Study countries

The studies included were from across the globe including studies conducted in Australia (Andriessen et al., 2019b; Lakeman & Fitzgerald, 2009; Moore et al., 2013), United Kingdom (Gibson et al., 2014; Wadman et al., 2019), Norway (Dyregrov, 2004), United States (DeCou et al., 2013, Moore et al., 2013), Ireland (Lakeman & Fitzgerald, 2009), Uganda (Mugisha et al., 2011), Europe (Moore et al., 2013), and Asia (Moore et al., 2013).

Although most of the studies were from the Western world, the variation in countries where the research was completed allows for a greater understanding of how suicide-related research is conducted globally, and the differences and similarities of challenges within different cultural contexts. Including studies from various countries allows for geographic diversity of knowledge (Hohberger & Wilden, 2022).

2.6.3 Study sample sizes and demographics

Sample sizes varied across the eight studies, with 25 participants being interviewed, from 25 to 41 individuals being surveyed, and 41 to 97 individuals asked to complete a questionnaire. One of the studies did not state specifically the sample size (Mugisha et al., 2011), but reported that 28 focus group discussions were held and 30 interviews took place.

Individuals recruited within these studies included researchers (Andriessen et al., 2019b; Lakeman & Fitzgerald, 2009; Moore at al., 2013; Wadman et al., 2019), as well as members of the public (Gibson et al., 2014), parents (Dyregrov, 2004), laypeople and community leaders (Mugisha et al., 2011), and students (DeCou et al., 2013), all of whom had engaged with, or participated in suicide-related research.

In terms of additional demographics reported for participants, five studies reported the gender of the participants (Andriessen et al., 2019b; DeCou et al., 2013; Dyregrov, 2004; Gibson et al., 2014; Moore et al., 2013), and two of the studies specified the ages of their participants. DeCou et al (2013) stated that participants were all students aged 18 to 37, and Gibson et al (2014) reported that the participants were between the ages of 16 and 67.

2.6.4 Data Collection and Data Analysis

Four studies used surveys to collect their data (Andriessen et al., 2019b; Lakeman & Fitzgerald, 2009; Moore et al., 2014; Wadman et al., 2019), two studies used questionnaires

(Dyregrov, 2004; Gibson et al., 2014), one study used interviews (DeCou et al., 2013), and one study used a combination of both interviews and focus groups (Mugisha et al., 2011). For data analysis, two studies used thematic analysis, two studies used grounded theory, two studies used content analysis, one study used frequency analysis and content analysis, analysing after Kvale's (1996) five-stage phenomenological mode of analysis (Dyregrov, 2004), and the data analysis approach was unclear in one study (Moore et al., 2014).

2.7 Quality appraisal

Completing a quality appraisal assessment ensures that the literature is assessed for quality, allowing for 'low' quality studies to be potentially eliminated from the review (Pati & Lorusso, 2018). This is an essential part of the SLR process (Shaw, 2021). To assess the quality of research there are multiple appraisal tools which can be used. The quality of each of the articles included within this review were assessed using the Critical Appraisal Skills Programme (CASP) checklist (CASP, 2018). The CASP was deemed appropriate for use due to it being reported as 'user-friendly' for early career and novice researchers (Long et al., 2020).

Within the CASP checklist there are 10 items to assess quality. Scoring of the CASP is determined by assigning 'Yes', 'No' or 'Cannot tell' to each item. A score of 1 was given for all 'Yes' items, and a score of 0 was given for both 'No' and 'Cannot tell' items. An overall score was given for each paper, with ratings of poor (total score: 1-4), fair (total score: 5-7) or good (total score: 8-10).

Although it's recommended at least 10% of studies are screened independently for quality by 2 reviewers (NICE, 2022), a member of the research group reviewed 100% of the relevant papers identified. There was a 92.5% concordance rate between the reviewers. Disagreements were mainly present when assessing whether the studies recruitment strategy was clearly defined. These disagreements were resolved through discussions about the papers themselves and what was specifically written within them. The combined scores for each of the CASP items for this SLR are shown in Table 10.

2.7.1 Quality of the studies

Although appraisal results are commonly used to exclude lower quality papers from a review (Hannes & Macaitis, 2012), as studies with lower quality can be found to contribute less to the synthesis (Thomas & Harden, 2008), the validity of excluding studies based on quality assessment alone is limited (Thomas & Harden, 2008). The CASP was therefore used to assess and recognise the range of quality across the studies.

The majority of studies were given a ‘fair’ to ‘good’ quality rating, with just one study receiving a ‘poor’ quality rating. With the debating literature surrounding the impact of excluding studies due to quality, a post-synthesis sensitivity analysis (P-SSA) was completed to judge the impact of excluding the ‘poor’ rated study from the overall synthesis (Carroll et al., 2012). Sensitivity analysis is used to “determine how sensitive the results of a study or systematic review are to changes in how it was done” (Shoptaw et al., 2008, p. 6). Through P-SSA, it was identified that exclusion of the ‘poor’ quality rated study would have removed aspects of important themes identified from the synthesis. Conducting this analysis allowed for an informed decision to be made to include this paper within the review.

It’s recognised that the scorings provided were based on the written format of the studies, rather than the actual research and research topics themselves. When critically appraising these studies and considering their value, it’s important to reflect on the factors that may result in these studies not meeting the criteria for all of the items in question, including: word count, aspects that may have been considered but not written, and the way in which the authors had wanted the research to be read (e.g., as a story rather than a description of the processes involved). In addition, it's important to disclose that the scores provided for each study are subjective to the researcher. A sample of one of the studies full quality assessment can be found in Appendix B, and a detailed description of the eight studies outcomes of the quality assessment can be found in Appendix C.

Table 10

Quality appraisal

	Was there a clear statement of the aims of the research?	**Is a qualitative methodology appropriate?**	**Was the research design appropriate to address the aims of the research?**	**Was the recruitment strategy appropriate to the aims of the research?**	**Was the data collected in a way that addressed the research issue?**	**Has the relationship between researcher and participants been adequately considered?**	**Have ethical issues been taken into consideration?**	**Was the data analysis sufficiently rigorous?**	**Is there a clear statement of findings?**	**How valuable is the research?**	**Score**
Dealing with Ethical Concerns in Suicide Research: A Survey of Australian Researchers. Andriessen et al., 2019b	Yes	Yes	Can’t tell	Yes	Can’t tell	No	Can’t tell	Yes	Yes	Yes	6 Fair
The Impact of Participating in Suicide Research Online. Gibson et al., 2014	Yes	Yes	Yes	Can’t tell	Yes	No	Yes	Yes	Yes	Yes	8 Good

Bereaved parents' experience of research participation. Dyregrov, 2004	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Yes	No	Yes	Yes	7 Fair
Ethical suicide research: A survey of researchers. Lakeman & Fitzgerald, 2009	Yes	Yes	Yes	Can't tell	Yes	No	Can't tell	Yes	Yes	Yes	7 Fair
Doing qualitative research on suicide in a developing country: Practical and ethical challenges. Mugisha et al., 2011	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Can't tell	Yes	Yes	7 Fair
The benefits of discussing suicide with Alaska native college	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10 Good

students: Qualitative analysis of in-depth interviews. DeCou et al., 2013										
Challenges and opportunities for suicide bereavement research: The experience of ethical board review. Moore et al., 2013	Yes	Yes	No	Can't tell	Can't tell	No	Can't tell	No	Yes	Yes	4 Poor
Supported and valued? A survey of early career researchers' experiences and perceptions of youth and adult involvement in mental	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	9 Good

health, self-harm and suicide research. Wadman et al., 2019											

2.8 Synthesis strategy

There are various methodologies that can be used to synthesise qualitative research, including thematic synthesis and narrative synthesis (Schick-Makaroff et al., 2016). Although other methodologies were considered, thematic synthesis was chosen to be used within this review as it allowed for the findings of the studies to be synthesised in a transparent way (Thomas & Harden, 2008). It involves using thematic analysis to analyse and synthesise qualitative studies (Thomas & Harden, 2008). To support this analysis, NVIVO 14 software was used.

The review synthesised the findings from the eight papers using guidance from Siddaway et al. (2019). Following the initial review of the studies, and the researcher familiarising themselves with the papers, Thomas and Harden (2008)'s techniques were followed to synthesise the studies. These techniques include: coding the text line-by-line, developing descriptive themes, and generating analytic themes.

2.9 Synthesis of findings- Results

An overview of the key findings across the articles will be discussed. From the synthesis process, five main themes and seven subthemes were identified (see Table 11).

Table 11

Themes and subthemes

Themes		**Subthemes**
Theme 1	Ethical approval process	Perceptions of risk/harm Length of process Boundaries
Theme 2	Cultural differences	Relationship/trust with researchers Impact of legal status Shared language Taboo
Theme 3	Community expectations	
Theme 4	Potential harm to participants	
Theme 5	Recruitment	

2.9.1 Theme 1: Ethical approval process

The ethical approval process to conducting suicide-related research was reported within four studies as a challenge. Specifically, the concerns raised by the ethics committee, the length of the process, and unclear boundaries were identified as difficulties impacting conducting suicide-related research.

Perception of risk/harm

Four of the studies evidenced a barrier to conducting suicide-related research as being the perception of risk or harm that the ethics committees held (Andriessen et al., 2019b; Lakeman & Fitzgerald, 2009; Moore et al., 2013; Wadman et al., 2019). Moore et al. (2013) described that concerns related to risk or harm that were highlighted in ethics applications included: '*Survivors would be traumatized by discussing their experiences'* (p. 301) or that there was a *'danger of ripping open wounds'* (p. 301) when participating in suicide-related research. Additionally, ethics committees were reported to state that *‘talking about suicide could lead to contagion’* (Moore at al., 2013, p. 301). Literature has identified that this is a myth and that talking about, or asking about suicide will not result in individuals taking their own life (O’Connor, 2021). Despite this, it continues to act as a barrier due to the misconceptions held by those assessing research proposals for ethical approval.

Within some studies it was reported that the ethics committees have been seen to be overly cautious. It’s important to highlight that research can be done well to avoid harm, and that there is a need to educate ethics committees about this. Ensuring that studies are assessed on an individual basis was highlighted within Wadman et al. (2019)’s study when they described ethics committees as being ‘*risk averse to the detriment of research and rather than weight up the implications of a study case by case, they try to manage the risk with blanket policies’* (p. 7). Blanket policies may be suitable to reduce the time spent approving research, but shouldn’t be detrimental to research taking place, or act as a barrier to particular research topics being explored.

The need for researchers to engage in careful consideration when making an ethics application was highlighted within Lakeman and Fitzgerald’s (2009) study where researchers *‘had been careful to anticipate possible concerns’* (p. 14). Anticipating possible concerns related to harm provided ethics committees with the knowledge and understanding of how researchers would overcome or manage potential difficulties. Without these considerations and ethics committees being educated on the topic of suicide, this can delay the ethical approval process and may result in multiple applications needing to be submitted (Moore et al., 2013).

Length of process

Three of the studies highlighted how the lengthy timeframe of the ethical approval process had resulted in additional costs, delays in starting research, and recruitment difficulties. It was reported that '*the duration had caused issues, such as delays in the study (36.4%), additional cost (9.1%) or unavailability of staff (9.1%)'* (Andriessen et al., 2019b, p. 7), and the process was '*costing a lot of time and effort to the researcher'* (Wadman et al., 2019, p. 7).

Boundaries

An additional challenge evident within two studies related to the boundaries that ethics committee members should work within. Participants of Lakeman and Fitzgerald's (2009) study reported '*that the paternalistic and overprotective attitudes of ethics committees towards perceived vulnerable groups posed a problem in designing good research protocols'* (p. 13). These attitudes may impact the number of suicide-related studies conducted, and the number of researchers who are willing and able to consider researching this topic, due to the perceived barriers documented by previous researchers.

Without ethics committees understanding, acknowledging, and working within the guidelines of their work, members of these committees may make ill-informed decisions when reviewing a research proposal. Moore et al. (2013) highlighted that *'some ethical boards may not be well informed about the boundaries of their own responsibility, and may be bringing with them prejudices and myths about suicide and suicide bereavement commonly reported in the broader community'* (p. 301). To ethically review an application, it's essential for committee members to be aware of their own biases and prejudices, and to ensure they don't impact their decision-making, as doing so may result in valuable research not taking place.

2.9.2 Theme 2: Cultural differences

Four of the studies specified that cultural differences acted as barriers to conducting suicide-related research (DeCou et al., 2013; Lakeman & Fitzgerald, 2009; Mugisha et al., 2011; Wadman et al., 2019). Specific topics included: trust of the researchers, the impact of legal status of the topic, language, and suicide as a taboo topic.

Relationship/trust with researchers

Three papers (DeCou et al., 2013; Mugisha et al., 2011; Wadman et al., 2019) spoke to the idea that to support the facilitation of meaningful research, participants need to feel there's shared trust with the researchers, and that a participant-researcher relationship needs to be formed. A lack of trust with the researchers and no relationship formed can therefore act as a barrier to research taking place (Mugisha et al., 2011).

As reported by Mugisha et al. (2011),'*people become reluctant to speak about their experience because they do not "trust" the researcher'* (p. 17). This distrust may be impacted by the cultural differences, or the lack of connection between the researcher and the community in which they're conducting the research. As DeCou et al. (2013) highlighted there can be an experienced '*difficulty communicating cultural beliefs related to suicide'* (p. 73) when the culture and beliefs of the researcher is different to the participants. Difficulties in communication can be managed through forming relationships and building trust. As Wadman et al. (2019)'s reported: *'improvements in the relationships between community groups and researchers was mentioned as a facilitative factor'* (p. 9).

Without forming a relationship, making connections, and promoting trust within research, researchers can be faced with challenges, these being particularly prevalent when aiming to conduct suicide-related research within cultures whereby suicide is not talked about freely.

Impact of legal status

As suicide is still a legal offence within multiple countries around the world, challenges may arise regarding recruitment when conducting suicide-related research. Mugisha et al. (2011) described, that legal connotations of suicide can mean that *'gaining access to study respondents may be compounded by the prevailing laws in the country'* (p. 17), and if able to access potential participants, they may exhibit apprehension. Mugisha et al. (2011) reported that *'participation in the study had some legal connotations, so that respondents were fearful of giving written consent'* (p. 18).

Due to the barrier that legal status can create in conducting suicide-related research and individuals participating in this, individuals' suitability for research needs to be considered to ensure there aren't unnecessary consequences to participation. As suggested by Lakeman and Fitzgerald's (2009), *'there are broader questions about who should be approached to be involved in research and how to approach them'* (p. 13).

Shared language

Within two of the studies, a theme of not having a 'shared language' was evident as a challenge to conducting suicide-related research. Challenges related to language impacted: obtaining informed consent, understanding between participant and researcher, and the emotions felt by the participant. Within DeCou et al. (2013) study, participants described experiencing *'frustration when they felt they could not adequately communicate, cross-linguistically, the essence of their experiences'* (p. 73), describing this challenge through their attempt of explaining their experience: *'you have a word for…something and you try to* *translate it into English and it's not as powerful as it is in …the language…and it's really frustrating sometimes…or I don't know how the…to explain this word in English and it's not gonna have the same effect'* (p.73).

This barrier of not having a shared language was evident in relation to communication between the researcher and the participant, and also regarding the participants understanding, for example when obtaining informed consent. Mugisha et al. (2011) highlighted that *'apprehension about informed consent in developing countries may also be compounded by the high illiteracy levels'* (p. 18). Not having a shared language between the researchers and participants, can therefore act as a barrier to conducting research or gaining a true understanding of an individual's experience.

Taboo

Four of the papers (DeCou et al., 2013; Gibson et al., 2014; Lakeman & Fitzgerald, 2009; Mugisha et al., 2011) considered the impact that the view of suicide as a 'taboo topic' can have on the research conducted. DeCou et al. (2013) reported that students expressed *'the conflict they experienced in sharing sensitive feelings and information about a topic that is often culturally bound to silence.'* (p. 72). This conflict in sharing information and experiences can have clinical implications on how meaningful the data is, and how comfortable an individual is to participate. The taboo, stigma, and silences around suicide can lead people to not directly discuss it, and instead avoid or talk around the topic. This was evident within Mugisha et al. (2011) findings where individuals reported that the community of *'Baganda fear to approach the subject death directly; they prefer to talk around it'* (p. 19).

Although the subject of suicide continues to be experienced as a taboo topic, which can result in less research taking place within this field, a participant within Gibson et al. (2014)'s study highlighted the importance of engaging in this research despite it being a taboo topic, as it provided them with a space to acknowledge and discuss the topic: *'[participating] made me think about my suicidal feelings in depth, as we don't really talk about them in depth.'* (p. 378).

2.9.3 Theme 3: Community expectations

Another challenge highlighted focused on the expectations that individuals within the community being researched have about the research, it's purpose, and their involvement. Particularly within communities whereby suicide is viewed as a criminal offence, or it remains a 'taboo topic', there were discrepancies between the expectations of the purpose of engaging in research, experienced by participants, and the expectations of the researchers. Mugisha et al. (2011) described that '*poor communities looked at their information as goods that they had to sell to the researcher'* (p. 19). This misalignment of expectations was highlighted as being particularly present within cultures where there is perceived or actual risk to discussing suicide. Mugisha et al. (2011) highlighted that '*communities were seeing themselves as dealing in goods that are culturally risky given the cultural meaning(s) of discussing suicide-related issues openly'* (p. 19). This misalignment or lack of clarity of the purpose of participation can bring into question whether participants engaging in this research have made informed decisions to consent to taking part, resulting in ethical dilemmas associated with this.

Although DeCou et al. (2013) highlighted benefits of participating in suicide-related research (including participants experiencing affective benefits and expanding how they think about suicide), the individual and the communities' expectations of the 'appropriateness of the topic' was found to impact the involvement and experience of being a participant. Students described obstacles to sharing their experiences due to *'the tension of converging* *western and traditional cultures'* (p. 72), and community expectations of talking about a topic which is *'inherently sensitive and personal'* (p. 72)

Clearly outlining and discussing these differences in expectations would hopefully result in researchers and participants expectations being more aligned, allowing for informed consent regarding participation, and clearer understanding of the purpose of the research. Additionally, being aware of different community expectations will provide researchers with a greater understanding of what may be viewed within different cultures and communities as 'appropriate', which will identify gaps within the research, and ways to conduct this research in a culturally sensitive way.

2.9.4 Theme 4: Potential harm to participants

Whilst risk of harm was highlighted as a difficulty during the ethical approval process, an additional theme captured included the care of individuals during the research process, following ethical approval. Potential harm to participants impacts the level of care that is required when working in a research capacity. Six of the studies identified the concern of potential harm to participants during the research process as challenges (DeCou et al., 2013; Dyregrov, 2004; Gibson et al., 2014; Lakeman & Fitzgerald, 2009; Moore et al., 2013; Wadman et al., 2019).

Within Dyregrov (2004)'s paper a parent described that they *'had been afraid that the interview would be agonising and they felt that they had mustered a lot of energy in the days before the interview'* (p. 395). Potential harm to participants was also described within DeCou et al. (2013) study whereby *'students also described the difficulties that arose from not having discussed suicide prior to completing and interview'* (p. 72), with one participant describing their experience of engaging in suicide-related research as *'...kind of saddening, because I had to talk about what suicide has done personally in my life'* (p. 72). Potential harm or distress to participants can therefore act as a barrier to people participating in research due to anticipated fear and worry.

This theme highlights the need for researchers to prepare individuals for participation, ensuring that they're fully aware of what their participation will involve, to alleviate or remove participants concerns about discussing sensitive topics.

Potential harm to participants not only has an impact on the participants themselves, but also on the researchers, as part of their role is to identify this potential risk (Lakeman & Fitzgerald, 2009). Within Lakeman and Fitzgerald's (2009) study, one individual spoke to there being *'a fine balance between being a researcher and being a clinician'* (p. 13). This concern experienced by researchers does not only impact those individuals who hold the dual-identity of researcher and clinician though, as all researchers may be required to identify participants at risk of harm and those who may be "imminently suicidal" (Lakeman & Fitzgerald, 2009, p. 13). This can therefore act as a barrier to researchers undertaking research projects within this area due to their fear, or lack of training in managing these potential risks, and due to the potential blur of roles as a researcher and the need to use clinician skills. Despite this being identified as a potential barrier, it can also be considered as a reason for individuals who hold a dual-identity of researcher and clinician to conduct this research as their skills may support these difficulties.

The literature not only identifies what the issues are regarding potential harm to participants, but also ways to address these risks. DeCou et al. (2013) highlighted that offering participants a debrief session where they can use reflective thinking (Dufrene & Young, 2014) to discuss their participation, and share and reflect on any distress they encountered during participation, can support participants further. Another way the potential risk of harm to participants was addressed included the researcher ensuring safety during participation for the participant. DeCou et al. (2013) highlighted the importance of *"thoughtful questioning and active listening"* (p. 72) by the researcher to ensure safety to speak and to encourage in-depth inquiry of participants experiences. Lakeman and Fitzgerald (2019) emphasised this point, highlighting that researchers need to *"ensure that participants feel safe and secure in the interview, and that the distress they feel is no more than they would feel in their normal lives"* (p. 13). Checking in with participants throughout the interview, and offering them to 'pass' on questions, or stop the interview all together can support this.

Participants within Dyregrov (2004) study outlined recommendations for researchers to support participation process being thoughtful, safe for the participant, and attempts to reduce or eliminate the risk of potential harm to participants. These recommendations included: *"give us thorough and written information before research participation; listen respectfully to the momentos we find relevant to show, or tell you about; give us the opportunity to reflect and ask questions during and after the interview; offer follow up after the interview, e.g. information, contacts for professionals"* (p. 395). With that said, the recommendation to offer a follow-up after participation may blur the boundaries between research and support. Participants have consented to take part in research, dependent on the information provided to them, however they haven't consented to receive psychological support. Researchers need to ensure that their rationale for providing or not providing support is clear, and can provide support details to participants if required.

Despite some studies reporting distress and emotional impact experienced by participants, participants within Gibson et al. (2014) study expressed levels of distress as being manageable, with one participant stating: *'I wouldn't say it is upsetting but it is challenging having to look back and describe feelings that are difficult to me'* (p. 377). Other participants expressed their worry *'that more vulnerable individuals might not be able to take such careful, informed decisions about their participation'* (p. 377). This concern may be due to the potential bias caused by the observer-expectancy effect. The observer-expectancy effect involves individuals changing their behaviour due to the fact that they're being observed (McCambridge et al., 2014). In this context, participants may not make careful, informed decisions about participation, or ask to withdraw or not answer questions, because the researcher is present. This highlights the need to carefully consider the potential harm or distress that participation may cause an individual, as well as how this is assessed and monitored throughout the research process, and how it's managed if distress arises. These are important aspects of the researcher's role in minimizing the potential negative impact of sensitive research, such as suicide.

It's essential for researchers to acknowledge the potential harm to participants in sharing their experiences and to ensure that appropriate and adequate care is provided during the research process. Although, as mentioned within the literature, there could be potential harm when engaging in research of this topic, this doesn't mean that the research should not take place, as many of the papers outlined the anticipated upset was greater than the actual emotions experienced (DeCou et al., 2013; Dyregrov, 2004; Gibson et al., 2014).

2.9.5 Theme 5: Recruitment

A final theme identified was the difficulty of recruiting individuals to participate in suicide-related research. There are organisational factors to this difficulty, factors related to personal and familial impact, as well as the legal and language factors mentioned previously. Wadman et al. (2019) highlighted that *'organisations aren't willing to engage for fear of perpetuating suicide'* (p. 7). If organisations perceive there's a risk to supporting suicide-related research, this can impact recruitment and advertisement.

Difficulties related to recruitment were expressed regarding the impact that participation may have on individuals and members within their system. Lakeman and Fitzgerald (2009) identified that *'accessing the population was considered an ethical problem* *that might involve unnecessarily pathologizing the person's experience, pose problems in terms of causing distress to family members and maintaining confidentiality (particularly in small populations)'* (p. 13). Pathologising involves using "pathology terms to describe human experience (Rubin, 2000, p. 176). When conducting suicide-related research, researchers need to be aware of not labelling someone's behaviour as a problem, or something that requires intervention. As Rubin (2000) highlighted, pathologizing someone's experience tends to label their experience as bad, despite this not being the view of the person themselves. To reduce unnecessary pathologising, researchers should use the language used by the individual, and have constructive discussions to ensure that assumptions aren't made about participants experiences. When considering the recruitment of participants, particularly when conducting focus groups and other group qualitative data collection methods, researchers need to ensure that participants are fully aware that their identity within these certain methods cannot always remain anonymous. In addition to explicitly making potential participants aware of this, when writing up their findings, researchers need to ensure that their data is anonymised, and identifiable information is removed to prevent potential distress to family members who may not be aware of the individual's participation.

Despite these factors acting as difficulties when conducting research, Mugisha et al. (2011) attempted to respond to difficulties related to recruitment. In order to support access to participants, Mugisha and colleagues (2011) spoke of working with gatekeepers which involved *'approaching different power centers at different levels'* (p. 17). Gatekeepers within this context were political leaders, who were able to provide both direct and indirect access to the community (Mugisha et al., 2011). Accessing gatekeepers to the community allowed for greater opportunities of recruitment due to there being a clear indication from community leaders of endorsement that the research was accepted (Mugisha et al., 2011). It's therefore important for researchers to consider the different avenues and relationships they can form in order to promote their research.

2.10 Discussion

This systematic review on the potential barriers and challenges to conducting suicide-related research identified eight research studies, which were effective in ensuring that the voices of both researchers and participants were heard.

Overall, the reviewed literature highlighted the complexities in conducting, or attempting to conduct, suicide-related research, particularly due to the process of gaining ethical approval. It’s clear from the studies reviewed that, although there are barriers and challenges to completing research within this topic area, this research can be completed safely and well when considerations are made to the potential risks, and perceived and experienced challenges previous researchers have faced.

The systematic review identified both challenges and potential solutions in relation to completing suicide-related research (Table 12).

Table 12

Challenges and potential solutions

Challenges	Potential solutions
The process to gaining ethical approval can be lengthy in duration.	Factor in time in the planning phase for this.
Ethical review board committee members can overestimate the potential risk to individuals participating in suicide-related research, resulting in them rejecting or questioning research proposals.	Ensure that proposals carefully consider risk with thorough risk assessments, including risk management strategies.
Due to suicide continuing to be a taboo subject or a stigmatised topic of conversation within different cultures, this can cause barriers to individuals participating within suicide-related research, or a barrier to researchers having access to and being able to recruit for studies focusing on this topic.	Ensure researchers have an understanding of cultural beliefs/understanding and appropriate language for sensitive culturally-appropriate discussion Approach community leaders- community leaders were not approached within this research due to the time limitations of the project.
Individuals need to be aware of the benefits experienced by participants following engaging in suicide-related research, including the space to discuss topics they had not had the opportunity to talk about before	Ensure time for reflection, not only planned interviews
Individuals may not chose to participate in research due to the fear of what may be asked of them during the interview process.	Providing participants with the semi-structured interview schedule prior to participation to enable them to have a full understanding of their participation and provide fully-informed consent.
Management of risk of potential harm to the participant, if they were to become distressed within the research process due to the topic being sensitive.	Creating a risk management protocol in the event that a participant becomes distressed or is at risk of potential harm within the interview process. Providing participants with a signposting sheet with professional support and contact details following completion of the interview.

A strength of this SLR involves the rigorous methods used to minimise potential bias when reviewing the individual studies. This rigorous method involved using a peer who was a member of the research group to support not only the screening process of articles, but also to complete the quality assessment of the articles reviewed. Another strength of this review is its relevance to supporting future research as it identifies not only the barriers to conducting this research, but also highlights ways to overcome these barriers. This is important in providing best practice recommendations for future researchers.

A potential limitation of this review involves the fact that the search was limited to English written papers. Future researchers may benefit exploring whether there are additional studies related to this topic written in languages other than English, and if so, to discover whether additional challenges, barriers and solutions are captured. It would also be beneficial for future reviews to explore the experiences of ethical committee members when examining suicide-related research proposals. This would allow for a greater understanding as to whether the barriers and challenges identified within this review are shared or experienced by the individuals providing ethical approval, and could inform training and professional development.

To assess the quality of this SLR, the Critical Appraisal Skills Programme (CASP) checklist (CASP, 2018) was used. Table 13 outlines the quality assessment of this review.

Table 13

CASP assessment of SLR

	Did the review address a clearly focused question?	**Did the author look for the right type of papers?**	Do you think all the important, relevant studies were included?	Did the reviews authors do enough to assess quality of the included studies?	**If the results of the review have been combined, was it reasonable to do so?**	**What are the overall results of the review?**	**How precise are the results?**	**Cam the results be applied to local population?**	**Were all important outcomes considered?**	**Are the benefits worth the harms and costs?**	**Score**
Systematic Literature Review	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes-precise	Yes	Yes	Yes	8 Good

2.11 Conclusion

The review demonstrates that the societal narratives held in relation to suicide can impact how straight-forward the process of gaining ethical approval is. Researchers should use this knowledge to educate ethical committee members so that they're able to have a clear understanding of the relevance and need to conduct research within this topic, and to reduce any stigmatised views or beliefs held by members of the public when thinking about suicide. The literature emphasises the need for researchers to provide detailed proposals for their research, outlining any anticipated possible concerns and ways in which they would overcome these. This would hope to reduce the number of amendments and changes needed during the proposal process, allowing for research to be completed in a timely manner.

Best practice recommendations to conduct suicide-related research include the need for researchers to consider cultural differences and expectations that can impact an individual's ability or readiness to participate in research. To improve relationships between researcher and participant, researchers need to ensure that they fully disclose to the individuals what participation will involve, and that they allow the individuals the time and space within the interview process to express themselves and share their experiences, even if this were to mean that interviews lasted longer than anticipated.

Participants themselves have identified recommendations to support the completion of suicide-related research and ensure the safety of those involved. Recommendations included: establishing connections with community leaders to support recruitment, researchers being explicit and clear with potential participants regarding participation and anonymity, and the potential risk of participants becoming distressed during participation being a factor that is considered, assessed throughout the process, and that a plan to manage this distress is in place.

2.12 Rationale for the Current Study

The themes highlighted within the SLR reflect the experienced and perceived difficulties in conducting suicide-related research. It also highlights the need for this research to take place, as if more research is conducted in this field, it's hopeful that the stigma associated with suicide will be reduced, as understanding of the topic increases.

When conducting research of a sensitive topic, specifically suicide-related research, ethical review boards express concerns about potential risk of harm to participants (Moore et al., 2013). Research has been found to the contrary of this whereby participation in suicide-related research has been reported to have benefits of personal growth (Andriessen et al., 2018), and that participating in research of a sensitive topic can be cathartic when talking about personal experiences (Elmir et al., 2011). I had a desire to complete a research project that was of direct importance to me, despite it being identified as a field of research that has challenges and barriers. Through having explored the current literature available related to suicide and suicide bereavement, it became evident to me that talk of suicide and suicide bereavement experiences can be inhibited (Dauhoo et al., 2024) and silenced (Maple et al., 2010). Due to this silencing, it led me to wonder what aspects of the survivors experiences were not spoken, or what they felt unable to share with others. These initial questions I had led me to wanting to explore what narratives that those bereaved may not share and may be unspoken. With this in mind, the SLR findings built the foundation to be able to conduct the empirical study in a way that was both meaningful and safe for participants, and would produce effective outcomes overall. Both the challenges and potential solutions captured, highlighted what needed to be considered and adapted for best practice in conducting suicide-related research safely and well.

Recommendations reported within the reviewed literature, and the researcher's interpretations of how to overcome some of the barriers identified, have been taken into consideration when planning this current study. Some of the recommendations used include: providing participants with the semi-structured interview schedule prior to participation to enable them to have a full understanding of their participation and provide fully-informed consent; creating a risk management protocol in the event that a participant becomes distressed or is at risk of potential harm within the interview process; and providing participants with a signposting sheet with professional support and contact details following completion of the interview.

Following from the rationale outlined above, the current study aims to examine:

- What unspoken narratives exist for self-defined family members who have experienced suicide bereavement?

In order to answer this question, the study aims to establish:

- If unspoken narratives exist for self-defined family members who have experienced death by suicide of a loved one, or someone they care about?
- If present, what unspoken narratives exist for self-defined family members who have experienced suicide bereavement?
- What support might be helpful in supporting this population, given the unspoken narratives, and the impact this might have on help-seeking/help availability?

3 Methodology

3.1 Overview

This research aims to explore the unspoken narratives that exist for self-defined family members who have experienced suicide bereavement. This chapter describes how this research was conducted and the qualitative methodology used. It shall outline the process of data collection and data analysis, ethical considerations, participant information, and the quality appraisal.

3.2 Design

This study utilised qualitative methods, completing individual, semi-structured interviews with participants to explore their experiences of suicide bereavement and any unspoken narratives evident within this. Interviews were conducted using video call software or on the telephone. Face to face interviews were offered to broaden accessibility for participation, but all of the participants opted to participate in the interviews remotely.

3.3 Rationale for qualitative design

Quantitative methods are proven to be beneficial in providing detailed analyses within research (Macur, 2013); however, these methods can be reductive in nature, and therefore were not used within this research. To ensure that participants experiences could be examined in-depth, a qualitative approach was deemed appropriate to examine survivors' experiences following a death by suicide (Hjelmeland & Knizek, 2010).

Qualitative research typically involves systematic collection, organisation, and interpretation of data from a variety of sources including: interviews, focus groups, journals, prayers, letters, or through visual materials (e.g. drawings or photographs) (Grossoehme, 2014; Malterud, 2001). These methods are often used to understand individuals' experiences, beliefs, meaning-making, interactions and attitudes (Pathak et al., 2013).

Interpretation is viewed to play an important part within qualitative research as it aims to make meaning of experiences (Willig, 2017), allowing insight into different perspectives and subjective realities. The use of interpretation can support the rich and in-depth understanding of the data, as it involves undergoing the process of making sense of "what is going on in the data, and why that might matter, and what the implications are" (Braun & Clarke, 2022b, p. 199).

Whilst planning this research project, initial literature searches conducted highlighted that, although there has been research related to survivors' experiences of their bereavement, highlighting the stigma experienced (Peters et al., 2016), there is a gap within the literature related to the consequence of this stigmatisation and the potential silencing it causes. Dauhoo et al. (2024) identified that talk of suicide is viewed "as inhibited" (Dauhoo et al., 2024, p. 52), resulting in individuals not talking about their experience of suicide bereavement.

This current research is well placed to offer a greater understanding of the potential silencing experienced by survivors, to explore what is silenced, and reasons as to why certain narratives remain silenced. It's hoped that the findings will inform clinical practice and have wider implications within the field of suicide bereavement support.

3.4 Expert by Experience Consultation

There is an emphasised need for survivors of suicide to be actively involved in research (Peters, 2009), to bring about "more flexible and responsive services" (Bowden, 2017, p. 9). In total, six Experts by Experience (EbE) were involved in supporting this study. One EbE was recruited from the Support After Suicide Partnership, following contact with PAPYRUS and Samaritans. Additional EbE's were recruited from the Samaritans Lived

Experience Network, who shared an advertisement poster for consultants through their newsletter. The network was provided with information about the study and asked to contact the Network administration if they wanted to be involved within the study as a consultant. Two individuals expressed interest and their email addresses were shared with the researcher, who contacted them to arrange initial meetings to offer additional information about the research, and to discuss their role as a consultant. Two additional EbE's were recruited through discussions had between NHS employees and the secondary supervisor, Dr Farah Dauhoo. The sixth EbE was recruited through snowball sampling.

Table 14 highlights the identified and suggested tasks for consultants/EbEs.

Table 14

Experts by Experience tasks

Research Stage	Task
Methodology	Helping to construct the interview schedule (including the language used) Reviewing the interview schedule Engaging in pilot interviews Reviewing the Participant Information Sheet Reviewing the Consent Form Reviewing the Study Advertisement Poster
Analysis	Reviewing the construction of themes
Discussion	Supporting identification of recommendations for service development
Dissemination	Assisting with dissemination (outside of academic journals)

3.5 Qualitative Methodology

3.5.1 Why Reflexive Thematic Analysis?

Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2006, 2013, 2019) was used to analyse the data collected within this current study. RTA is a form of analysis which is purely qualitative and methodically captures and organises themes across a specific dataset (Braun & Clarke, 2012). In comparison to other versions of Thematic Analysis (TA), RTA allows for researchers to use reflexivity to “critically interrogate what they do, how and why they do it, and the impacts and influences of this on their research” (Braun & Clarke, 2022b, p. 5). Taking a critical realist position when using RTA means that the data collected doesn’t provide a direct reflection of reality, and instead allows the researcher to “access a mediated reflection of reality” (Braun & Clarke, 2022b, p. 171). This methodology allows researchers to access the participants perceptions of their reality, whilst considering how social structures may influence these experiences (Braun & Clarke, 2022b). It’s suitable for use from a critical realist epistemological stance, as this position allows for subjectivity and recognises that social structures and contexts shape an individual’s experiences. As RTA involves coding across a whole dataset, whereby interview transcripts are analysed, it allows for details of each participant’s account to be considered and analysed (Braun & Clarke, 2021).

As RTA uses both an inductive and deductive approach when developing themes, this also supported the selection for its use. Inductive orientation to the data involves analysis and development of themes being “driven by the data content” (Braun & Clarke, 2022b, p. 10), whereas deductive orientation involves the analysis and development of themes being “shaped by existing theoretical constructs” (Braun & Clarke, 2022b, p. 10). The use of both of these approaches allows for the data to be analysed comprehensively, involving the researcher immersing themselves within the data and using existing theoretical constructs to make sense of the data as a whole (Azungah, 2018).

RTA involves a six-phase process. The term phase is used rather than step to allow for flexibility, and therefore is viewed as “guidelines rather than rules for the process of analysis” (Braun & Clarke, 2022b, p. 34). Table 15 outlines the six-phases and a description of each.

Table 15

Six-phases of RTA (Braun & Clarke, 2021; Braun & Clarke, 2022b)

Phase	Description
1 Familiarisation	Becoming familiar with the content of the data by the researcher immersing themselves within the dataset through reading and making notes.
2 Coding	Identifying parts of the data that appeared relevant and meaningful to the research question. Coding within RTA can be completed at a “semantic or latent” (Braun & Clarke, 2022b, p. 35). Coding at a semantic level involves capturing surface meaning, whereas coding at a latent level involves capturing implicit meaning (Braun & Clarke, 2022b).
3 Generating initial themes	Identifying patterns across the dataset. Identifying potential themes by clustering the codes (Braun & Clarke, 2022b).
4 Reviewing and developing themes	Assessing the provisional themes identified, ensuring that themes make sense to the codes and the whole dataset.
5 Refining, defining and naming themes	Ensuring the themes are “built around a core concept for essence” (Braun & Clarke, 2022b, p. 36). Writing a synopsis for each theme and identifying the names of themes.
6 Writing up	Putting together through writing the analytic narrative and extracts from the data to address the research question and tell the reader a story of the findings (Braun & Clarke, 2022b).

There are different qualitative methodologies which allow researchers to gain an understanding of an individual’s experiences. When selecting the methodology to best fit the epistemological stance, the research question, and the aims of the research, RTA and other qualitative approaches were considered for data analysis. Table 16 summaries these additional methodologies and provides reasons as to why they were not used.

Table 16

Rationale for Reflexive TA

Qualitative methodology	Description	Reason not used
Interpretative Phenomenological Analysis (Eatough & Smith, 2017)|	Allows for a detailed understanding of subjective experience and how individuals make sense of their experiences (Larkin & Thompson, 2012). Explores the complexities of individual cases.	This study aims to capture themes across participants, whereas IPA analyses the unique details of each individuals experience.
Narrative Analysis (NA)	Used to capture the meanings of individual's experiences. Assumes that individuals lead storied lives (Clandinin, 2006). NA is underpinned by constructionist epistemology.	This study takes a critical realist epistemological stance.
Content Analysis	Classifies text into categories. Descriptive in its nature rather than interpretative.	This study aims to gain a greater and deeper understanding of participant experiences, rather than just descriptions and focusing on frequency of 'content' explored.
Grounded Theory (Charmaz, 2014)	Data collection and analysis take place concurrently (Thornberg & Charmaz, 2014). Hypotheses and theories are constructed through collecting and analysing data. Used to develop theory. Focuses on sociological processes.	This study does not intend to develop a grounded theory or model. This study focuses on exploring individuals' experiences.
Discourse Analysis (DA)	Examines the language used by participants.	DA focuses on the use of language and 'how' stories

	DA fits with a social constructionist epistemological stance.	are constructed, rather than ‘what’ the story is about.

RTA was the chosen methodology as it was found to be the most suitable for the epistemological stance, and appropriate to answer the research question and aims. RTA highlights the value of researchers practising reflexivity within their work (Braun et al., 2023), allowing the researcher to critically reflect on their role within the research (Braun & Clarke, 2022a), and the influence this may have on the research process. Although RTA holds the researchers position and influence as an important factor within the analysis of the data, it also takes into consideration the participants contexts and the wider societal context whilst capturing themes.

3.5.2 Strengths of RTA

The six-phases of RTA and the guidance provided to complete these supports the need for researchers to be immersed within the data and continuously reflect on their position as a researcher (Campbell et al., 2021). This is a strength of RTA as it supports reflexivity which allows the research to be rigorous, researchers to be self-aware, and there to be accountability and trust-worthiness within the research process (Probst, 2015).

Another strength of RTA involves the inductive and deductive approaches it allows for (Braun & Clarke, 2022b). This study invites an inductive approach as specific observations and discussions within interviews allowed for patterns and themes to be recognised (Blackstone, 2012). Deductive approaches were also utilised when focusing on factors such as stigma related to suicide, a well-researched area (Hanschmidt et al., 2016; Kucukalic & Kucukalic, 2017).

3.5.3 Weaknesses of RTA

Although the flexibility within RTA is identified as a strength, it can also be considered as a weakness. Holloway and Todres (2003) spoke to the concern that flexibility can also lead to "inconsistency and a lack of coherence" (Holloway & Todres, 2003, p. 346). Therefore, a weakness of RTA involves the different interpretations of the data that may be inferred by different researchers.

Additionally, the six-phases of RTA can be deemed a weakness if researchers view this process as linear. These phases are not set to be linear and instead may involve researchers returning to previous stages if necessary within a complex dataset (Finlay, 2021).

3.6 Data collection

3.6.1 Participation criteria

The inclusion and exclusion criteria (see Table 17) for this study were developed with members of the research team. It was decided to recruit individuals from the general public to attempt to reach individuals living across the country, to support the sample including the various Social GGRRAAACCEEESSS (Burnham, 2018). Social GGRRAAACCEEESSS stands for "gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality" (Totsuka, 2014, p. 86) and are aspects of an individual's identity which may be visible or not visible, and impact an individual's power and privilege within society (Burnham, 2018). Participants were required to reside in the United Kingdom so that recommendations identified as a result of the findings can be specific to the UK health and social context. A restraint to recruitment within this study was lack of budget, resulting in the use of interpreters not being an option. Due to this, individuals were required to be able to speak English, but it wasn't required for this to be their first language. A consideration discussed amongst the research team, and in consultation with EbE's related to the time period of participation since the bereavement had taken place. The conclusion reached was that the death by suicide must have taken place over 6 months ago, to allow for the individuals to be provided time to potentially process the loss. Research has found that "when people are faced with traumatic experiences, they primarily focus on survival and self-protection" (Van der Kolk, 2000, p. 8), this being known as the 'trauma response'. Six months allows for an extended period of 'watchful waiting' (NICE, 2018, p. 54), which was used to support the mitigation of the risk of distress caused by participation.

This research allowed for individuals to self-define their 'closeness' with the individual who had died by suicide to extend the definition of family. Rose & Hebblethwaite (2020) identified the need to extend the definition of family, as having a narrow and traditional definition can result in experiences of single-parents, minority and poor families being overlooked (Rose & Hebblethwaite, 2020).

Table 17

Inclusion and exclusion criteria

Inclusion criteria	**Exclusion criteria**
Participants must be over the age of 18.	Participants cannot be known to the researcher.
Participants view themselves as 'self-defined' family member to the individual who has died by suicide.	Participants under the age of 18.
The death must have taken place over 6 months ago.	Participants who do not speak English or would require an interpreter to conduct the interview.
Participants are a resident of the UK.	
Participants must be able to speak English, although this does not need to be their first language.	
A diversity sample to include all Social GGRRAAACCEEESSS (Burnham, 2018).	
Participants who reported their chosen family member had died by suicide, despite the verdict of their death (e.g. death by misadventure).	

3.6.2 Sample size

When using RTA, there is no clear figure identified regarding how many participants should be recruited. However, in-depth data tends to be collected from a relatively small number of participants. Malterud et al. (2016) suggest that when completing qualitative research, the sample sizes depend on several key factors, including the study aim and sample specificity. When considering the sample size of a study using RTA, researchers need to consider these different factors, as well as the research question itself, the diversity and amount of data collected, and the potential restraints to the study.

Previously, it has been recommended that there's a minimum sample size of 12 when conducting qualitative studies to reach data saturation (Guest et al., 2006; Vasileiou et al., 2018). With that said, the concept of data saturation in qualitative research has controversial findings. Data saturation in qualitative research is not always applicable or theoretically neutral (Levitt et al., 2018). Varpio et al. (2017) highlight that unless data collection and analysis are conducted simultaneously, saturation cannot be used as an endpoint to stop recruitment. RTA involves interpreting the meaning within data, and data analysis is not completed concurrently with data collection. Due to these reasons, reaching data saturation would only become apparent following analysis. Due to the time restraints and budgets of the study, it was agreed amongst the research team that 20 participants was set as the maximum amount, and 12 participants were set as the minimum amount.

3.6.3 Ethical Considerations

Full ethical approval was granted by the University of Hertfordshire's Health, Science, Engineering and Technology Ethics Committee (protocol number: LMS/PGR/UH/05361) (see Appendix I). Ethical issues considered during the process of this study are outlined in further detail below.

Informed consent

Providing a Participant Information Sheet (PIS) (Appendix G) allowed the individuals to make a fully-informed decision regarding consenting to take part in the study. Participants consent was recorded by them signing a consent form (Appendix H). Both within the PIS and at the start of each interview, participants were informed of their right to withdraw from the study without giving a reason. They were informed that they were able to withdraw up to two weeks following participation, as after this time their anonymised data will have become part of the analysis and could therefore not be removed.

Confidentiality and Anonymity

Participants were informed about the confidentiality policy, including that their data would be anonymised, and any identifiable information would be removed or changed. Participants have been provided pseudonyms for this purpose. Within the PIS (Appendix G) participants were also informed that it may be necessary for the researcher to break confidentially to ensure their safety, if any information was disclosed which highlights risk to self or others. The confidentiality policy was also reiterated verbally prior to the interviews taking place.

Protection of participants

Due to the study exploring the sensitive topic of suicide bereavement, it was pertinent to consider how participation may evoke psychological distress. In order to mitigate this risk, the interview schedule (see Appendix J) was developed with EbE. Acknowledging the potential for distress, the language used within the interview schedule was discussed and considered, as well as identifying questions that ensured participants were able to share their experiences in as much detail as they felt comfortable. Although there was an anticipated duration as to how long to interview would be, I chose to not follow this if the participant required a longer period of time to speak about their experience.

The EbE reported that participants would benefit from engaging in this study, rather than it causing distress. Research has found that when interviewing individuals about sensitive topics, they can find that they're provided with a sense of relief from telling their stories, and that engaging in this can be liberating, allowing them to discuss topics they'd previously felt unable to (Elmir et al., 2011).

To further mitigate risk, a risk management protocol was developed (see Appendix K) to support the management of any discomfort, harm and upset that could arise during the interviews and the research process. As participants had consented to participate in research rather than therapy, although therapeutic skills were planned to be used for comfort and containment if needed, it was agreed amongst the research team that the researcher cannot provide therapeutic support to the individual due to the consent obtained and boundary between research and therapy that must be maintained.

Protection of researcher

In addition to considering the potential psychological distress and impact on participants, considerations were made for the potential distress the researcher may encounter.

The risk management protocol (Appendix K) outlined a process for both participants and researchers to support the mitigation of this risk. Regular meetings with the research team took place which involved discussing the emotional impact on myself as a researcher. Additionally, a reflective journal was kept throughout the research process. Keeping this journal allowed me to reflect on the potential impact to my own mental-wellbeing as a result of exposure to individual's experiences, encouraging me to engage in self-care activities after each interview and have regular check-ins with the research team to discuss how I was feeling. Research has found that individuals being exposed to the knowledge of traumatising events that others have experienced can cause secondary traumatic stress (Clark et al., 2022; Figley, 1995). The reflective journal enabled me to process the knowledge I was being exposed to, and encouraged me to document my fears and anxieties related to the research (Browne, 2018), which supported me in making sense of the complexities of completing research as an insider-research (Vinjamuri et al., 2017).

Data storage

All of the data collected during the duration of this study were stored securely using encrypted files on the University of Hertfordshire OneDrive storage system, which was accessed using double authentication. Within the PIS, it stated that data would be shared within the research team, following anonymisation, to further support confidentiality.

Signposting

Prior to participation, and following the completion of each interview, participants were provided a Signposting sheet (see Appendix L), providing relevant contact details of support services available.

Covid-19

Covid-19 was considered in case individuals were to prefer face-to-face interviews. If face-to-face interviews were conducted, individuals were to be sat at a safe distance during interviews, and it would be optional for the participants to wear face masks. If a participant were to report that they were feeling unwell or experiencing Covid-19 symptoms at the time of the interview, interviews would be offered virtually (if well enough) or at a later date.

3.6.4 Recruitment

Following ethical approval being granted, fourteen charities and organisations were contacted to inform them of the research taking place and to explore potential avenues to advertise the study (see Appendix D for details of these contacted charities and outcomes). Following successful contact with multiple charities, three charities/organisations agreed to support advertisement of the study within their newsletter and through advertising posters in their hubs. Additionally, two of the charities agreed to provide consultation for the study.

Recruitment took place via email advertisements within newsletters distributed by Samaritans (National Suicide Prevention Alliance- NSPA) and Kent County Council Suicide Prevention Team. Recruitment also took place via study posters (see Appendix E), which were advertised within The Andy Mans Club.

A purposive sampling technique was identified as suitable within this research as the inclusion and exclusion criteria (see Table 17) clearly specifies what is required of each participant. Purposive sampling is used to “select respondents that are most likely to yield appropriate and useful information” (Kelly et al., 2010, p.786).

Once a potential participant expressed interest in taking part in the study via email, they were sent the PIS (Appendix G), informing them of the purpose of the study and what their participation would involve. Additionally they received a copy of the interview schedule (See Appendix J), and were requested to complete a Research Demographics form (RDf) (see Appendix F). It was decided amongst the research team that it was essential for potential participants to complete this form due to the high level of interest expressed to take part in the study. Overall, interest was expressed by 43 potential participants, of which 31 individuals completed the RDf. The RDf's were then screened by the researcher and a member of the research team using Burnham's (2018) Social GGRRAAACCEEESSS. This was used to increase the diversity of the sample, in hope of widening the applicability of results. Despite efforts to screen this way, as evidenced within the participants demographics (Table 18), the sample of individuals that came forward were less diverse than hoped and the dominant characteristics of the participants identified that the majority of individuals were White Females.

Through the screening process, 20 potential participants were identified as eligible to take part. These individuals were then provided with a consent form (Appendix H) to gain informed consent. The consent form was revisited and discussed at the start of each interview to ensure that potential deficits in participants understanding of informed consent due to the written format were overcome (Dunn & Jeste, 2001). Out of the 20 potential participants provided with this information, 19 consented to take part. The reason as to why the 20th potential participant withdrew from the study was due to lack of availability to attend the interview.

Potential participants were informed that interviews could take place within a booked room at the University of Hertfordshire, or they could take place using an online platform (Zoom or Microsoft Teams), or via the telephone. The decision to widen the options as to how the interviews were conducted was taken due to aspects of financial affordability, availability of potential participants (Lo lacono et al., 2016), and considering ways to allow individuals to feel more comfortable talking about a sensitive topic (Heath et al., 2018). Heath et al. (2018) highlighted the importance of being flexible regarding the ways in which individuals can participate in research related to a sensitive subject, and to offer multiple ways of collecting data to allow for participants to feel able to communicate openly with the researcher. Using an online platform was the preferred option for the majority of participants, with just one participant opting to complete the interview via the telephone.

3.6.5 Interview Modality

Semi-structured interviews (SSIs) involve following a guide related to the core topic, but allowing for discovery amongst the topic, for additional discussions to take place, and space for different trajectories to be followed within the interview (Magaldi & Berler, 2020). Use of SSIs allows researchers to ensure that they're focusing on their research aims and answering their research questions, whilst permitting flexibility and for adaptations to be made to questions asked (Mashuri et al., 2022).

3.6.6 Interview Schedule

The interview schedule (Appendix J) was developed through consultation with EbE. The first stage involved developing interview questions that helped to answer the research question and explore participants experiences following a suicide bereavement. These questions were shared with EbE within a consultation meeting to check the suitability of the questions being asked. Additionally, pilot interviews took place with EbE to gain an understanding of the perspective of how the questions were perceived and answered. This part of the developmental process was key in ensuring that the schedule asked questions that were not only able to answer the research question, but did this sensitively, with the participants at the centre of this.

3.6.7 Interview Procedure

Initially participants were talked through the PIS, and verbal consent was re-established. Following the completion of the interviews, participants were asked if there were any aspects of their experiences they wanted to mention, which had not been asked by the interviewer, or had not been focused on as closely as they'd hoped for. Participants were also asked towards the end of the interview how they'd found participating and discussing their experiences, to ensure that any distress or discomfort from participation was reported. Although distress was not reported by any of the participants, it was important to ensure that participants left the interview feeling supported, and were provided a signposting sheet to support facilitation of this (Appendix L).

3.6.8 Participant Demographics

Table 18 presents the demographic information of each participant, in addition to their relation to the individual who died by suicide and the year in which this individual died. Occupation and education level were not collected due to the fact that this study aimed to explore their experiences of suicide bereavement and unspoken narratives, rather than how other demographical factors may influence these.

16 participants identified as female, and 3 participants identified as male. Participants ages ranged between 31 and 66. The participants ethnicity was collected and highlighted that 13 participants identified as being White British, one participant identified as White Asian, 4 participants identified as White European, and one participant chose to not disclose this information. The relation to the person who had died by suicide varied and included siblings (6), parents (2), friends (3), partners (5), and children (7). Four of the participants spoke within their interviews about multiple individuals who had died by suicide.

Table 18

Participant demographics

	Pseudonym & Ethnicity	**Gender**	**Age**	**Relation to the person who died by suicide**	**Year the individual died**
1	Sarah White British	Female	61	Brother	2017
2	Lauren White British	Female	52	Sister	2007
3	Julie White British	Female	63	Mother	1968
4	Charlotte White European	Female	39	Two significant male friends	2011 2014
5	Katherine White British	Female	58	Son	2020
6	Laura White British	Female	39	Brother	2020
7	Lily White British	Female	60	Son	2020
8	Rebecca White British	Female	56	Husband & son	2015
9	Evi White British	Female	39	Husband	2022
10	Anika British Asian	Female	31	Best friend	2019
11	Sharon White British	Female	66	Husband	2017
12	James White British	Male	61	Son	2021
13	Tony Not stated	Male	55	Brother	2020
14	Emma	Female	44	Brother	2013

	White British				
15	Mia White European	Female	41	Father & brother	1992 2005
16	Claire White British	Female	54	Partner	2021
17	Hayley White British	Female	43	Daughter & son	2018 2019
18	Erik White European	Male	48	Spouse	2018
19	Aisling White European	Female	47	Daughter	2017

3.7 Data Analysis

The process of analysing the data involved following the six-phases of RTA, outlined by Braun & Clark (2006, 2013, 2019). See Table 19 for an explanatory outline of these phases. To support the data analysis process, the researcher transcribed the interviews, and the computer software NVivo 14 was used to code the data. The codes created and themes captured were cross-referenced by a peer within the research group to support the trustworthiness and quality of the findings. This aimed to support the resonance of the study's findings, an important criterion for qualitative research (Tracy, 2010).

Table 19

Studies Six-Phase Process of Reflexive TA

Phase	Task
Phase 1: Data Familiarisation	The researcher listened to audio recordings of the interviews and read the transcripts multiple times to become familiar with the data. Whilst reading the transcripts, the researcher made note of relevant information. The researcher transcribed all of the interviews which supported the process of immersion in the data.
Phase 2: Generating Initial Codes	Initially, the researcher read through the transcripts and coded the words, phrases and sentences relevant to the research question. The initial codes identified were shared with the research team and discussions were held regarding potential biases that the researcher may have held when identifying these codes. Transcripts were shared with a member of the research group to establish whether another researcher would identify different codes within the data. Differences and similarities within the codes amongst the two individuals were discussed.
Phase 3: Generating Themes	The researcher wrote the codes out, and used a mind-mapping technique to group the codes together to highlight relationships between the codes. The relationships between the codes were examined in detail, and supported the identification of provisional themes. During the process of theme generation, different themes were captured, some of which were merged together, others became discarded due to their lack of relatability to the research question, and others were sorted into subthemes.
Phase 4: Reviewing Potential Themes	Through further examination, the themes were constructed. Themes and subthemes were initially reviewed with the research team. Following this, the researcher continued to review the themes and subthemes until it was felt the themes highlighted the stories told within the interviews.
Phase 5: Refining, Defining and Naming Themes	The researcher and research team re-examined the themes and subthemes to ensure that they meaningfully mirrored the

	experiences of the participants and the data collected. Quotations from the interviews were organised and identified for each theme and subtheme to ensure that all participants experiences and voices were represented within these.
Phase 6: Writing Up	Time was spent with the research team to reflect on the lead researcher's interpretation and position in the themes. This included discussions related to the researcher wanting to 'do justice' to the participants stories and questioning how this would be illustrated within the write up. Quotations were used to illustrate the experiences of the participants and the unspoken narratives reported.

3.8 Quality, Validity and Self-Reflexivity

3.8.1 Assessing Quality and Validity of the Methodology

This study was evaluated by both the researcher and a member of the research group using the 'Eight "Big-Tent" Criteria for Excellent Qualitative Research' as recommended by Tracey (2010). This quality assessment shall be detailed within Chapter 5. As mentioned within Table 19, transcript extracts, codes and themes were shared with the research team to increase the rigor of the qualitative analysis. Sharing these amongst the research team allowed for the consistency of the findings to be examined by multiple individuals. Examining inter-rater reliability ensured that the interpretation of the data was a correct representation of the data collected (McHugh, 2012).

Individuals have reported that a way in which qualitative research and results are viewed credible is by member checking (McKim, 2023). Member checking involves the process whereby participants are provided with transcripts, codes and themes captured within the data (Varpio et al., 2017) to establish whether these accurately represent their experiences. Although member checking may allow for participants to identify information that they find inaccurate, and want to be eliminated from the research (Thomas, 2017), it has been questioned whether member checking is an appropriate way to measure credibility as others have reported that it does not “enhance the credibility or trustworthiness of qualitative research” (Thomas, 2017, p. 37), and it has been found that following the process of member checking, minimal information is gained from participants (McKim, 2023). Member checking was not used within this study as considerations were made to the different contexts that participants may have been in between participating in the interviews and reading the transcripts, and the distressing content of the interviews. Although member checking can be useful to obtain participant approval regarding quotations used (Thomas, 2017), this was discussed within each interview held and verbal consent was provided.

3.8.2 Self-reflexivity

Throughout this research process it was essential that I remained aware of how my relationship to the topic might influence the interviews and research process. To support self-reflexivity, I remained open and honest in discussions with the research team by taking ownership of my feelings, and speaking my mind. During discussions with the research team, I expressed how I felt I could personally relate to some of the experiences shared, but also didn’t relate to some of the other experiences reported, all whilst considering the need to remain unbiased and not assume what an individual’s experiences and story would look like. I also recorded my thoughts, feelings, and reflections in a reflective journal which I shared aspects of with the research team (see Appendix A).

4 Findings

4.1 Overview

This chapter presents the qualitative analysis of the SSI's using RTA (Braun & Clarke, 2019). Six themes and eight subthemes were constructed from the data, as shown in the thematic step-up-step process (Figure 2). Each theme is described in detail, with quotations used to illustrate the meaning of each theme and subtheme. Appendix M and N presents the process of theme construction from codes.

Figure 2

Thematic process

Throughout the presentation of the constructed themes, quotations have been selected to consciously include all of the participants, to ensure that all of the individuals voices who contributed to this research are heard and provided the space to speak to their experiences.

Within the quotes … is used to indicate words being omitted, and [ ] is used to add words to improve clarity and understanding of the conversations that took place.

4.2 Theme 1 - Explicitly unspoken - nobody talks about it

This theme captured participants narratives related to topics that were deemed ‘explicitly unspoken’. The term explicit refers to topics expressed without vagueness, and, in this context, highlights that there are particular topics of conversation, or part of their story, which participants felt they couldn’t share or discuss with others, deeming them unspoken. Such topics included: disclosing difficult parts of the relationship with the deceased, the last moments of the deceased’s life and the last encounter that the participants had with this individual, and the difficulties some participants experienced when providing care for their chosen family member prior to their death. This theme shall not only describe what topics are explicitly unspoken, but shall go beyond this and incorporate potential reasons as to why they remain unspoken.

Participants alluded to societal expectations about refraining from talking negatively about individuals following their death. This links to the common phrase that you ‘don’t speak ill of the dead’, which came about as part of a teaching from a Spartan called Chilon (Laertius, 1853). It indicates that it’s socially inappropriate for the living to speak ill of the dead, who cannot justify or defend themselves.

Although participants were not purposefully speaking ‘ill of the dead’, they highlighted that, due to this societal expectation, they were encouraged to remain silent about the difficulties they experienced with their chosen family member. This resulted in individuals questioning what the purpose of these disclosures might be, and wondering about the social judgement they may experience as a result of sharing these difficulties.

> *I know part of this research is about maybe sharing things people don’t know, and people don’t know this side of him with me and my relationship with him – Katherine*

> *I've not felt able to speak with necessarily everything like like the level of violence in the relationship…it's just like I don't know what purpose it would have served me to go and dish out all the stuff that's gone on in our relationship – Erik*

Participants shared memories of their last encounters with the deceased, expressing that the memories were explicitly unspoken due to their personal and precious nature, as well as the emotional impact they continue to have on the individual. The realisation that those moments were 'last encounters' prevented participants from sharing these with others as they want to hold them close to themselves to treasure.

> *he laughed and said 'yeah' and then he walked away and that was the last time I saw him, the last time I saw him…there was so much guilt I felt around that…and like I said it's precious to me as well isn't it? So even though I'm guilt ridden, that is precious because I I can almost still feel that hug and kiss, you know. You know, it's that it's still that real – Sarah*

> *I remember the last thing I said to him was 'I love you and it's going to be okay' – Emma*

These memories remained unspoken due to their personal connection and impact, as disclosure of these moments may feel less personal if shared. Additional memories were also deemed explicitly unspoken, such as the memories of providing care for the deceased prior to their death. Some of the participants spoke of the difficulties and impact of providing care. Similarly to the societal view of not speaking ill of the dead, expressing difficulties experienced when providing care were also deemed inappropriate following their death. This was due to potential judgement of others, such as: that the individuals didn't want to provide care, or the perceived idea that not enough care was provided, or that care should not be difficult as it's an essential responsibility for a chosen family member.

> *I'd rather he was still with us–but, well because it is an incredible, incredible burden on people, that's the wrong word, it's a real strain on those to provide that support – Laura*

4.3 Theme 2 - Never ending tasks for the survivor – we all do it, but secretly

The second theme concerns the tasks that survivors have to engage in which are unknown to others and not spoken about. From the interviews, it was clear that there are a vast number of tasks that survivors have to engage in following being bereaved by suicide, some of which are known and spoken, others of which are unknown to general members of the public and unspoken. The tasks which were reported to be known and spoken included attending coroners court, and meeting with the police. This theme highlights specific never-ending tasks that participants reported engaging in, but should not be considered an exhaustive list. Participants reported constantly having mental dilemmas about whether they should speak about their bereavement, the deceased, or about suicide as a topic in general. This impacts the degree to which survivors share their story and experience, and can result in their experience, or aspects of it, remaining unspoken. Within the interviews, it was evident that these daily and never-ending mental decisions were done so with members of the public being unaware. One participant highlighted that they feel as though they're acting as their own public relations (PR) due to the tasks they have to complete. PR refers to the "management of communication between an organization and its public" (Grunig & Hunt, 1984, p. 6). Acting as your own PR therefore involves the task of managing what can and cannot be spoken about between the bereaved and others.

> *What I have to do is basically be my own PR, I have to sort of find ways of of of telling the story that felt fruitful [to honour and not forget the deceased] but didn't go into details…it's sort of, there are moments when you sort of feel like it's ridiculous to live with this kind of level of self-monitoring – Charlotte*

For some participants the outcome of these decisions and what would remain unspoken was dependent on the situation, the person, and whether it was deemed the 'right time' to speak.

> *I try and gauge the situation, and depending on the person, I try and fluff it up a little bit, and just make it seem less intense as it was, or is, it's it's weird.– Julie*

> *I think what I do is I read the person. Not that I'm a mind-reader, but I look at them and I think could they cope if I told them? And then I make that decision, and I kind of work out where I am…perhaps it's not the time…I think the majority of people I've met since don't know because I'm not confident they could cope with that conversation – Laura*

Making these decisions, and the outcome of them, were identified as, not only factors that could result in narratives remaining unspoken, but also in friendships being lost and individuals' social circles reducing.

> *We found that we were selective about who we saw…because some people say some ridiculous things and make it worse. So you quite quickly begin to sift through who you feel comfortable to be with – James*

> *We keep our circle small now – Hayley*

4.4 Theme 3 - 'Them and us' – the unspoken act of othering

This theme illustrates how participants viewed the difficulties of speaking to others due to the experience of differentiating between 'them and us', and the 'othering' that took place following their bereavement. Othering is defined as the process whereby "through discursive practices, different subjects are formed" (Thomas-Olalde & Velho, 2011, p. 1). Within the context of this research, this experience of othering refers to the phenomenon of stereotyping and differentiating between those who have been bereaved by suicide, and those who haven't. Within this theme, three subthemes were constructed: experienced othering, perceived othering, and solidarity.

4.4.1 Subtheme 1 - Experienced othering

Participants voiced that they experienced 'othering' following the bereavement. They were excluded, felt to feel different, and removed from social encounters. Within the interviews, the reasons as to why this experienced othering took place were at times unclear. However, othering resulted in the survivors feeling isolated and silenced in sharing their experiences, and feeling rejected by those they previously called 'friends' or 'acquaintances'. These experiences of othering came about when participants were attempting to speak their narratives of their experience of being bereaved by suicide, and also as a result of others being aware that they'd experienced a suicide bereavement.

> *We're never invited to New Year anymore…you know an invite would still be nice…it almost feels as if we're growing an extra head or something. It's just bizarre. Yeah, nobody invites us anywhere anymore – Hayley*

I have lost friends because I realised very early on that I can't, I can't make plans, I couldn't say to someone 'I'll be there on Friday, no problem', because my mind will, but my body is going 'no' – Katherine

This experience of othering may take place because other people don't know how to be, or what to say following a death by suicide and therefore distance themselves from the bereaved person. Additionally, othering may take place because the bereaved individual is struggling and therefore may not interact in the same way with their friends as they'd done prior to their bereavement.

One participant spoke of a friend outlining rules for her interactions, which she reported believing was as a result of othering, as this was something that she had not encountered prior to being bereaved by suicide. The same participant also spoke of the physical responses by others when disclosing that she had experienced a bereavement from suicide, highlighting the physical expressions of othering.

I remember going out the one time and it was with…so you know we went out, and my friend at the time said to me, 'just don't cry'… 'Just don't start crying when you are out' – Rebecca

…then this woman actually said something to me and I actually said, 'oh, no, you know my son died', you know that normal question- 'how many children do you have?'…and as soon as I said that he died, by suicide, [the random woman] turned her back and couldn't couldn't speak to me again. She didn't know what to say, so she just blanked me – Rebecca

The experience of othering was reported to have taken place literally, in the sense that individuals viewed the survivors differently and outwardly expressed this, but it also took place inexplicitly through others' responses to the survivors.

I couldn't play with this group of children, because my mother, I didn't have a mother. So again, that was the unspoken – Julie

One participant spoke of the need to hide part of themselves due to the experience of othering, comparing this to the act of walking round naked, something that we may not do, and instead we hide private parts of ourselves that are deemed socially inappropriate to share.

I went to [...] with some friends and I, and that made me feel really awkward because I mentioned it and everything went silent and then I thought it's a bit like, you know it's a bit like I've taken all of my clothes off and run around naked you know, and it's a bit like you..you know and it, because for me I was so exposed...– Lily

Death is around us all the time but we don't...really talk it through properly, and people don't know how to be with you, and perhaps you know they have very good intentions, but they, it may be because they don't know what to say, that they say something that is quite hurtful.– James

Participants reported that, at times when they hadn't shared that they've been bereaved by suicide, they experienced othering through communications had with others who spoke of the act of suicide. One participant referred to a specific encounter with a stranger which resulted in them experiencing feelings of anger and frustration, perpetuating the need to keep their experiences and narratives unspoken.

She said 'there was a mother who took her own life, I just can't understand how anyone could do that to the children?' And I didn't know quite what to say to that, I didn't, I just kind of shook my head – Julie

It was clear that the experience of othering was not just a factor that came from the public, but also from the survivors themselves. Throughout the interviews, participants referred to themselves as different to those who hadn't been bereaved by suicide.

I just generally don't bother because no one gets it, no one understands – Aisling

I don't think until you've been there you understand, quite understand how all-encompassing it is – Lily

Othering was also reported to take place amongst the system of individuals who had been bereaved. One participant spoke of their lack of connection to other individuals who were impacted by the same death due to cultural beliefs that were held. Different cultural beliefs may result in individuals viewing death differently and having different ways of making sense of their chosen family member's death. For example, one participant spoke of individuals not accepting that the person had taken their life, and had reported they must have been 'possessed', and wouldn't use the word suicide. This was identified as a barrier to having conversations, leaving the survivor feeling isolated, even from those who had experienced the same bereavement.

> *I think they might be using that as a bit of denial because they don't want to believe what actually happened, and actually that she was struggling. So I think it's very easy just to say 'well she was possessed' - Anika*

4.4.2 Subtheme 2 - Perceived othering

Participants alluded to not only experiencing othering, but also experiencing fear that they would be othered. This subtheme captures the perceived othering that was reported. This perceived othering widened the gap between survivors and others, who they perceived were othering them, strengthening the need for certain narratives to remain unspoken.

Participants described the lack of understanding or consideration from those who haven't been bereaved by suicide, despite their potential efforts to understand and provide support. Individuals spoke of friends attempting to provide comfort and reassurance that they'd 'done enough' in supporting their chosen family member, but that often this was not what the survivor needed. Participants indicated that others may not have an understanding of what support the person needs, and can often be fearful to ask them. Despite these efforts, the perceived differences and othering between these two 'groups' of individuals (those who have been bereaved by suicide, and those who haven't) resulted in individuals not sharing details of their bereavement experience, and the emotions and difficulties experienced resulting from this. This is because they feared that individuals would not understand.

> *It's had so many resounding effects throughout my life which you wouldn't, people don't consider or understand – Julie*

Much like the findings within the ‘experienced othering’ subtheme, some participants reported that interactions with others changed, conversations were lost, and relationships diminished. These changes occurred as a result of the survivor’s perceptions and fears of how people may respond to them following their bereavement. This perceived othering resulted in individuals not revealing the emotions experienced living as an individual bereaved by suicide, and not outwardly showing their emotions when with others.

> *I don’t know whether they’re afraid to ask in case they think it’s gonna bring it back to me, or…people are bit worried to ask if you’re okay in case you cry…if I do get upset or do cry, that doesn’t mean that I don’t want to talk about it…I think people…I think they think ‘oh, I need to stop talking because I’m upsetting them’…you’re not upsetting them. I can’t be any more upset, I’ve been the most upset I could ever be in my life…just because I’m upset doesn’t mean I don’t want to talk about things, but I don’t think people see it like that – Evi*

Although individuals bereaved by other causes may also experience perceived othering, the stigma associated with suicide and the silencing that this causes (Peters et al., 2016) was reported to further complicate the interactions had with others and their manner towards the bereaved, both experienced and perceived. The findings demonstrated that participants want to talk about the sudden, traumatic bereavement that they’ve experienced, but others don’t want to do this, or don’t initiate these conversations.

To attempt to overcome this perceived othering, participants felt the need to push themselves to make connections with new people, attend social events in moments when they didn’t feel up to it. Participants also disclosed they wouldn’t share their true narratives, and they would ‘armour up’ in preparation for encounters with others to reduce the perception of ‘them and me’.

> *I was going into social settings where basically all I wanted to do is to talk about what happened to me. All I wanted to, and I thought I can't, I can't and therefore you feel you feel a bit of an alien because it's this conversation going on around you,…but for me I wanted to be, I wanted to be there with them, I wanted to have my relationship to those people. So I've, I was a bit of a bystander– Lily*

> *I would leave my house and I would enter a revolving door in my head, and the mask would go on, the armour would go on – Aisling*

4.4.3 Subtheme 3 - Solidarity

There was a consensus amongst participants of the benefits of 'finding those within your tribe', and finding a sense of solidarity and closeness with others bereaved by suicide, whether as a result of experiencing othering, or due to shared experiences of loss.

> *I see them as the people that know, understand, and I can say anything I want to, and that is incredibly important, but…we had to do our own searching to find our tribe, and it is a tribe, it's a group that no one wants to be a member of, but it is a tribe – Sarah*

Whilst some participants described that they'd found closeness and solidarity through meeting other individuals who had been bereaved by suicide, it was stated by multiple participants that they were yet to connect with others who had been bereaved by suicide. Due to this lack of connection and understanding from others who had similar experiences, participants acknowledged feelings of frustration and anger towards others not understanding, and felt they weren't able to share their stories and experiences. These emotions were expected following a loss, but were compounded by the lack of support to process them, which reinforces the sense of the situation being unjust, that the survivors have these additional experiences whereas others don't, only adding to the distress felt.

> *It makes me angry because I'm just like where are my people?…Where are my people who have been bereaved by suicide?…Like I want to share this feeling with people, I want people to realize how devastating this is and it's, I can't share that with my everyday people – Anika*

Finding individuals who have shared experience, or an understanding of what the survivors were experiencing was expressed by participants as a pertinent part of their journey. Through both experienced and perceived othering, individuals felt they were different and therefore felt misunderstood by others. That feeling of being misunderstood influenced how the participants communicated with others and it was frequently shared that they felt unable to speak due to their perceived concerns of a lack of understanding from others. The opportunities to 'find their tribe', or find others that were willing and able to understand their experiences, were limited, and left survivors with experiences of being let down, not being able to speak, and being unable able to identify who they could speak to. One individual spoke about their experience of attempting to find those who understand what they were experiencing, however encountered difficulties as they received negative and unhelpful responses from others. They spoke of having to overcome these difficulties themselves through 'trial and error' in starting conversations, to find those who they felt able to speak to.

> *If you go to the butchers and ask for some carrots and they didn't have them – you shouldn't be disappointed – you went to the wrong place. Yes, so once you know that you*

> *don't, don't go, you don't keep going, don't keep trying, because you're just gonna get more and more disappointed in them, and probably not doing anything on purpose, but when you find the right people you know where to go when you need that help. Stick with those ones you know.– Lily*

4.5 Theme 4 - Protection - unable to tell the whole story

This theme captured participants' unspoken narratives which related to their need to protect. The need to protect was identified as a barrier to speaking, and a reason as to why narratives may be unspoken. Within this theme, three subthemes are presented: protecting deceased, protecting others, and protecting self.

4.5.1 Subtheme 1 - Protecting deceased - 'I want to talk about who they were' - Hayley

Participants reported the continued stigma around suicide and how this can result in survivors feeling unable or encouraged to be silent about the circumstances around their chosen family members death. This stigma related to both public-stigma, whereby the deceased is negatively viewed and positioned within a stigmatised group by the public, and self-stigma, whereby survivors anticipate social rejection and stigmatisation from the public (Livingston & Boyd, 2010). Fear of judgement from others was shared by most participants, including the fear that others will judge the deceased. To continue supporting and protecting the deceased after their death, participants felt unable to speak about their death to others, and there being a need to think about and talk about the positive aspects of their life. By focusing on the positives, and who the person was prior to their death, it ensured that the individual was not 'lost' amongst the story of how their life ended.

Due to the stigma associated with suicide, if survivors were to talk about their chosen family members death, this may result in judgement from others and the deceased's memories and reputation being tarnished, as they would be ‘seen’ only as their suicide. The need to protect the deceased, and maintain the positive image and aspects of who they were as a person, therefore led to certain events and aspects of their life being unspoken.

> *Kind of like my brother kind of got a bit lost in in the…it's just nice to to try and remember him as not not all the bad, shitty stuff, but kind of like who he was and, I don't often, haven't really made space to do that properly since he died I don't think – Tony*

> *There's only a few people I've been able to say to them what he said to me because I don't want to feel like I will tarnish… tarnish his reputation – Claire*

Some participants reported that when they'd attempted to talk about their chosen family member following their death, individuals had responded negatively and questioned why the survivor was not ‘angry’ towards them for ‘leaving them’, emphasising that members of the public felt there was a choice made to die, in comparison to death by other causes. At no point during the interviews did the participants display this as an emotion they felt towards the deceased, but rather an emotion provoked when referring to lack of support from services, or from others who don't have an understanding and are unable to talk about suicide or suicide bereavement. This lack of understanding, and lack of curiosity in asking the survivors how they're feeling or have felt, results in survivors needing to vocalise positive characteristics and aspects of the deceased, in order to ensure these are known, and to protect them against potential judgement.

> *She still remains an inspiration to me, very much still a role model, because, but what comes to mind is the living her you know, not what happened to her…I like to protect her*

> *memory, to protect my sister–I don't want anyone to think badly of her, because there's no reason to. She was a very, very strong, remarkable person, and I love her – Lauren*

As highlighted within Chapter 1, the word 'commit' was used when suicide was classified as a criminal act. Participants confirmed that they continue to hear this term being quoted within their daily interactions, despite the change in legislation developed within The Suicide Act. Although some participants felt a need to clarify to others that this word should not be used, other participants spoke of the difficulties they'd encountered in attempting this, resulting in them 'giving up on educating others'. Within these contexts, participants spoke of both trying to bring up within conversation that they'd experienced suicide bereavement, but also that there were situations where they'd simply been pointing out the language used by others. The efforts to educate others and raise the topic of language used was often silenced due to the fear that their chosen family member may be criminalised in the minds of others. To protect the memory of the deceased, and others views of them, one participant spoke about their desire to reframe this word and to use the term 'commit', but to remove it's negative associations. Reclaiming terminology within this context was used to remove negative perceptions of suicide and support it being destigmatised.

> *The word commit…commit was a beautiful word and it's time we reclaimed it, and and I…I want to tell you about all the things my son committed himself to, and that was to living a good life, to being a good person, these are the things he committed to in his life – Lily*

Participants expressed a perceived fear that the deceased would be viewed negatively by others, or that their qualities and positive characteristics may be forgotten or removed due to the way in which they died. Therefore, the need to protect the deceased's memory, their image, and the views others have of them, impacted the way or degree in which participants spoke about them with others.

> *I am fighting for you in death as well as life, and I'm presenting you as the most amazing person that you were – Katherine*

4.5.2 Subtheme 2 - Protecting others

This subtheme was constructed following multiple participants expressing that their lack of spoken communication with others was an act to protect and care for those they're engaging in conversation with.

Discussions were had during the interviews about the incongruity of the survivors experiencing difficulties and therefore requiring support, yet they continue to consider the impact of others and ensure that they're protecting others. The act of protecting others and making conscious decisions about what should be spoken and what should remain unspoken, to not provoke negative emotions for others, places the survivor as a helper, rather than a person in need of help themselves.

> *I don't want to go and just say whatever comes into my mind without having thought about it because, yeah, I guess I did feel responsibility in talking about it, and that sometimes something might upset someone – Erik*

Some of the participants reported that they've yet to talk about their bereavement with individuals they've met since their bereavement. This came about as a result of the participants awareness of the difficulties that individuals may encounter when suicide is mentioned, such as not knowing what to say or do, or experiencing upset as a result of them thinking about the cause of death. Despite the survivors feeling able and wanting to talk about the deceased and their experiences, conversations about the deceased, memories of them, their death and the survivors bereavement can remain unspoken due to the need to care for and protect others. Protecting them in this sense includes not upsetting them, not putting them in situations where they don't know what to do or say, and not causing them any distress. Participants also spoke of the desire to not 'burden' others with the traumatic experience they'd faced.

I often don't say because I don't want to upset anyone. When you tell people that you lost someone to suicide, they don't know what to say, it gets really weird, they just stop talking.– Mia

I'm mindful or conscious of the person who's receiving it, like I'm worried, I guess worried for them, you know rather than just going like 'hey, this is an adult they can, they can deal with, this is fine, you know this is the story you've asked, and this is what happened'…I don't wanna make…I don't want to go out of my way to upset people, or alarm people, or anything like that…so yeah maybe it is around, so just wanting to make sure everyone is ok – Tony

There is a very big fear of upsetting others and not wanting to burden people – Julie

The 'others' whom the survivors were protecting included family members, friends, and members of the public. Participants felt the need to filter what they say to their family members, to protect them from experiencing distress. It was highlighted that family members were not aware that this filtering and consideration of conversations took place. Erik highlighted that family and friends are not trained to deal with such conversations, emphasising the need to receive support from trained professionals.

> *I think obviously family and friends can love you, but they are, they're not necessarily trained to deal with it and it does put pressure on the bereaved person…it's it's not a spoken thing and it's not anything that the friends and family would wish, but there is that pressure I think, of having to filter one's words and be careful – Erik*

4.5.3 Subtheme 3 - Protecting self

Due to the life disruptions that are experienced following a suicide bereavement (Hanschmidt et al., 2016), participants spoke about the need to protect and care for themselves. Although these life disruptions may resemble other forms of bereavement, survivors are reported to be "at an increased risk of developing depression, suicide ideation, and a pathological grief reaction" (Hanschmidt et al., 2016, p. 2) after experiencing bereavement as a result of suicide. The identification and the need to protect and provide care for themselves pervaded different aspects of the survivor's interactions with others. Discounting views of others, remaining silent, and filtering conversations were identified as ways in which participants were able to protect themselves. Topics that participants felt should remain unspoken as a form of protection included: disclosing that they'd been bereaved by suicide, details about their experience of being bereaved by suicide, and discussions about the deceased. Although keeping these topics unspoken was meant to act as a way of protecting the survivor, discomfort was still experienced as a result of having to remain silenced and filter conversations. Discomfort, including emotions of anger and upset, therefore are an unintended consequence experienced due to these narratives remaining unspoken.

> *I know now that I have to protect myself as well. I have to look after me…I do find situations where I shut up because I don't know what to say. It's made me kind of angry inside, or upset, or everything, but I've kind of got to the stage where I, I'd walk away rather than speaking out…maybe again it's a self-protection thing – Sarah*

Following the death by suicide, survivors revealed they'd engaged in many legal tasks, including attending inquests and having meetings with coroners. In order to take part in these tasks, participants divulged they'd held back their emotions and not discussed the impact that the death was having on them. If they had, they reported that they would have felt unable to manage and complete the necessary tasks, as the stress and emotional impact may have resulted in decision avoidance and failure to act (Anderson, 2003), something which they wanted to avoid to ensure justice was achieved, and truth was told. Additionally, the legal tasks required may have unspoken elements within themselves, whereby certain things may not be allowed to be discussed due to legal procedures. Engagement in these tasks therefore appears to act as a reinforcement to narratives remaining unspoken during this period following the death.

> *There's a lot of anger, and there's also a lot of trauma and grief that you feel you have to sort of hold back until you get justice. So I thought if I let it all out, I wouldn't be able to cope with all the legal side of things – Hayley*

Several participants reported that they'd chosen to not disclose their experiences of bereavement by suicide as they did not want to be defined by the death, and they wanted others to get to know them for who they are and the joy in their life, rather than the loss and heartbreak that they'd experienced. Despite these narratives remaining unspoken as a result of the survivors choice, discussions within the interviews led participants and myself to question whether this would even need to be a choice for the survivor if suicide was freely spoken about with no stigma associated to it.

> *I've made a conscious decision not to talk about this for as long as I possibly can…I want…to get to know me as me, and not as the stuff that's happened to me – Charlotte*

> *There's more to me and my life than my brothers suicide, like it's a massive part. It's a massive part of my life, but there's a lot more, there's a lot more to it – Emma*

Participants also alluded to not wanting to be labelled because of their experience and emotions felt as a result of this. They don't want to be 'the hurt', 'the sad' 'the delicate', or 'the rejected' person. By narratives remaining unspoken, it protects the survivor from unwanted labels from others that may negatively impact the survivor. Laura worried how others would view her, for example, as being delicate, or unable to speak about siblings due to her experience, highlighting the concern that disclosure of her experience may prevent general conversations from taking place.

> *Do people start looking at you differently?...do people think 'oh that's the lady whose brother died by suicide?' You know you'd like to hope not, but I think people do put sort of*

labels on people don't they? They might think 'oh she might be a bit delicate', so you know, 'is she suddenly gonna cry on me one day if I talk about my own sibling?' – Laura

To protect themselves, participants found practical coping strategies to allow them to manage their interactions with others, without necessarily having to disclose information about their experience. One participant spoke about the social changes that they made in their daily life to protect themselves from potential judgement and to reclaim their lives following their bereavement.

We moved churches because we wanted to be anonymous…We wanted to go somewhere different, so that we could walk in and people wouldn't, they wouldn't know…so they're not gonna come up and ask or say something silly. So again, it was like a safety mechanism – James

Several other participants highlighted that they were able to protect themselves by expressing their experience non-verbally, through different outlets. Some participants began hobbies such as running to compete in races in memory of the deceased and raise awareness of suicide, whilst others founded charities in honour of the deceased. Others engaged in bonding exercises to keep them connected to the deceased, or took on roles within their careers that supported suicide prevention and suicide teaching.

It's a cavernous hole where they should be, and it's finding something to put in that place. It's not them, you won't find them in it, but if you find something else to put in it, so it, the hole is not, the hole is not there, they're not, they're never going to be there but something can be put in that hole so it's not gaping, so you're not literally emptying out – Lily

4.6 Theme 5 - Comparisons to physical illness - Nobody says ‘oh they’ve committed cancer’ – Hayley

This theme captures the unspoken narrative related to the comparisons of an individual dying by suicide, to individuals dying by natural causes or a terminal illness. Participants reported that there were unspoken narratives associated with the way in which these deaths are viewed, the way in which individuals bereaved are supported, and the expectations of grieving between different causes of death. It’s questionable how, as humans, we can differentiate between grief, as all deaths cause individuals to grieve. With that said, from the interviews conducted, there was a clear indication to the differences between death by suicide and death by other causes, and bereavement by suicide and bereavement by other causes. Both death by suicide and bereavement by suicide were reported by participants to be viewed negatively and differently by members of the public. Reasons as to why these differences were present included the way in which members of the public viewed mental illness as different to physical illness, and that individuals may view suicide as a ‘chosen’ death, and therefore display a different emotional response in comparison to a death by physical illness or accident.

> *I suppose it’s more acceptable, more acceptable to die from cancer than suicide – Rebecca*

Participants told how the reaction from others about their bereavement was different to reactions they witnessed when death was due to physical illness. They reported receiving less practical support from those around them (e.g. prepared meals being given to others known to have been bereaved by other causes, but none being provided to them), as well as less emotional support, and instead being questioned ‘why’ their chosen family member ‘did this to them’. These differences resulted in the participants feeling unworthy in comparison to those bereaved by other causes, and encouraged silence around the disclosure of how their chosen family member had died.

> *The message is being sent [by members of the public, friends and acquaintances] that this is not worthy of sympathy compared to a child who died by cancer – Lily*

> *A lot of outpouring of sympathy and kindness and thoughtfulness for the person bereaved by cancer, but the person suicide – no, nothing. Just awful, and I don't understand why it is that mental illness isn't an illness the same as cancer or heart problems…it is an illness, it's an illness. What's wrong with you people? – Sharon*

Due to the differences in reaction and comparisons to death by physical illness made by others, survivors questioned the support that they'd provided to the deceased as they were sometimes viewed to have not provided the right, or the right amount of support they were expected to, as Laura highlights below. In order to avoid others questioning their support, participants avoided expressing to others how their chosen family member had died.

> *[I have had people ask me how I let them become so unwell]…you wouldn't say that about cancer…you wouldn't say ‘oh how did you let your child get cancer?’ you know, ‘why didn't you look after them properly?’ And then, you know, mental health isn't, it is an illness isn't it? But people don't see it like that – Laura*

Participants observed they were treated differently because of the cause of death, and that their bereavement was viewed differently and more negatively in comparison to those bereaved by physical illness. Participants alluded to the fact that when an individual dies by cancer, for example, cancer is the ‘killer’ and therefore blame is placed on this illness for the death of the individual. With this position of blame, the deceased is able to be remembered for who they were without their illness. Dissimilarly, when a person dies by suicide, participants noted how the person themselves is viewed by members of the public as the ‘killer’, and therefore blame is assigned to them, rather than the illness they had. Due to this assigned blame on the deceased, participants reported fearing that their chosen family member would only be remembered by their death, rather than who they were as a person. These comparative views of death held within society left participants feeling unable to talk about their loved one or share with others how they’d died.

> *I think one of the things about suicide is that you’re very conscious of how it compares to deaths, and if a child died by cancer you wouldn’t just think about their cancer, you you do, and, but the the problem with suicide, and a part of that is the stigma associated with it, I think the problem is that there’s a danger that the suicide becomes who they are, you know, that’s what they define and that’s that’s travesty – Lily*

4.7 Theme 6 - When and who are ‘allowed’ to grieve?

Many participants shared that, following their experience of bereavement by suicide, there were expectations from others that the duration of grief should be finite, and that only ‘selected individuals’ could grieve. Some participants reported feeling unconsidered, uncared for, and unable to speak about their grief and experiences because others had identified them as not the ‘selected individuals’, or because they had grieved for too long.

4.7.1 Subtheme 1 - The expiry date on grief

This subtheme represents the unspoken narrative of the duration in which an individual is expected to grieve following a suicide bereavement. Not only was the topic of duration and grief having an ‘expiry date’ reported as unspoken, but as a result of it, it affected individuals’ ability to share their experiences and express the continuous emotional impact after what was expected to be the ‘timeframe’ to grieve, due to the reduction in support provided.

Participants shared that they’d witnessed others putting an expiry date on grieving, but did not state if this was done consciously or unconsciously by those around them. Three participants specifically spoke of how the support they received significantly reduced a year after the bereavement, and continued to reduce, until it completely disappeared between years two and three since the death.

All of the contacts you get, all of the checking up you get, which is probably much more helpful in years 2 and 3, disappears. So probably when you need it most, when everything’s back to normal, but you’re left still standing, it’s all gone…and it’s just a reflection on how I think this happens a lot doesn’t it, the contact dies off – Katherine

I think it’s got to the point now, 3 years on, where people just don’t talk about it anymore. It’s almost like there’s a kind of cut-off point, like that’s not relevant to talk about anymore because it’s it’s not been, it’s not happened recently – Laura

> *I think it's time. I think people get to, you know…especially like after, we've passed the year mark now, I think they just think, well you know, 'you know, you're fine, you've moved on, you're ok', and I just think people don't ask how things are – Evi*

The quote from Laura demonstrates that initially individuals may have felt able to express their emotions and grief, but due to them now being outside of the appropriate expected timeframe of grieving, they were silenced by virtue of not being invited to openly express their feelings.

Amongst the interviews, mention of the expiry date for grief involved individuals receiving less support over time from those around them, and they were often questioned as to whether they were 'over it', or why it was still impacting them. Individuals responded to this unspoken expiry date by not disclosing with others the continuous and constant impact, or by reducing or removing contact with the individuals who were making comments or questioning them about their grief.

> *He even said to me a month after she died 'oh, I thought you'd be over it'. I mean why would I want to have a conversation with you if that's how you view it – Anika*

Participants sought to attempt to make sense of this 'expiry date' that they'd explicitly experienced but they didn't verbally discuss this with others. Participants made sense of the expiry date by reflecting on the fact that others' lives move on, and that these individuals have to deal with their own daily struggles. Although some of the participants admitted that their lives had also had to move on to a degree, they reported feeling stuck, left behind, and left alone in their grief.

> *Everybody who was there in the beginning, they do just drop off, because people got their own lives to lead you know, and I understand that, you know they can't, they can't live in your grief…they have still got their own families and their own... and I think people just get caught up with life – Evi*

4.7.2 Subtheme 2 - Hierarchy of grieving

Linked closely to the expectations in subtheme one, subtheme two represents the unspoken narrative of the expectations of who should be grieving following a death by suicide. Participants remarked how there seemed to be an unspoken hierarchy held by the public regarding who should grieve, resulting in certain individuals within the hierarchy receiving more support, consideration, and empathy from others. Furthermore, no consideration of the ripple effect of impact following a suicide, as mentioned within Chapter 1, is acknowledged, or verbally expressed by members of the public.

> *The fact that there is limited research for those who feel like they're defined or self-defined family members…yes it has an immediate impact on the family, but never underestimate how much of an impact it's had on the friends, or close people around that person, or even work colleagues, or whoever it might be. It's, I think, the ripple effect is huge – Anika*

Some participants outlined the hierarchy positions that they'd observed: at the top of the hierarchy were partners, these being the individuals who required the most support and were seen as needing to grieve most. Lower down within this unspoken hierarchy came children, parents, and then siblings, which participants described as potentially being positioned lower by members of the public due to the perceived impact that this death would have on the survivors daily lives. Participants spoke of the absence in consideration for friends, acquaintances, and colleagues, resulting in them receiving minimal or no support, despite their closeness to the deceased.

> *It did wind me up quite a lot to start off with and it was always like how you know, there's always 'how is everyone else?': 1. 'how's his wife?', 2. 'how are the boys?', 3. 'how's your mum?', and then at the end, at the end of the line: 4. 'how are you?'…why am I not at the front of the line or on the equal measure? Why is a sibling relationship not as important as those relationships? – Emma*

> *I felt like generally ignored because you know at the funeral everybody was coming up to my mum with their condolences, but they never looked at, they never looked at me – Mia*

Despite participants reporting this unspoken hierarchy having an immense impact on their emotional responses and ability to share their experiences with others, the importance of others acknowledging their relationships and closeness to the deceased was highlighted as incredibly important in reducing the degree to which they questioned their grief, which in turn allowed them to grieve.

> *First thing he said was 'please no one forget Emma. Emma never knew her life without her brother, whereas everyone else had known their lives without him'. The power of somebody validating that relationship was incredible, and just very very helpful to me – Emma*

Emma's quote demonstrates that despite the experienced unspoken hierarchy, nobody should presume the impact a suicide will have on individuals and nobody should assume that a particular relationship correlates to the closeness between two people.

The unspoken hierarchy of who should be grieving or who needs support following a suicide bereavement was reinforced by the actions and questions of others. Individuals asking questions may not have meant to cause harm, but their actions and expressions of their care and concern for others resulted in some participants feeling as though they required less support, or they were excluded from others thoughts.

> *I find interestingly as well, they don't, they always say 'how are your mum and dad? How are they coping?' It's really nice that they ask, but I don't know whether that's because people think it's worse for parents than it is for sibling – Laura*

One of the most striking comments from a participant related to feeling lost amongst others who were grieving, due to the position the survivor held within the hierarchy. This experience of feeling lost, and the unspoken hierarchy itself, resulted in participants questioning their own grief and their right to grieve. Charlotte spoke about her position as a 'good friend' and how she felt this position resulted in her grief and need for support being viewed as less and also how she was 'lost' in comparison to others who held positions 'higher' in the unspoken hierarchy.

> *I knew I was lost as a good friend at the centre of the grieving international community.– Charlotte*

The findings illustrated within these six themes highlight the unspoken narratives experienced by individuals who have been bereaved by suicide, and provide reasons as to why certain narratives remain unspoken. In light of the results outlined, the next chapter shall explore how these findings relate to existing literature, and identify how support for survivors needs to be developed.

5 Discussion

5.1 Overview

This chapter shall firstly outline the six themes captured, and consider their relevance to the existing literature. There will be discussion of the clinical and research implications, prior to a critical appraisal of this study. This chapter shall conclude with suggestions for future research and concluding remarks.

5.2 Summary of Findings

This study aimed to investigate whether individuals who had been bereaved by suicide had experienced unspoken narratives, and if so, what these were. The research question was:

What unspoken narratives exist for self-defined family members who have experienced suicide bereavement?

Through RTA (Braun & Clarke, 2006, 2013, 2019), six themes were constructed from interviews with nineteen participants. The six themes were: '*Explicitly unspoken'*, '*Never ending tasks for the survivor*', '*'Them and us'- the act of othering'*, '*Protection*', '*Comparisons to physical illness'* and '*When and who are 'allowed' to grieve?*'

In line with the epistemological stance taken, this study didn't aim to discover or understand an objective 'truth' regarding participants experiences, instead the constructed themes and subthemes offer an insight into the experiences of survivors, and the unspoken narratives they encountered as a result.

The stories shared by participants were rich in content and offered an insight into what survivors experience on a daily basis. The unspoken narratives identified, and the potential reasons as to why these remain unspoken or silenced, such as the need for the survivor to protect themselves and others, has provided a greater understanding as to some of the factors acting as barriers to survivors receiving the support they need. These barriers include members of the public lacking understanding of their experience, and therefore not knowing what support to provide, this being particularly evident after the expected ‘timeframe of grief’ has passed. It has also shed light on what the support for survivors could involve, which shall be discussed further within the Clinical Implications section of this chapter.

5.3 Relevance of Findings to the Literature

5.3.1 Theme 1: Explicitly unspoken

The narratives that participants shared within their interviews captured that there are certain topics which survivors feel that they cannot voice and share with others. Previous research has identified that ‘speaking ill of the dead’ is a social taboo (Leonard & Toller, 2012). This social taboo is upheld within the findings of this study as it highlights that survivors did not want to be perceived by others as ‘speaking ill of the dead’, therefore don’t disclose difficult parts of their relationship with the deceased.

This theme also concerned participants not sharing with others their last encounter with the deceased. This unspoken narrative resulted from either participants feeling guilt about this last encounter, or feeling as though this memory was too personal and precious to share, or both. Research has explored professionals, particularly nurses, experiences of confronting death and caring for individuals who are dying, both in the context of natural and accidental deaths (Ek et al., 2014), and when providing care when death is as a result of assisted suicide (Asch, 1996), but there is limited research exploring chosen family members encounters and confrontation with death when this death is caused by suicide. Previous research has highlighted that other professionals may not be aware of the impact on nurses confronting death (Asch, 1996), and that it is important to provide continuous support to these nurses both when the individuals are dying, and following their death (Ek et al., 2014). This current study therefore adds to the current literature by identifying that participants also report that others don’t fully understand the impact, and that it is important for the space and support to be provided to allow them to speak about their experiences. Participants have shared within the interviews their reasons as to why the last encounter itself is unspoken, which provides a clearer understanding of the complexities and emotional attachments to what remains unspoken.

Another explicitly unspoken narrative involved participants difficulties of providing care for their chosen family member prior to their death. Research has explored healthcare support prior to an individual taking their own life (Ahmedani et al., 2014), as well as the experiences of carers when providing care for individuals who are struggling with their mental health (Asare-Doku et al., 2017; Marshall et al., 2022), but there is limited research exploring self-defined family members experiences following the death of the individual who they were providing care for. It has been previously found that the societal stigma around mental health contributes to the burden experienced by caregivers (Venkatesh et al., 2016), and that family members have concerns that members of the public will blame them for their loved one’s illness (Shibre et al., 2001). These concerns may act as a reason as to why participants within this study felt unable to talk to others about their experience of providing care. The findings within this study are therefore centralised around the views of society, and how these views can cause narratives to be unspoken due to fear of judgement or being assigned blame.

Explicitly unspoken narratives can be explained by the literature in relation to the continued public stigma of suicide. Whilst extensive research has examined the stigma of mental illness (Angermeyer et al., 2004; Corrigan et al., 2012; Pescosolido, 2013; Stuart,

2016) and suicide (Sudak et al., 2008; Tadros & Jolley, 2001), participants reported within this study that the stigma remains and that they were unclear as to how, as a society, we can move away from this. This stigma does not only refer to the deceased being stigmatised, but also the survivors (Evans & Abrahamson, 2020). The reported issue of survivors experiencing stigma reinforces the explicitly unspoken narratives which were captured within this study. This supports the current literature highlighting how stigma can contribute to survivors avoiding topics of discussion and reinforcing secrecy (Evans & Abrahamson, 2020).

5.3.2 Theme 2: Never ending tasks for the survivor

Participants spoke of the mental processes which they have to complete prior to discussing or bringing up the topic of the individual who has died, or their bereavement experience. The never-ending tasks for survivors is something unknown to those around them, due to inhibited conversations and the participants feeling unable to express this process with others. This theme appears to have not been researched or identified within past literature. Identifying this unspoken narrative therefore provides further insight into the experiences of those bereaved by suicide, and aspects of the impact that we had not previously been aware of. Shining light on this unspoken narrative hopes to promote conversations around the topic, making others aware that these mental processes are taking place, providing them with the opportunities to initiate conversations and emphasise that these conversations are OK, acceptable, and allowed to be had.

By undergoing the mental processes reported, survivors can reduce their chances of being faced with others discomfort and therefore reduce the burden they experience. This potential burden is highlighted within current literature whereby survivors have reported feeling “the burden of other’s discomfort” (Peters et al., 2016, p. 253) when talking about suicide or suicide bereavement. The current findings therefore highlight ways in which survivors are preventing this burden.

5.3.3 Theme 3: 'Them and us' – the act of othering

Experienced othering

Within Begley and Quayle's (2007) research, societies unease in relation to suicide was highlighted as an experience of survivors. Societal stigma and lack of understanding of both suicide and the impact on those bereaved by suicide reinforces the lack of discussions on this topic and the continued experience of othering for those bereaved. Participants reported experiences of othering in various forms, similar to those found by Zou et al. (2022), including: "'us versus them', 'our world versus their world', and 'spectators versus victims'" (Zou et al., 2022, p. 2038-2039).

The process of othering within this context highlights that there is a societal view of what is defined as "'normalcy' and 'deviance' – whereby the suicide incident can be constructed as a case of the latter" (Silven Hagstrom, 2013, p. 187). The current study's findings of experienced othering corresponds with previous literature. Similarly to the current study's findings, whereby the process of othering strengthened narratives remaining unspoken, Silven Hagstrom (2013) highlighted the impact that othering can have on the breakdown of communication between individuals, which can perpetuate the breakdown of relationships, resulting in survivors not accessing or receiving support (Peters et al., 2016).

The findings highlighted within this research emphasise the continued stigma experienced by those bereaved by suicide, and highlight how stigma strengthens the divide between those bereaved by suicide and those not, resulting in othering. Understanding this stigma can support us in identifying ways to tackle and overcome this societal barrier, and lack of understanding and support that appears to be present following an individual dying by suicide.

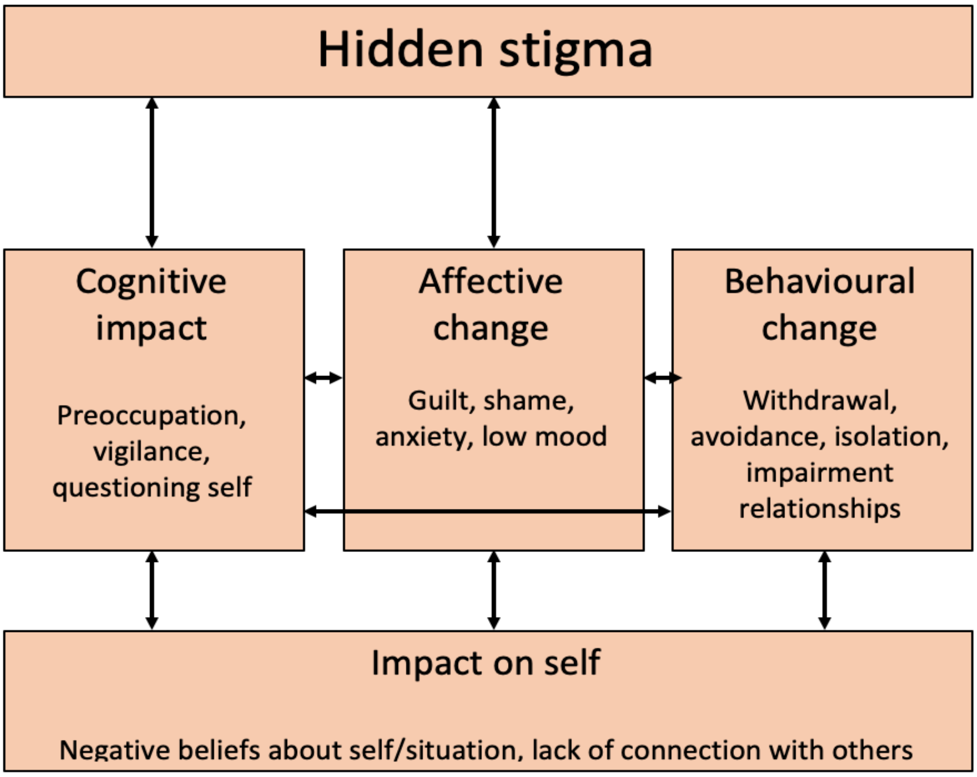
Perceived othering

Participants described not sharing details of their bereavement, or not disclosing that they'd been bereaved by suicide, to reduce the potential of 'othering' taking place. These findings extend those of Dauhoo et al. (2024) who found that talking about experiences of suicide was inhibited due to fear of being judged or misunderstood. Tillman (2006) found similar findings within their research whereby participants feared judgement from colleagues following a client taking their own life. This fear of judgement perpetuates perceived othering and therefore adds to silencing.

Although this lack of disclosure was used to shield survivors from potential stigmatisation from others, it did not appear to have an impact on self-stigmatisation and survivors perceiving that they would be 'othered'. This correlates with previous literature that identified that othering as a process takes place both outside and inside the individual (Silven Hagstrom, 2013). Pachankis (2007) outlined a Cognitive Affective Behavioural Model of Concealed Stigma (see Figure 3). Within this model it describes that when there is a 'hidden stigma' or an aspect of an individual's identity is concealed, due to it being stigmatised by society, this can have a cognitive, affective, and behavioural impact on the individual.

Figure 3

Cognitive Affective Behavioural Model of Concealed Stigma



Survivors attempting to hide this stigmatised aspect of their identity, due to perceived othering, can experience negative impacts on their relationships with others, as disclosed by participants that they'd felt less connected to others. Additional negative impacts may include experiencing anxiety when specific questions are asked to the survivor, such as 'do you have any siblings?', a question which left some participants feeling unsure how to answer. Although disclosure of the stigmatised aspect of the individuals identity is viewed to reduce self-stigma (Corrigan et al., 2010; Pachankis, 2007), participants within this study highlighted the complexities and difficulties in doing this, and spoke of the need to 'find their own tribe' for solidarity.

Solidarity

There was a sense within the participants' experiences that due to both experienced and perceived othering, there was a keenness to find solidarity amongst others. Participants spoke of the desire to share their experiences, but would prefer to do this with people who may have a better understanding than the 'everyday people' in their lives. The need to find solidarity and to be able to break the silence around suicide bereavement is evident within previous literature, whereby survivors have found comfort in talking with others who have also experienced a loss to suicide (Ross et al., 2021), and wished to "find a voice and reach out to other survivors as a way to counter these aversive experiences" (Oulanova et al., 2014, p. 161). The current findings emphasise this need for peer support.

Whilst some of the participants had reported 'finding their tribe', which they'd done independently through contacting suicide bereavement organisations and engaging in activities (e.g. running for charity) to raise awareness of suicide, others were yet to find these individuals who they felt able to connect with. This need for connecting with individuals who have also experienced suicide bereavement highlights the importance of survivors being provided details for relevant organisations and charities who promote survivors connecting. Walker (2017) highlights the importance of survivors providing hope for other survivors and showing them that there is "the possibility of making a meaningful difference as a result of their loss" (Walker, 2017, p. 637). Organisations such as the Alliance of Hope, which Walker (2017) describes in their work as a "sacred place of connection" (Walker, 2017, p. 637), allows survivors to connect through a forum specifically related to suicide bereavement.

Although these organisations and charities exist, identification of this unspoken narrative highlights the need for suicide bereavement support services to ensure they are all providing enough of this support, as well as the counselling support available. Additionally, other services and organisations that have contact with the survivors following a death by suicide (e.g. the police, mental health services, and the coroners) should be equipped to provide adequate signposting to these organisations and services, to allow for survivors to make these connections and receive peer support if desired. Use of a proactive support model would aid the facilitation of "timely access to essential information and appropriate services" (Ross et al., 2021, p. 641).

5.3.4 Theme 4: Protection

Protecting deceased

It has previously been documented that "suicide almost always entails a rupturing of the relationship with the deceased" (Jordan, 2015, p. 356), however within the current study, this claim is questioned, as the participants reported no ruptures in their relationships with the deceased, but rather a need to continue to protect, honour, and remember them.

Memorialisation of the deceased (Jordan, 2015) was evident within the findings, with participants emphasising their desire to "remember and honor the whole life of the deceased" (Jordan, 2015, p. 356), rather than them being defined or remembered by the nature of their death or their mental health difficulties. Previous research has highlighted how memorialisation can support individuals' adjustment to loss and grief (Rumbold et al., 2021). The findings of the current study add detail to this previous literature, highlighting that participants felt responsible for ensuring the memory of the deceased was preserved, and exploring how this responsibility and need to protect the deceased can result in narratives remaining unspoken.

Protecting others

Survivors limiting or filtering their conversations due to the responses and reactions from others was identified within this study and can be found in previous literature. Peters et al. (2016) identified that participants often felt “a sense of responsibility to alleviate the discomfort demonstrated by others” (Peters et al., 2016, p. 255). The findings from the current study have a slightly different emphasis in comparison to Peters et al.’s (2016) findings in that participants were attempting to ensure that the discomfort of others was not experienced, therefore there would be no need for them to alleviate the discomfort. Participants not only expressed that they would protect the listener from engaging in these conversations, but that also due to the difficulties and tasks that they were having to engage in (as mentioned in *Theme 2*), they didn’t want to add to their burden by upsetting someone else and potentially then requiring to alleviate their discomfort.

By ensuring that certain narratives related to their bereavement remain unspoken, survivors reported that this may protect those around them and maintain social bonds (Slavich, 2020). The desire to protect and maintain these bonds is supported by the Social Safety Theory (SST) whereby the development and maintenance of social bonds and social attachment is thought to be a fundamental human response and behaviour, and crucial for survival (Ainsworth et al., 2015). This theory relates to the findings of the current study as it highlights why survivors may maintain their unspoken narratives, to protect others, and protect their relationships and connections with others.

Protecting self

Previous research has highlighted that survivors can feel “defined by the nature of the death of their loved one, causing the partial loss of their personal identity” (Peters et al., 2016). Participants within this current study expressed that because of this they refrained from speaking about their suicide bereavement experience in order to protect themselves and their own identity.

Protection Motivation Theory (PMT) developed by Rogers (1975,1983) supports the findings of this study. PMT is a theory that focuses on explaining people’s tendency to protect themselves (Marikyan & Papagiannidis, 2022). Although this theory primarily focuses on the behaviours to protect oneself from health-related threats, it can be used to explain the findings of this current study, that survivors may choose to not speak of their bereavement in order to protect their identity and prevent judgement from others, despite the fact that disclosure of their experiences may be viewed as a protective behaviour (Marikyan & Papagiannidis, 2022) for their own mental wellbeing.

5.3.5 Theme 5: Comparisons to physical illness

Literature has highlighted the differences experienced by individuals bereaved by suicide and those bereaved by other causes, including the increased level of social rejection (Silverman et al., 1995). This was supported within the current study's findings in relation to participants shared how they were treated differently by others, in comparison to how they witnessed individuals bereaved by other causes of death be treated.

This theme represented the stigma that is associated with suicide and how this impacts the way in which members of the public view this type of death, and how this influences their responses. The findings from this study emphasise the findings within previous literature, that those bereaved by accidents or other causes are treated differently and receive more positive reactions than those bereaved by suicide (Range & Calhoun, 1990). Due to this difference in treatment, the participants within Range and Calhoun (1990)'s study reported, similarly to participants within the current study, that they may not disclose how the person died, maintaining this unspoken narrative. Range and Calhoun (1990)'s research was published 34 years ago, yet corresponding experiences by participants in both studies were noted. This highlights that there is an evident ongoing lack of community support provided to those bereaved by suicide, in comparison to those bereaved by accidents of other causes (Range & Calhoun, 1990). When considering the differences between suicide and other causes of death, it's important to think about the awareness around these topics. There are frequent adverts about cancer on the radio and television, highlighting that cancer is a 'leading cause of death', with suggestions to do regular 'checks' for this. Adverts and campaigns raising awareness of suicide, although have improved and increased over time, don't appear to be as prevalent as those for other illnesses. Improved campaigns and awareness of mental illness, including increased advertisement of how to 'check in' with loved ones, may support the societal divide between death by physical health illnesses and death by mental health illnesses.

Identification of this unspoken narrative has relevance to organisations attempting to raise awareness of suicide, to ensure that they consider how the public view different types of death, and to consider the social comparisons of different forms of bereavement, to attempt to close the gap between the different views and responses of these deaths.

5.3.6 Theme 6: When and who are 'allowed' to grieve?

There's an expiry date on grief

The findings that members of the public consciously or unconsciously appear to put an expiry date on grief following a suicide complements current literature that reports that individuals who have been bereaved by suicide are at high risk of developing complicated grief (a prolonged form of grief) (Young et al., 2012), and that individuals who have a diagnosis of prolonged grief disorder (PGD) are judged by member of the public to be relatively less “emotionally stable, and more dependent and sensitive” (Eisma, 2018, p.176). These findings indicate that members of the public hold judgements towards survivors whose grief lasts ‘longer than expected’, emphasising the unspoken narrative of an expiry date on grief.

Literature highlights that individuals who have been bereaved by suicide, and exposed to suicide, are at risk of developing their own mental health difficulties, including an increased risk of depression (Pitman et al., 2014). Research exploring support provided to survivors identified that individuals who experience their own mental health difficulties following a bereavement also experience negative social consequences, such as reduction in social support (Chapple et al., 2015; Pitman et al., 2016a). This suggests that members of the public lack the understanding or ability to provide a certain level of empathy for survivors who are not viewed as able to ‘work through their grief’. This aligns with the current study’s findings in that members of the public had questioned whether individuals were ‘over it yet?’, and that there was an evident reduction in support over time.

Hierarchy of grieving

Researchers have previously highlighted that the ‘legitimacy’ of bereavement and identification of who can and cannot grieve is not binary, but viewed within society as hierarchical (Robson & Walter, 2013). With the majority of previous research focused on the impact of death for a spouse or partner, rather than other members of the family or those within the system (Peskin, 2019), this current study provides a greater understanding of how suicide impacts both family members and self-defined family members, attempting to challenge society’s constructed hierarchy of who is impacted by a death by suicide and who requires support.

The findings of this current study adds detail to previous literature by exploring the impact that this unspoken hierarchy has on the survivors (e.g. inhibiting conversations). Peskin (2019) reported that “the hierarchy of expressed grief roughly follows the generational family order of spouse and parent before child, immediate before extended, and consanguineous before non-consanguineous” (Peskin, 2019, p. 480). The experiences shared by participants within this current study clarify that this unspoken hierarchy does not reflect the truth about who is or can be impacted following a death by suicide.

The unspoken hierarchy of grief identified within this study may also be experienced by individuals bereaved by other causes, including bereavement due to natural deaths, and bereavement as a result of illness and accidents. With that said, due to the stigma experienced by those bereaved by suicide, individuals spoke within their interviews of an ‘extra layer’ to their bereavement experience, and that individuals ‘lower down’ the hierarchy receive a different and reduced level of support than those bereaved by other causes.

Due to this inaccurate societal expectation of the hierarchy of grieving, individuals who require bereavement support may not be offered this. Individuals who are viewed as ‘lower’ down the hierarchy may not seek support or, if they do, they may not feel entitled to this support due to their positioning within the hierarchy. Services need to ensure that they offer support for all individuals impacted by the ripple effect (Cerel et al., 2013) of suicide. This support may look different for certain individuals, and services need to be aware of this to ensure that they’re providing adequate and appropriate support for all, with no judgement of the relationship status held.

5.4 Strengths & Limitations

A primary strength of this study is the design, demonstrated by the resultant sample size recruited emphasising this strength, particularly due to the topic selected being of a sensitive nature and individuals potentially being reluctant to participate due to this reason. The use of consultants provided guidance of terminology to use, and ways in which the research can be completed safely (e.g. the inclusion of a signposting sheet). Additionally, the challenges and barriers of conducting suicide-related research, highlighted within *Chapter 2*, were considered, and solutions were implemented to overcome these difficulties to ensure that the research was set up safely, and to support individuals ability to participate.

The recruitment strategy was provisionally thought to be a main challenge of this study. The primary reason for this was the fact that the research was asking individuals to speak about the unspoken, and to talk about a topic that has been identified within previous literature as stigmatised and silenced (Peters et al., 2016). Despite this initial concern, the recruitment strategy was proven to work well in allowing individuals to self-identify their suitability for this study, and as mentioned previously, resulted in a screening process needing to be completed, due to the large number of individuals interested in taking part.

The use of 'self-defined family members' within this study was deemed both a strength and a potential limitation. This was chosen to be inclusive when identifying and recruiting individuals. As mentioned, there is a need to extend the definition of family to accommodate the various relationships people have (Rose & Hebblethwaite, 2020), and to ensure that the voices of individuals impacted by the ripple effect following a death by suicide are heard (Neimeyer et al., 2017). Despite standing by the decision to use this particular language, as it allowed for non-first-degree relatives and non-relatives to take part, it was evident within the participation queries from perspective participants, that they were unsure whether they met the criteria of being 'self-defined'. These queries mainly came from individuals who were first-degree relatives to the deceased. This emphasises how the use of certain terminology, e.g., ‘self-defined’, may cause confusion for individuals who are classified or classify themselves as 'defined' family members. To ensure less confusion within future research, it’s suggested that researchers use phrases such as 'family and self-defined family members', to ensure that they are reaching all appropriate individuals.

Another limitation of this study relates to the recruitment strategy and the researcher’s ability to reach individuals with diverse backgrounds. Reflecting on this, there is the potential that individuals who did not self-select to take part in this study experience unspoken narratives that this research did not capture. The individuals this research did not reach, and those who feel completely silenced and not able to participate in research within this field could therefore remain the unspoken population:. As individuals were recruited via suicide support newsletters and posters, individuals that are not connected to these organisations and charities may not be aware that this research was taking place. This method of recruitment may therefore have created a potential bias in the sample. Although this is a difficult limitation to overcome, it’s important to acknowledge that, due to this potential bias, alternative experiences and perspectives may have been missed from the sample. Recommendations as to how to potentially reach this unspoken population and overcome this limitation are discussed in more detail within the ‘Implications’ section of this chapter.

Although there may be potential ways in which research can attempt to reach individuals who are not aware of, or engaging with organisations and charities, there continues to be differing views about suicide amongst different cultures (Eisler et al. 2020), which may have impacted the cultural diversity within this study. As highlighted within the findings, different cultures may not use the word suicide (*Theme 3- subtheme 1, Anika*), or may not view the individual's death as suicide, or, as literature highlights, may hold different meanings to the term (Colucci, 2012). Additionally, the current study focused on individuals’ experiences of suicide bereavement. Taking an individualistic approach may have prevented individuals from participating due to them not grieving in this individualised way, but rather in a relational grieving approach within the community (Venema et al., 2023). With that said, it's important to consider that communities may also experience unspoken narratives both within them, as well as from others outside of the community.

5.5 Implications

It's important to highlight that the results of this study are specific to the time and context in which this research took place. Implications of this study shall be discussed at the levels of clinical (including services and support), research, and wider societal implications.

Previous literature has highlighted that in addition to suicide being a stigmatised topic, "stigma may be a cause of suicidality" (Carpiniello & Pinna, 2017, p. 1). In line with the governments aims to reduce suicide and provide appropriate, effective, and timely support for individuals bereaved by suicide (NICE, 2019; Public Health England, 2023), efforts need to be made to continue increasing awareness of the difficulties survivors experience. To facilitate this, it's important to consider how to ensure that individuals feel safe to be able to speak about this topic. As Dauhoo et al. (2024) also highlighted within their study, NHS services may benefit from liaison with specialist suicide bereavement charities and organisations to gain a greater understanding of how their services are able to generate safety and promote discussions.

As evidenced within the literature, research conducted with individuals bereaved by suicide has increased over the past two decades (Bosticco, 2002; Bowden, 2017; Maple, 2016; Neimeyer et al., 2017). Despite this, it appears that, from the participants experiences, the support provided for those bereaved has not progressed at the same pace. It could be questioned whether the lack of progress in relation to support for individuals bereaved by suicide is impacted by the chronic underfunding of services, particularly in 3rd sector organisations and within the voluntary and charity services. The impact of austerity on public services may result in services not having the budget to train their team members or expand and improve their services. Additionally, service structures may impact the support offered and received for those who have been bereaved by suicide due to the inclusion and exclusion criteria's that services may have in regard to the individuals that they provide support to.

These factors may have impacted the distinct lack of progress in relation to support for those affects by the suicide of a chosen family member or loved one.

Organisations, charities and NHS services attempt to provide effective support for those bereaved, including offering bereavement counselling services and creating documentation to identify what support is required and available. The ‘Help is at Hand’ booklet (Public Health England, 2015) aims to provide both emotional support and practical guidance to support survivors. It’s important that these documents, booklets and signposting materials are readily available to those impacted. Support that was specifically referenced within the findings of this study, including both support that was received, and improvements needed regarding support, included: connecting with other survivors (*Theme 3- subtheme 3*), being provided support from trained individuals (*Theme 4- subtheme 2*), there being a removal of the ‘timeframe’ which support is provided (*Theme 6- subtheme 1)*, and the abolishment of the hierarchy of grief (*Theme 6- subtheme 2*).

Services need to be aware of the type of support that survivors require, and to allow a space for their narrative to be heard. To do this, support needs to be collaboratively identified and created between survivors and the services. By engaging in consultation with EbE, this can ensure that support is ‘done with’, rather than ‘done to’ the survivors.

Due to the ripple effect identified within this study and previous literature, it’s essential for support to be offered to all individuals who have been impacted by a death by suicide. Although Public Health England (2023) have aspired to work towards this within their ‘5-year cross-sector strategy’ for suicide prevention, whereby support aims to be provided for family members, friends, and acquaintances, the participants experiences reported in this study highlight that this isn’t a change they’ve personally seen. Survivors may benefit from there being specific groups available for individuals who hold different relationships to the deceased. Despite this not necessarily removing the hierarchy of grief that is evident within this research and society (Peskin, 2019), it would ensure that there are additional avenues of support for all individuals impacted following the death of their chosen family member.

In relation to the implications within the field of clinical psychology, it’s essential for all mental health professionals to receive training to be competent in supporting survivors. Current Psychology training programmes across the country promote teaching around risk, managing risk and support individuals who are currently expressing suicidal ideations, but from my own experience, having completed training, there’s been minimal teaching related to bereavement in general, and no teaching related to suicide bereavement specifically. Similar experiences were reported within Dauhoo et al. (2024) study whereby it was recommended for both psychology programmes and training programmes for other mental health professions to have dedicated “lecture time and group discussions on the topic of suicide and suicide bereavement” (p. 59). Although within our profession we aim to reduce suicide rates by supporting individuals who are expressing suicidal risks, it’s paramount for Trainee Clinical Psychologists to have the abilities to provide effective support for those bereaved by suicide as well as. University doctoral courses may benefit from the creation of special interest groups focusing on this topic to ensure that soon-to-be qualified Clinical Psychologists actively engage in the up-to-date research within this field. By providing additional training to Clinical Psychologists, not only can this support the facilitation of conversations related to suicide bereavement within therapy sessions, but it can also support service development. Within services and organisations, Clinical Psychologists can contribute to service development through both completing service audits and research within the service, and also by engaging with EbE and collaboratively identifying what improvements and changes need to be made in a service to meet the needs of those bereaved by suicide. To support colleagues within the service, Clinical Psychologists may also be able to provide consultation to staff to provide support to staff so that they feel equipped and are able to provide the appropriate care for the individual they are working with.

In addition to training being provided to unqualified professionals, it would be beneficial, through Continuing Professional Development teaching, for qualified practitioners to also access and undergo training related to suicide and suicide bereavement. Dauhoo et al. (2024) made recommendations within their study to provide psychoeducational material to practitioners "about the value of opening up conversations about suicide and/or skills development for staff in how to initiate such potentially difficult conversations" (p. 58). By providing practitioners with this information and skills, it will hopefully facilitate more conversations about suicide and suicide bereavement.

Conducting this study on a wider scale, both with more and different participants, would be beneficial to establishing whether additional unspoken narratives are present which haven't been captured within these findings. It would be important for future research to gain an understanding of the different terms used to describe death by suicide amongst different cultures, and different ways in which research questions can be adapted to use this language. To support the inclusion of participants from different cultural backgrounds and increase the diversity of the sample, future research would benefit from the use of interpreters to allow for individuals who don't speak English to participate. Researchers may also benefit from examining and considering different preferences for the participants regarding who interviews them, as cultural differences in individuals' preference has been previously identified as a predictor of "culture-related communication problems" (Schouten & Meeuwesen, 2006, p. 21). As mentioned within *Chapter 2*, future researcher may also benefit from making initial contact with community leaders to advertise research and improve community access (Mugisha et al., 2011).

Despite not being identified as an unspoken narrative, participants alluded to the fact that some suspected deaths by suicide, or deaths known to the individual to be a result of suicide, are documented and reported to be ‘death by misadventure’. It would be valuable for future research to investigate the current figures documented for suicide deaths and explore whether these correspond to the narratives that the survivors hold about the death of their chosen family member. This could be completed using a quantitative research design.

The stigma that continues to impact how the deceased are viewed by members of the public has detrimental consequences for the survivors, who are evidently, as highlighted within this study, treated differently to those bereaved by other causes. Despite multiple campaigns (including Samaritans World Suicide Prevention day campaigns, and MIND’s Time to Talk campaign) to reduce this stigma, it remains within our society. The use of mass media as a tool for awareness campaigns may be an important step in attempting to reduce the stigma associated with suicide. It has been reported that the media plays a large part in the continued stigmatisation of suicide (Niederkrotenthaler et al., 2014), but could instead be used as a “type of social advertising” (Niederkrotenthaler et al., 2014, p. 238) to promote suicide awareness and educate the public.

The findings of this study highlight that the way in which members of the public respond to suicide and suicide bereavement needs to drastically change. Highlighting the unspoken narratives that currently exist for survivors provides evidence of the difficulties that survivors experience, and the factors that are maintaining these silences. This identification has the potential for gaps in support to be addressed (Ross et al., 2021), and gaps in discussion to be acknowledged and tackled.

When considering government policy, the study contributes to the wider debate around how to improve suicide awareness and reduce the stigma attached to this. Recent TikTok trends have highlighted a potential change in the language used around suicide and using terms such as ‘unalive’ to attempt to move away from the stigma associated with the term ‘suicide’ (Carpiniello & Pinna, 2017). It’s questionable whether a change in the language used will remove the stigma attached to deaths by suicide, or whether the stigma will be relocated in the different terminology used. Terms such as ‘unalive’ don’t specifically reveal that an individual has ended their own life, therefore potentially adding to the silence around disclosure, resulting in this narrative continuing to be unspoken. From completing this current study, I personally don’t believe that changing the terminology would have the desired effect of reducing stigma. Rather, resources should be invested in educating the public about suicide and suicide bereavement in order to see any potential changes in the stigmatisation of this topic.

5.6 Critical Appraisal

A critical appraisal of the study was carried out using the “Big Tent” criteria (Tracy, 2010). This is reported in Appendix O.

6 Conclusion

This study explored the unspoken narratives that exist for self-defined family members who've been bereaved by suicide. Despite previous research exploring survivors' experiences of suicide bereavement, the topic of 'unspoken narratives' related to suicide bereavement is relatively neglected. This study therefore bridged this research gap.

It was found that unspoken narratives exist for survivors, and they include explicit topics, such as their last encounter with the deceased, the difficulties experienced in providing care for their chosen family member when unwell, and difficult parts of the relationship with the deceased. Additionally, participants spoke of the unspoken comparisons and differences between a death by suicide and a death by other causes, the societal unspoken expectations as to how long an individual should grieve after a death by suicide, who should grieve, and the tasks that they'd complete on a daily basis which were unknown to others. Factors that resulted in these narratives remaining unspoken included the need for survivors to protect the deceased, others and themselves, and the experiencing of othering that was a result of how their chosen family member had died. These factors resulted in survivors feeling isolated and unable to discuss their bereavement with others.

The research emphasised the emotional impact experienced by the survivors due to the encounters they had with others following the death of their chosen family member. Where support was experienced, it was identified as time-limited, and only provided to certain individuals. Services within the UK need to ensure that they have a clear understanding of what specific support survivors need. The support offered must consider the stigma associated with the death, and the unspoken narratives that exist, to allow these narratives to be spoken when accessing support.

Reflecting on the ‘ripple effect’ of impact following a death by suicide (Maple, 2016), I am hopeful that this study shall itself be a ‘drop in the ocean’ within the realm of research, that creates its own ripple effect. The aims of this desired ripple effect include: encouraging others to conduct research related to suicide and suicide bereavement, providing survivors with the opportunities to discuss their experiences, providing members of the public with a greater understanding of the experiences of survivors, and kick starting the conversation to make these narratives spoken.

6.1 Dissemination

The findings of this study shall be disseminated in the following ways:

- SLR manuscript within relevant peer reviewed journal
- Empirical study manuscript within relevant peer reviewed journal
- Poster presentation at the University of Hertfordshire DClinPsych conference
- Summary of findings to be presented to participants and EbE – by sharing the summary of findings with the consultants and EbE who supported this study it is hoped that the relationships formed with the organisations involved can support future research within this field
- Findings of this study shall be shared within planned teaching sessions (related to suicide and suicide bereavement) at the University of Hertfordshire
- A comparison study shall be completed using the findings of this current study and the findings of a member of the research teams study who focused on exploring the unspoken narratives experienced by chosen family members who have/are caring for an individual who has attempted suicide
- Application sent to attend the Annual Suicide and Self-harm Early & Mid-Career Researcher’s Forum in 2025

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Appendices

Appendix A- Extracts from reflective log

Reflection- Conducting the search strategy (SLR)
I am aware that the search strategy completed was subjective and may be impacted by my views. Due to this reason, relevant studies may have been overlooked. In order to attempt to identify the relevant studies and minimise my selection bias, multiple discussions were held amongst the research team regarding the search strategy and the literature identified

Reflection- Starting the research journey
When starting this research journey, I felt both excited to conduct this research and to be able to add to the current literature of an under-researched but extremely important area, but with this excitement also came worries that I would not do the research justice. *I wanted to ensure that the participants voices were heard and to do this I felt a lot of responsibility to ensure that I did not misinterpret their stories. Having not undertaken such a large research project before, I questioned my abilities as a researcher and whether I was the right person for the job. Although 'imposter syndrome' is something that I experience often within my life, I noticed that when my study was designed and I had the opportunity to have discussions with experts by experience, my worries lessened. I continued to have a strong desire to do the research justice, but noticed that I became more confident in myself and in the decisions made in relation to the study, such as the decision to recruit 'self-defined' family members, rather than focusing on first degree relatives or family members only.*

Reflection- Preparing for my first interview
I have been spending time rehearsing my introduction and re-reading my semi-structured interview questions multiple times to ensure that I come across as 'professional' when completing the interviews. I spent time reflecting on this and questioned how to be both 'professional' but also not come across as emotionally detached. When in the interviews themselves, I noticed that I couldn't stop myself from feeling emotionally attached to the individuals experiences and narratives. The learning I have taken from this experience is that I am human and that sometimes, as a researcher, showing emotions is necessary and needed. It allowed for me to connect with my participants in a way that would not have been possible if I were to 'just follow the questions/script'

Reflection- Before the first interview
Due to the sensitive nature of this topic and the literature outlining the difficulties and challenges, I experienced feelings of anxiety on the morning of my first interview due to the fear of the interviewee becoming distressed during the interview. Although this anxiety was eased early on within the interview, when it became evident that the participant valued the space to talk about their chosen family members, something that they had not been given opportunities to do, and I was reminded that the emotional responses present within the

interview were not greater than the emotions experienced by the participants since the death. Following completion of the first interview, I reflected on how the anxiety I had experienced may be members of the public feel, hence why the topic of suicide and suicide bereavement is not spoken about. I aim to continue both within this research and within my daily life to have these conversations and not allow my initial fears and discomfort to stop me from starting these conversations and providing the space for people to talk.

Reflection- After completion of first two interviews

Having completed the first two interviews and re-watched the recordings, I am aware that at times during the interviews I had not asked additional follow-up questions for clarification, this being due to my assumption of understanding their experiences due to my own position as an insider-research. Reflecting on this has made me think about what information this may have resulted in me not obtaining in regard to their experiences. Having identified and acknowledged this, I plan to change my approach with future interviews and ensure that I ask follow-up and additional clarification questions, even if they may be describing a similar experience to my own.

Reflection- During analysis

Although I had completed the interviews, transcribed the interviews, read through the transcriptions multiple times to familiarise myself with the data, and spent time reviewing the data to identify codes and themes, it was when I was going through the quotes for each theme where I became extremely upset and needed a break from the project. During my time away from the project I reflected on why I can such an emotional response as this specific point within the research journey and identified that during parts of the research journey I had tried to remove myself emotionally from the topic to ensure the tasks were completed. This made me think about the similarities in my approach and those described by some of the participants about needing to put their emotions aside in order to complete certain tasks following the death of their chosen family member. During my time away from the project I allowed myself the time to lean into my emotions and think about the huge impact and difficulties that my participants had experienced. When returning to the quotes, I ensured that when reading each one I thought of the participant, their experience, their story and their chosen family member, and allowed myself to feel upset as, as some participants had mentioned- being upset is not a bad thing.

Reflection- The end!

Having reached the end of the write up of this thesis, I have spent time reflecting on the journey I have been on. From feeling nervous that I was taking on a project that felt 'bigger than myself', and feeling anxious about doing justice to this research and the participants stories.. to feeling honoured that I was able to provide a space for the participants to share their stories. The conversations had with all of the participants has changed my own approach to discussing death and dying, something that I may have previously avoided due to fear of upsetting others. I shall take away so much from completing this research and, despite this being the end of my thesis, I aim to continue conducting suicide-related research going forward within my career, and hope that this thesis can inspire other researchers to do the same.

Appendix B- Description of quality assessment

All studies met the criterions for clearly outlining their aims, and the use of qualitative research was appropriate. All studies provided a clear statement of findings and were deemed as valuable in contributing to this topic area. However, some of the studies did not provide clear or detailed information on their recruitment strategy and data collection process, their considerations of ethics and the relationship between researcher and participant, and their process of analysing data.

Four studies did not express, or did not express in detail, their recruitment strategy (Gibson et al., 2014; Lakeman & Fitzgerald, 2009; Mugisha et al., 2011; Moore at al., 2013). By not clearly outlining the recruitment strategy, it was sometimes unclear within the studies how the data had been collected. Lack of this information may present difficulties for future researchers wanting to elaborate on these topics or conduct research in similar settings.

Only two of the studies (Decou et al., 2013; Mugisha et al., 2011) discussed the relationship between the researcher and the participant. Although outlining the researcher-participant relationship is important as it informs the reader of the authors acknowledgement of potential bias, it can be questioned whether the authors considered these factors but had made informed decisions to not include this within the write up of their studies. Similar considerations may be made with regards to the three studies that did not explicitly discuss ethical issues (Andriessen et al., 2019; Lakeman & Fitzgerald, 2009; Moore et al., 2013). All of the eight studies were peer-reviewed journal articles; therefore they would have gained ethical approval.

Although all studies reported how their data was analysed, three studies did not provide a detailed and rigorous description of this process (Dyregrov, 2004; Moore et al., 2013; Mugisha et al., 2011). Again, this may be due to limited and strict word limits of journals.

Appendix C- Sample of full CASP of systematic literature review

Ethical suicide research: A survey of researchers (Lakeman & Fitzgerald, 2009)

Quality checklist question	Yes/No/Can't tell	Supporting information
Was there a clear statement of the aims of the research?	Yes	Needed research to address the current paucity of research that explores the suicidal experience.
Is a qualitative methodology appropriate?	Yes	Wanting to gain an understanding of difficulties experiences/perceived to be experienced (through opinions).
Was the research design appropriate to address the aims of the research?	Yes	Highlighted the advantage of making the data directly available and the fact that web-based surveys had been found to yield similar response rates and responses to paper-based surveys.
Was the recruitment strategy appropriate to the aims of the research?	Can't tell	Although the recruitment was explained, it was highlighted as a limitation: utilizing a review of recently-published research as a means of identifying researchers will inevitably exclude some potentially-valuable participants, such as those who have work in press, are currently engaged in research, or who have made important contributions to the field outside of the review period. 28 participants was only 35% of those emailed. Snowballing method of recruitment might have served to include other members of research teams rather than just the published contact person for correspondence.
Was the data collected in a way that addressed the research issue?	Yes	Data was collected using a web-based survey. Was not documented that methods was modified during the study. Saturation of data not documented.

Has the relationship between researcher and participants been adequately considered?	No	
Have ethical issues been taken into consideration?	Can’t tell	The research was approved and monitored by the Dublin City University Ethics Committee (Dublin, Ireland) and James Cook University Human Research Ethics Committee (Townsville, QLD, Australia). No mention of informed consent being obtained from participants.
Was the data analysis sufficiently rigorous?	Yes	The aim of the analysis was to generate an accurate, uncomplicated, and parsimonious representation of responses. The data set was reviewed sentence by sentence for new ideas or statements. Ideas or statements were clustered into categories or themes. At each point in which a new category or theme was added, existing coding was reviewed. When all data were categorised, the entire data set was reviewed and the categories were reduced to encompass themes where possible. The end-product of this analysis was a comprehensive list of categories under each question with associated verbatim examples. These were used to inform the narrative account of results and checked to ensure that all the main ideas expressed by the respondents were represented.
Is there a clear statement of findings?	Yes	
How valuable is the research?	Yes	Highlights further research that could be conducted.

Appendix D- Organisations and charities contacted

Name	**Contacted?**	**Responded?**
The Andy Mans Club	Yes	Yes - agreed to distribution of recruitment poster
Maytree	Yes	Yes - arranging time to meet to discuss Update: charity has closed down
Papryus	Yes	Yes - Redirected to Support After Suicide, email sent
Samaritans	Yes	Yes - redirected to a different email, email sent Update: put into contact with Lived Experience Network within the National Suicide Prevention Alliance National Suicide Prevention Alliance- agreed consultation and advertisement in newsletter
Survivors of Bereavement by Suicide	Yes	No contact
Amparo	Yes	No contact
The Ollie Foundation	Yes	Yes- virtual coffee 27th Jan at 1pm Consultation agreed Update: unable to support with research due to capacity
Support Line	Yes	Yes - Unable to help with the research
The Ted Senior Foundation	Yes	Expressed interest- to arrange virtual meeting Update: 1 chaser sent, no response following
Suicide Bereavement UK	Yes	No contact
York Suicide Bereavement MIND	Yes	No contact
Support After Suicide Partnership	Yes	Yes - Zoom meeting 11am, 1st February Consultation agreed
The Luna Foundation	Yes	Yes - Zoom meeting 06/04 Consultation discussed by payment required
Kent County Council Suicide Prevention Team	Yes	Yes- agreed advertisement in newsletter

Appendix E- Advertisement poster

Invitation to take part in research

Unspoken Stories: exploring the narratives of self-defined family members who have experienced suicide bereavement

This study hopes to contribute to an important area of research into suicide bereavement.

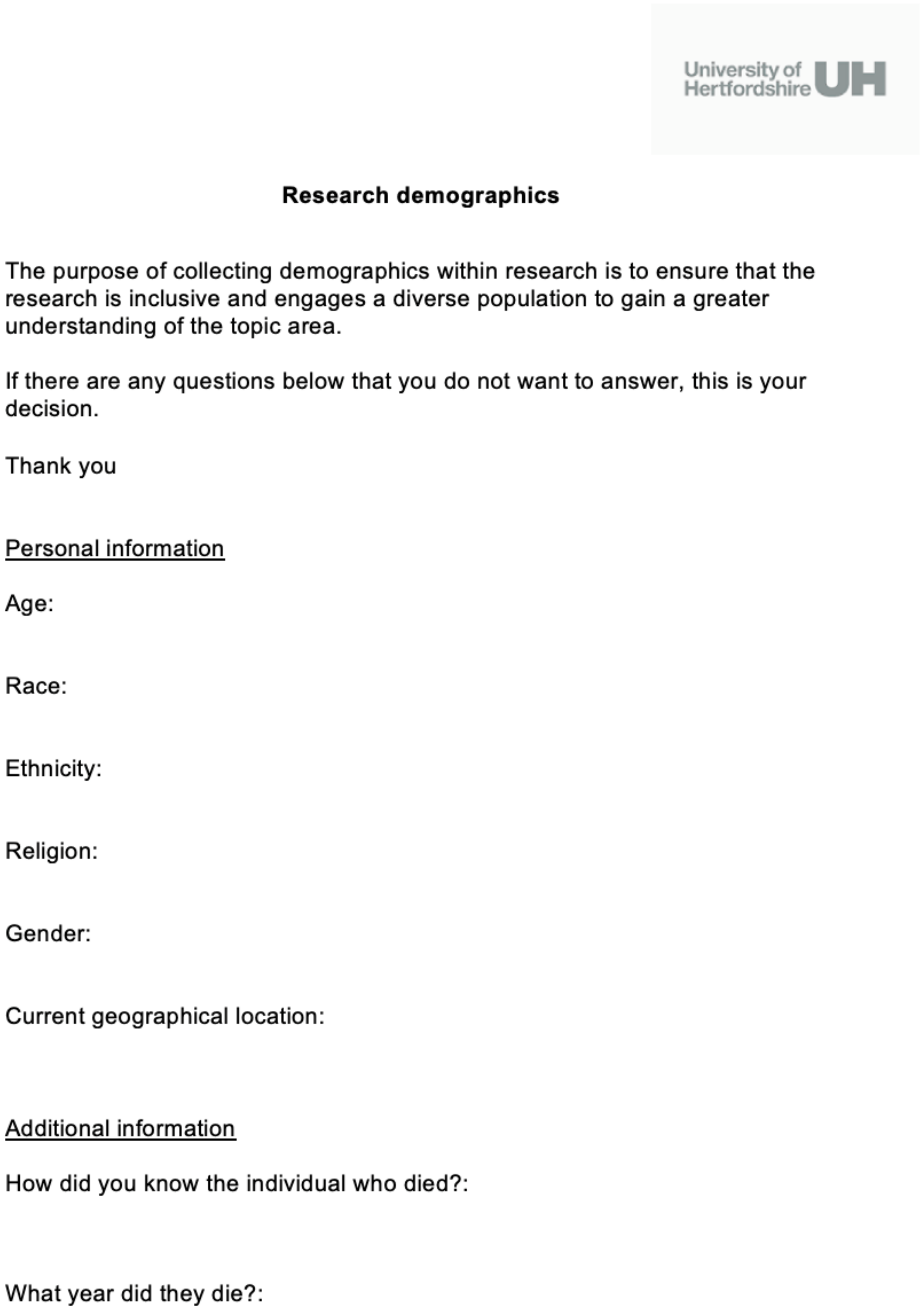
- Do you have experience of losing someone to suicide?
- Do you identify yourself as a 'self-defined family member' to this individual?
- Would you be interested in taking part in a semi-structured interview?

If you are interested in participating in this research, please contact:
Katie High
Trainee Clinical Psychologist at University of Hertfordshire
k.l.high@herts.ac.uk

*Self-defined family member: people who care about each other because they have a close relationship or shared interests

Protocol number: LMS/PGR/UH/05361

Appendix F- Research demographics form



University of Hertfordshire UH

Research demographics

The purpose of collecting demographics within research is to ensure that the research is inclusive and engages a diverse population to gain a greater understanding of the topic area.

If there are any questions below that you do not want to answer, this is your decision.

Thank you

Personal information

Age:

Race:

Ethnicity:

Religion:

Gender:

Current geographical location:

Additional information

How did you know the individual who died?:

What year did they die?:

Appendix G- Participant information sheet

1 Title of study

Unspoken Stories: exploring the narratives of self-defined family members who have experienced suicide bereavement.

2 Introduction

Thank you for taking an interest in this research.
This participation information sheet hopes to offer you an overview of the research study by stating why this research is being conducted and what your participation would involve.

Please take the time to read the following information carefully and discuss it with others if you wish.
Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part.

The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link: https://www.herts.ac.uk/about-us/governance/university-policies-andregulations-uprs/uprs (after accessing this website, scroll down to Letter S where you will find the regulation)

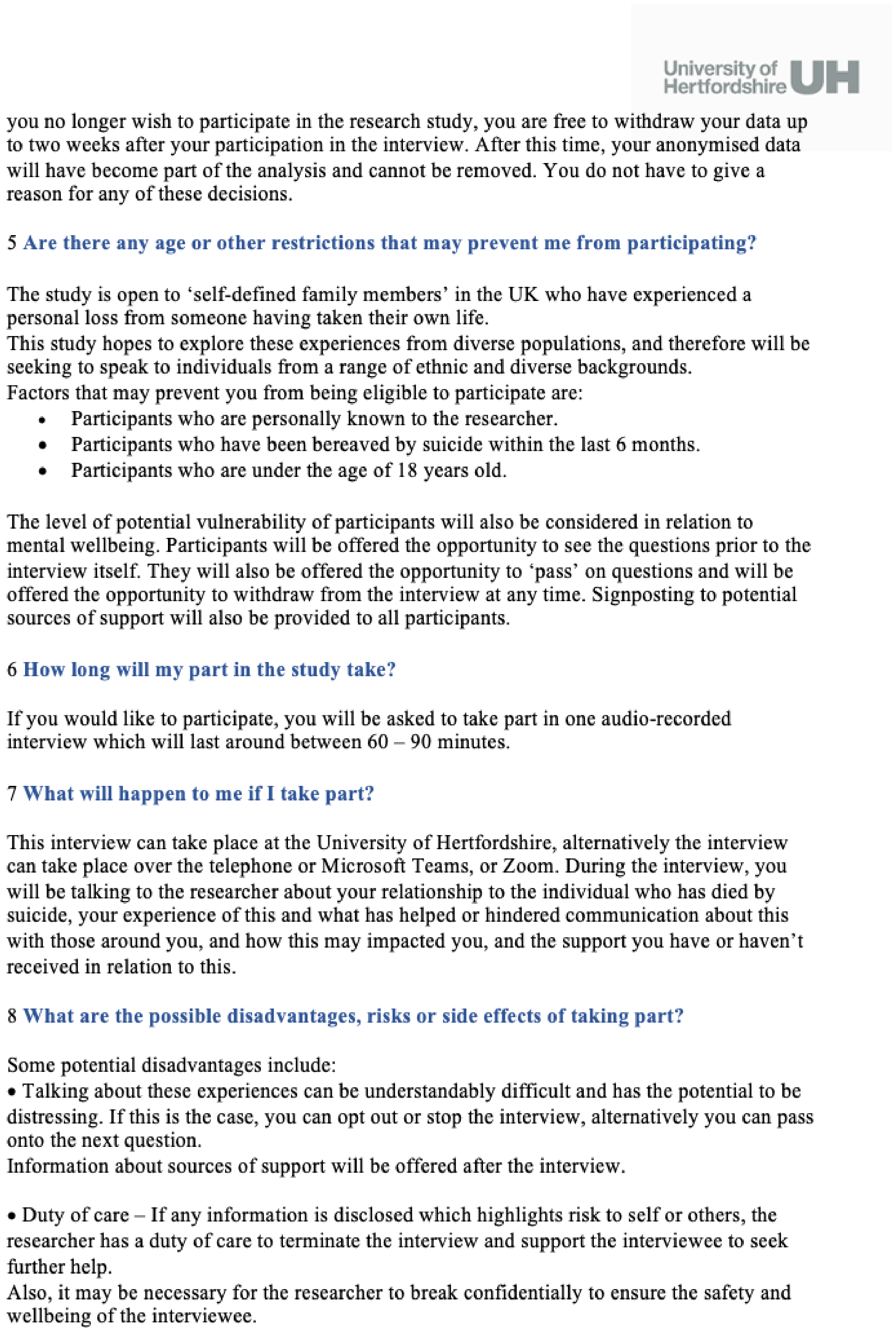
About the researchers- my name is Katie High and I am a Trainee Clinical Psychologist at the University of Hertfordshire. This research is being conducted as part of my Professional Doctorate in Clinical Psychology. I have had personal and work-related experiences related to suicide bereavement, and I have always been interested in how suicide is conceptualised. It is an area I am committed to exploring with a hope to contribute to the existing literature and evidence base, to make a difference to practice. This project is being supervised by Dr Jennifer Heath (Lecturer and Academic Tutor at the University of Hertfordshire), Dr Farah Dauhoo (Clinical Psychologist at the Looked After Children's Team and Older Adults Mental Health Team – Bedfordshire).

3 What is the purpose of this study?

The research aims to develop an understanding of self-defined family members (individuals who feel close to each other) experiences of suicide. The research also hopes to explore how suicide is spoken about, what is felt cannot be spoken about, and how this may have impacted individuals. Existing literature within the field of suicide bereavement, has focused on first-degree relatives experiences and the postvention support that can be provided. Currently, there are no known studies exploring the experiences of self-defined family members who have experienced a personal loss through suicide, and how this may shape their relationship with suicide.

4 Do I have to take part?

No. It is entirely your decision whether you would like to participate in this study. Should you accept to take part, you will be asked to sign a consent form. However, if you decide that



University of Hertfordshire UH

you no longer wish to participate in the research study, you are free to withdraw your data up to two weeks after your participation in the interview. After this time, your anonymised data will have become part of the analysis and cannot be removed. You do not have to give a reason for any of these decisions.

5 Are there any age or other restrictions that may prevent me from participating?

The study is open to 'self-defined family members' in the UK who have experienced a personal loss from someone having taken their own life.
This study hopes to explore these experiences from diverse populations, and therefore will be seeking to speak to individuals from a range of ethnic and diverse backgrounds.
Factors that may prevent you from being eligible to participate are:

- Participants who are personally known to the researcher.
- Participants who have been bereaved by suicide within the last 6 months.
- Participants who are under the age of 18 years old.

The level of potential vulnerability of participants will also be considered in relation to mental wellbeing. Participants will be offered the opportunity to see the questions prior to the interview itself. They will also be offered the opportunity to 'pass' on questions and will be offered the opportunity to withdraw from the interview at any time. Signposting to potential sources of support will also be provided to all participants.

6 How long will my part in the study take?

If you would like to participate, you will be asked to take part in one audio-recorded interview which will last around between 60 – 90 minutes.

7 What will happen to me if I take part?

This interview can take place at the University of Hertfordshire, alternatively the interview can take place over the telephone or Microsoft Teams, or Zoom. During the interview, you will be talking to the researcher about your relationship to the individual who has died by suicide, your experience of this and what has helped or hindered communication about this with those around you, and how this may impacted you, and the support you have or haven't received in relation to this.

8 What are the possible disadvantages, risks or side effects of taking part?

Some potential disadvantages include:

- Talking about these experiences can be understandably difficult and has the potential to be distressing. If this is the case, you can opt out or stop the interview, alternatively you can pass onto the next question.

Information about sources of support will be offered after the interview.

- Duty of care – If any information is disclosed which highlights risk to self or others, the researcher has a duty of care to terminate the interview and support the interviewee to seek further help.

Also, it may be necessary for the researcher to break confidentially to ensure the safety and wellbeing of the interviewee.

9 **What are the possible benefits of taking part?**

Some possible benefits include:

- An opportunity to share your experience
- This research may influence the support available for individuals who are bereaved by suicide
- An opportunity to be part of a research study focusing on an important topic which has emerging interest within the UK
- It is hoped that the research will enable training providers and psychologists to develop a greater understanding of the impact of experiencing a suicide

10 **What will happen to the data collected within this study?**

The information collected about you alongside the interview will be kept strictly confidential. Any identifiable information will be anonymised and kept separately from the interview, this is relevant to both yourself as a participant, and the individual that you shall be discussing within the interview process.

Interview transcripts will also be anonymised prior to data analysis and verbatim extracts used in the report will also be fully anonymised. Data will be stored electronically using password-protection for added security.

This data will be kept for 5 years post research project submission to allow for any secondary research to take place. The interview recordings shall be deleted following transcription and the interview transcripts shall be password protected and stored on a secure system for data protection purposes. Forms related to the research, such as consent forms and participant information forms, will be scanned and stored within the same secure system, with the paper copies being destroyed following this.

In the event that confidentiality needs to be breached, it will be managed in accordance with the regulations set out by the British Psychological Society code of conduct. If information is disclosed which indicates sufficient concern about your safety or the safety of others, it may be necessary to inform an appropriate third party without formal consent.

The researcher may contact their principal supervisor discuss possible concerns. This may be overridden if it is deemed that the risk is imminent and requires immediate attention

11 **Will the data be required for use in further studies?**

If you consent to take part, the data may be used in further studies in relation to suicide bereavement, suicide prevention and suicide postvention.

12 **Who has reviewed this study?**

This study has been reviewed by:
The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.

UH Protocol number: LMS/PGR/UH/05361

13 **Factors that might put others at risk.**

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

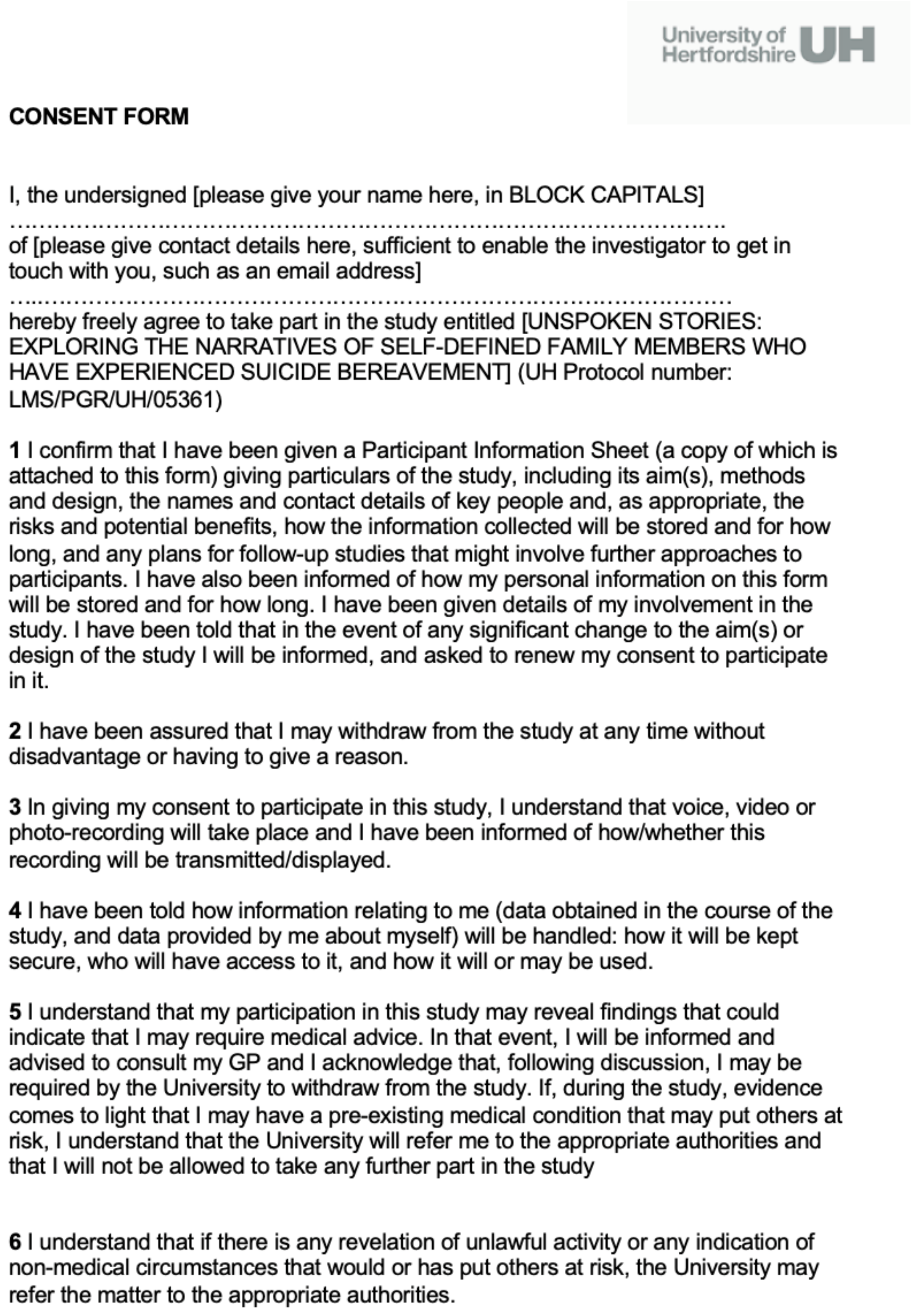
14 **Who can I contact if I have any questions?**

If you are interested in participating in this research study or if you have any questions, please feel free to contact me on **k.l.high@herts.ac.uk** to discuss your queries or to arrange an interview. If you would like to participate, you will be invited to sign a consent form prior to your participation. Please retain this invitation letter for reference.
Supervisor's contact details:
Dr Jennifer Heath
j.heath@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:
Secretary and Registrar
University of Hertfordshire College Lane
Hatfield, Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study

Appendix H- Consent form



University of Hertfordshire UH

CONSENT FORM

I, the undersigned [please give your name here, in BLOCK CAPITALS]
……………………………………………………………………………………….
of [please give contact details here, sufficient to enable the investigator to get in touch with you, such as an email address]
……………………………………………………………………………………….
hereby freely agree to take part in the study entitled [UNSPOKEN STORIES: EXPLORING THE NARRATIVES OF SELF-DEFINED FAMILY MEMBERS WHO HAVE EXPERIENCED SUICIDE BEREAVEMENT] (UH Protocol number: LMS/PGR/UH/05361)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5 I understand that my participation in this study may reveal findings that could indicate that I may require medical advice. In that event, I will be informed and advised to consult my GP and I acknowledge that, following discussion, I may be required by the University to withdraw from the study. If, during the study, evidence comes to light that I may have a pre-existing medical condition that may put others at risk, I understand that the University will refer me to the appropriate authorities and that I will not be allowed to take any further part in the study

6 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Name of (principal) investigator: KATIE HIGH
Signature of participant:……………………………………..………..
Date………………….………

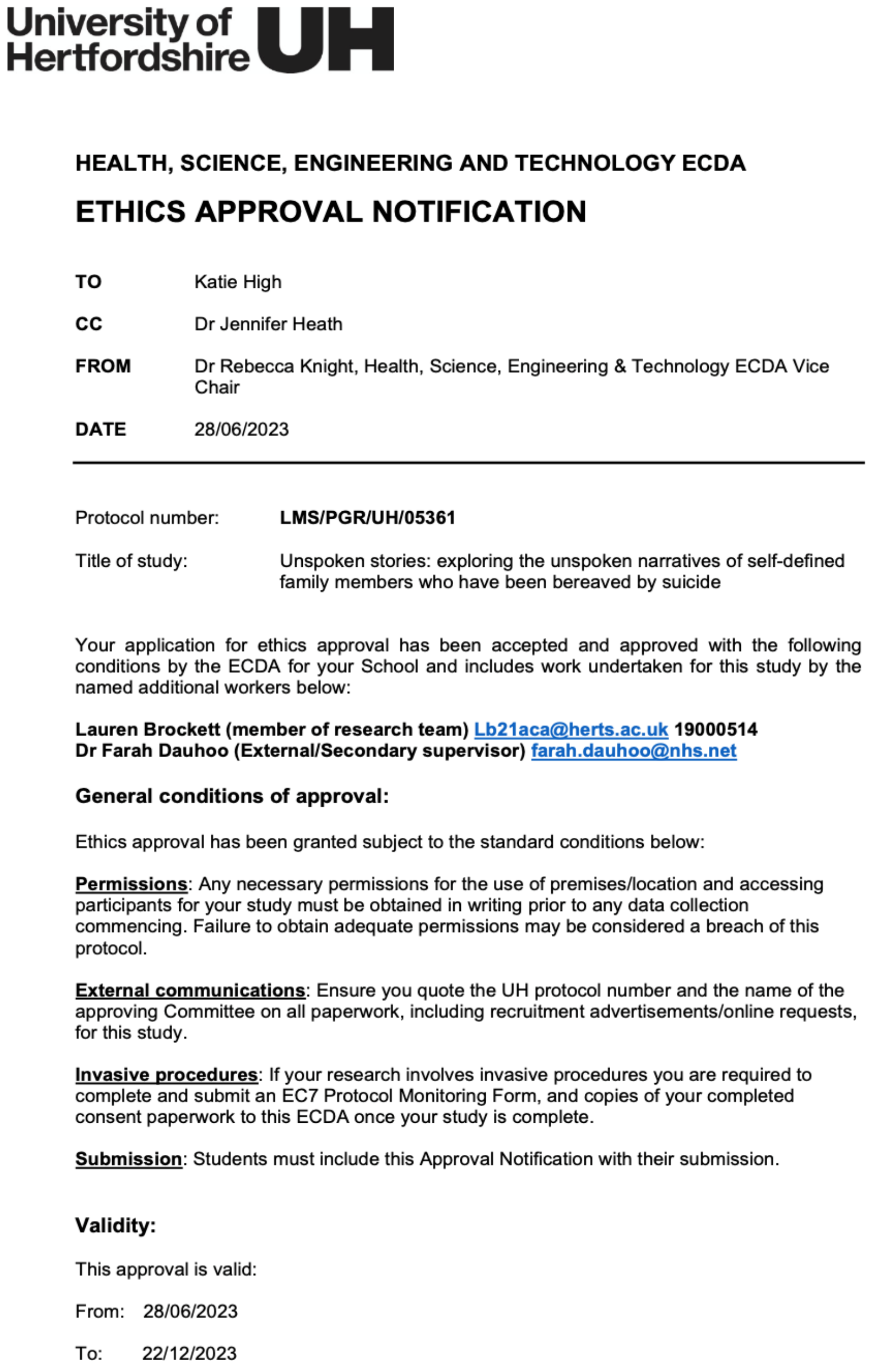
Consent Form

1. **I have read and understood the participation information sheet for the above study.**
2. **I have had the opportunity to contact the researcher and ask questions relating to the study.**
3. **I have been informed that I am free to decline participation and I am able to leave the study without giving a reason before or during the interview.**
4. **I have been informed that my data will be anonymised and stored securely.**
5. **I consent to the audio recording of my interview.**
6. **I understand that if I disclose information which leads to sufficient concern about my safety or the safety of others it may be judged necessary to inform an appropriate third party without formal consent.**
7. **I consent to the use of quotes from my interview to be used as excerpts in the research reports and publications. I have been made aware that this data will be treated as anonymous and confidential.**
8. **I consent to taking part in the above study.**

Signature of participant .... Date.............................

Signature of Researcher .... Date.............................

Appendix I- Ethical approval confirmation



University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Katie High
CC	Dr Jennifer Heath
FROM	Dr Rebecca Knight, Health, Science, Engineering & Technology ECDA Vice Chair
DATE	28/06/2023

Protocol number:	**LMS/PGR/UH/05361**
Title of study:	Unspoken stories: exploring the unspoken narratives of self-defined family members who have been bereaved by suicide

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Lauren Brockett (member of research team) Lb21aca@herts.ac.uk 19000514
Dr Farah Dauhoo (External/Secondary supervisor) farah.dauhoo@nhs.net

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

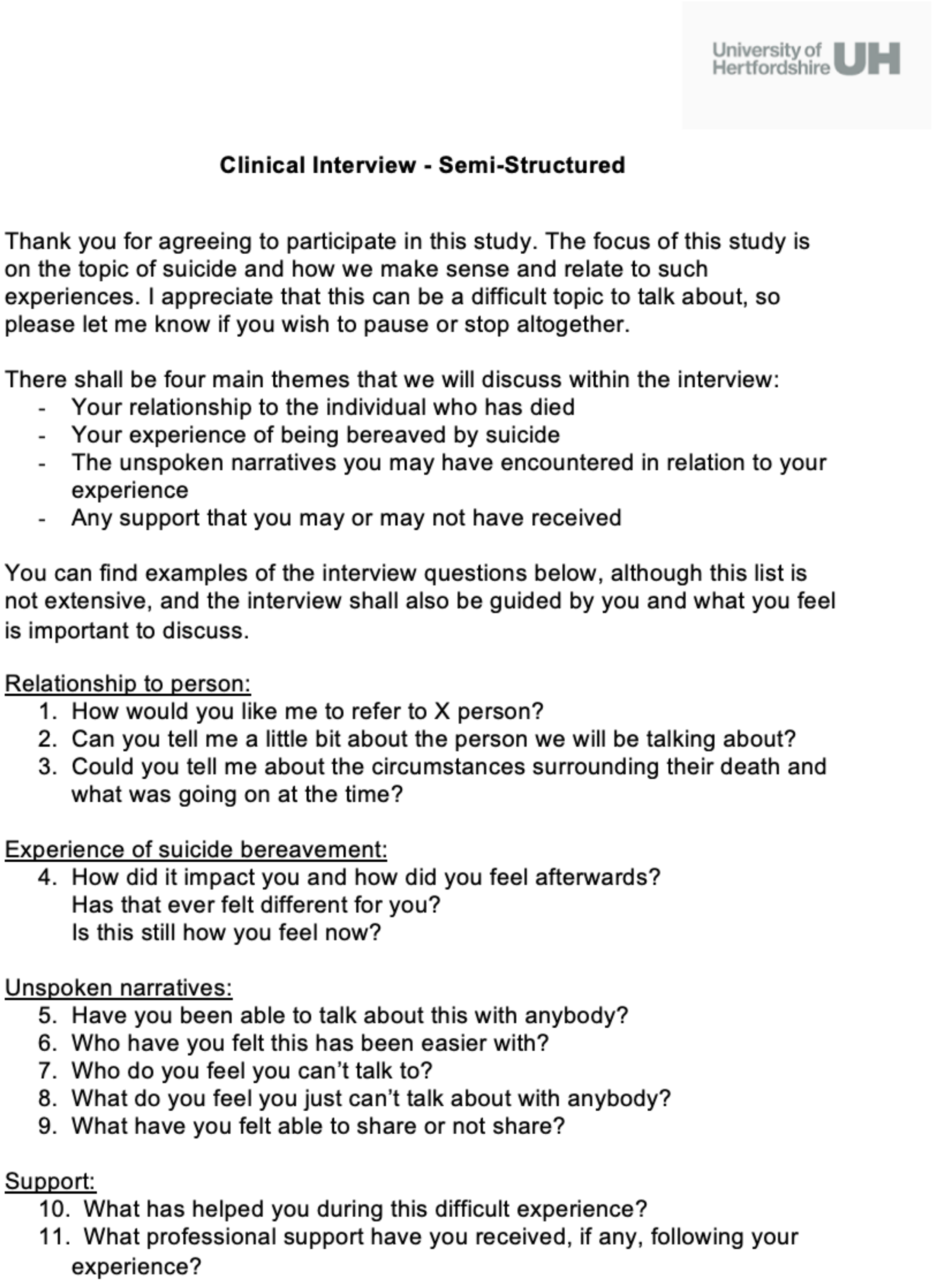
Validity:

This approval is valid:

From: 28/06/2023

To: 22/12/2023

Appendix J- Interview Schedule



University of Hertfordshire UH

Clinical Interview - Semi-Structured

Thank you for agreeing to participate in this study. The focus of this study is on the topic of suicide and how we make sense and relate to such experiences. I appreciate that this can be a difficult topic to talk about, so please let me know if you wish to pause or stop altogether.

There shall be four main themes that we will discuss within the interview:
- Your relationship to the individual who has died
- Your experience of being bereaved by suicide
- The unspoken narratives you may have encountered in relation to your experience
- Any support that you may or may not have received

You can find examples of the interview questions below, although this list is not extensive, and the interview shall also be guided by you and what you feel is important to discuss.

Relationship to person:
1. How would you like me to refer to X person?
2. Can you tell me a little bit about the person we will be talking about?
3. Could you tell me about the circumstances surrounding their death and what was going on at the time?

Experience of suicide bereavement:
4. How did it impact you and how did you feel afterwards?
   Has that ever felt different for you?
   Is this still how you feel now?

Unspoken narratives:
5. Have you been able to talk about this with anybody?
6. Who have you felt this has been easier with?
7. Who do you feel you can’t talk to?
8. What do you feel you just can’t talk about with anybody?
9. What have you felt able to share or not share?

Support:
10. What has helped you during this difficult experience?
11. What professional support have you received, if any, following your experience?

Appendix K- Risk management protocol

Risk Management Protocol - For Participants

-

Prior to any interview taking place, research supervisors will be made aware of the time and location of the interview so that the researchers are able to contact them (telephone or email) should any concerns arise.

For each interview, the second researcher will be local to where the interview is taking place. They will be easily accessible and will be able to offer support if needed

Situation – A Participant Becomes Distressed:

1. The interview will be paused and a break offered.
2. Researcher (and second researcher if required) will employ therapeutic skills to contain the participant’s distress. De-escalation skills can be used when required. Researchers will not provide advice or therapeutic support during at this time as participants have consented to research, they have not consented to therapy.
3. Participants will be reminded that they do not have to carry on with the interview and can terminate it at any time.
4. Researchers will check-in with the participant that they are safe to leave the interview room before they leave (using calming techniques if required). Supervisors contacted if required,
5. Before they leave, participants will be provided a de-briefing sheet which includes signposting to charities, foundations and help-lines.

Risk Management Protocol - For Researchers

- Prior to any interview taking place, research supervisors will be made aware of the time and location of the interview so that the researchers are able to contact them (telephone or email) should any concerns arise.

- For each interview, the second researcher will be local to where the interview is taking place. They will be easily accessible and will be able to offer support if needed

- Research supervisors also have therapeutic skills which can be drawn on if needed post-interview.

- The second researcher will offer a de-brief session following each interview.

Appendix L- Signposting information sheet

SIGNPOSTING INFORMATION SHEET

Thank you very much for participating and making this study possible.

You still have the right to withdraw your data from this study, up to two weeks' post-interview (for data analysis purposes). Please contact the main researcher or supervisor if this is something that you wish to do:

Researcher:
Katie High
Kh21abi@herts.a.uk

Supervisor:
Dr Jennifer Heath
j.heath@herts.ac.uk

Due to the sensitive nature of this topic, we have enclosed below details of services that are able to offer additional support, if needed.

Services offering support:
There are a number of local sources of support which may already be familiar to you if you find that taking part in this study and talking about your experiences has left you distressed. Whilst this is quite understandable and normal, if these feelings persist you may find the following services useful:

The Samaritans:
http://www.samaritans.org
Helpline telephone Number: 08457 90 90 90
The Samaritans is a helpline which is open 24 hours a day for anyone in need. It is staffed by trained volunteers who will listen sympathetically. Alternatively you can send them an email them at jo@samaritans.org and they will try their hardest to respond within 12 hours.

Facing the Future:
www.facingthefuturegroups.org
Facing the future offers support groups for people bereaved by suicide run by Samaritans and Cruse Bereavement Care.

If U Care Share Foundation:

www.ifucareshare.co.uk
This service provides timely practical and emotional support to people touched by a suicide and deliver training on suicide prevention, intervention and postvention.

Suicide Bereavement Network:
www.sbnwk.org.uk
This organisation provides face-to-face and online support for anyone who is coping with the suicide of someone close.

The Compassionate Friends (TCF):
www.tcf.org.uk
A UK-wide organisation where local volunteers provide support to parents who have lost a child, and siblings. Their Shadow of Suicide (SoS) groups support families where a child has taken their own life.

Survivors of Bereavement by Suicide (SOBS):
http://www.uk-sobs.org.uk
National helpline telephone number: 0844 561 68 55 (9am to 9pm every day)
Survivors of Bereavement by Suicide are a self-help organisation, and many of their volunteers have themselves been bereaved by suicide. They offer a confidential telephone helpline, support information and group meetings. You can contact them by email on sobs.support@hotmail.com

Cruse Bereavement Care:
http://www.crusebereavementcare.org.uk
Helpline telephone number: 0844 477 9400
Cruse is a national charity offering free support to anyone who has been bereaved. Cruse volunteers, who are trained and live locally, can visit you in your home or talk to you over the telephone. If you call the national telephone number they will put you in touch with your local branch. You can contact them by email on helpline@cruse.org.uk.

Alternatively, your GP may be able to refer you to more specialised local support services.

Appendix M- Construction of codes into themes- part 1

Appendix N- Construction of codes into themes- part 2

Appendix O- Critical Appraisal of study (Tracey, 2010)

Criteria	Description of criteria	Strengths	Limitations
Worthy topic	The research topic is relevant, timely, significant and interesting.	The research topic is significant as it explores an under researched area, and identifies clinical implications as a result of the findings. The research topic is timely as end of life care is in the spot light at present due to the assisted dying debates (Hitchcock, 2023) and the hypothesis that those bereaved by assisted dying will likely be another stigmatized group of individuals. It is important to acknowledge that support is required for the bereaved of all forms of death.	
Rich Rigour	The study shows sufficient richness, with an abundance of data sources. There has been a rigorous data analysis procedure which describes the phenomena being studied.	A good sample size (19) comprising of individuals of different backgrounds, ages, genders and different relationships to the deceased. This supports the study's data sufficiency. Analysis was carried out following well established procedure (RTA). This process is	Due to the recruitment strategy and language used, there was a potential recruitment bias which resulted in potential participants not being aware that the study was taking place, or not identifying that they were suitable to take part.

		transparently reported. The analysis of participants experiences was interpreted by the lens of the researcher. Interviews were offered at times of the participants preference and the modality of the interview was dependent on the participants preference.	
Sincerity	Self-reflexivity is evident within the study to highlight the researchers potential biases and goals. The study process is presented with transparency, including identification of challenges faced.	Acknowledgement of the fluidity and movement between the insider and outsider research position allowed the researcher to approach the study open-minded and curious of the participants experiences. Self-reflexivity was practiced in many forms, including: the use of a reflective diary, and discussions with the research team. The research process was described in detail with honest reflections included throughout.	Although all of the participants within this study opted for video or telephone interviews, the use of face-to-face interviews (which was offered) may have supported the identification of participants showing emotional cues.
Credibility	The study demonstrates plausibility and trustworthiness of research findings.	Quotations from all of the participants were included within the results to ensure that all voices were	

		heard and that rich details were provided. The research team supported the formation of the themes captured.	
Resonance	The study influences the reader by presenting relevant information that is clear and evocative in nature. The study is able to generate resonance in knowledge for different contexts and audiences.	Due to the sensitive and personal nature of this topic, it is felt that this study shall move readers, although it is difficult to objectively comment on this. Quotations were used throughout the results of this study to allow and encourage the reader to connect with the participants experiences. The meaningfulness of this study was enhanced by the involvement and consultation by experts by experience. Recommendations have been provided for future research and the limitations of this study have been presented.	Participants were all currently residing in the UK, so it is likely that the bereavement support that they have received, been offered, or are aware of is similar.
Significant contribution	The study provides a significant contribution to existing literature and the field of study by improving or extending knowledge, clinical practice, or	The findings of this study add to the limited literature exploring the unspoken narratives experienced. Recommendations are provided to	

	theoretical understanding.	improve bereavement services and reduce the public stigma associated with suicide.	
Ethics	The research considers and adheres to professional and research ethics guidelines.	Ethical approval was granted by the University of Hertfordshire's Research Ethics Committee (see Appendix I). Ethical considerations were adhered to throughout the research process. Different ethical concerns were discussed with the research team and within consultation with the experts by experience. Ethical concerns highlighted within the systematic literature review were discussed and considered in relation to the design of this study.	
Meaningful coherence	The study achieves what its set purpose was, it uses methods that fit with its stated goals and aims, and has meaningful connections with existing literature.	Epistemological position of the researcher was discussed and the impact that this had on the design of this study were documented. The use of RTA is compatible with the critical realist position taken.	

The findings of this study correspond with existing literature.

Detailed implications of this study in relation to clinical, research and wider societal implications are discussed.