Portfolio 1: Major Research Project

Words Left Unspoken: Exploring the Unspoken Narratives of Loved Ones Supporting a Person who has Survived a Suicide Attempt

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Abstract

Informal care (care provided by family/friends) is overlooked by policymakers in physical health contexts (Cruz et al., 2023), and is *significantly* overlooked by policymakers in mental health contexts (Eikemo, 2018). Academics, clinicians and those alike know little about the experience of informal carers, yet acknowledge that 7% of the UK population (approx. 4.9 million people) are currently providing informal care (Office for National Statistics, 2024). This thesis positions itself in the field of *suicide prevention*, aiming to broaden the current understanding of the experience of informal carers who provide support for a loved one following a suicide attempt. A qualitative Systematic Literature Review (Chapter 2) explores current academic understanding of the experience of carers when seeking and engaging with support provisions. The results emphasise how much is unknown about informal carers in this context, and invites researchers to rectify this. Using qualitative methodology, the empirical study presented (Chapters 1; 3-5) begins to address the identified gap in research. The study aimed to uncover and explore the unspoken narratives of informal carers who have provided care for a loved one following a suicide attempt. A convenience sample of 14 adult participants (78.6% female, 21.4% male) responded to a social media advert inviting them to participate in a semi-structured interview to talk about their experience of caregiving. The interviews were analysed using Reflective Thematic Analysis (Braun and Clarke, 2019). Five main themes were identified: The Conspiracy of Silence, Unequivocally Unspoken [Narratives], A Sense of Responsibility, Making Comparisons, and Relationships with Professionals. Findings are discussed in relation to existing literature, before highlighting clinical implications and offering further invitations for research.

Keywords: suicide, suicide prevention, informal care, carer, caregiver, family, friend, suicide-attempt, attempted suicide, loved one, loved-one, unspoken narrative

Chapter 1: Introduction

This research is situated within the field of suicide prevention. The field of suicide prevention has grown in recent years, with researchers placing increased resource into understanding the phenomena which has been described as a “multisectoral public health concern” (Henry, 2021). At present, academic interest appears to be largely located around the individual identified as being ‘suicidal’, with less interest being shown to the network around the individual (e.g., family, friends). What we know is that there are vast impacts when somebody presents as suicidal, with a high frequency of associated people experiencing distress (Cerel et al., 2019). This is often described as “the ripple effect of suicide” (Samaritans, 2023).

1.1 Chapter Overview

This chapter introduces the reader to the research area. The chapter begins with an introduction to the lens of the researcher when conducting this research, thinking personally and theoretically about positioning. The chapter then moves into defining the language and key terms used throughout this document. Following this, the research is situated in context (exploring history, current policy, and service provision), and theory (exploring theoretical underpinnings). The chapter ends with a rationale for the Systematic Literature Review (SLR; Chapter 2).

1.2 Theoretical and Personal Positioning

1.2.1 Personal Positionality and Reflexivity

‘My Stuff’. I don’t think its uncommon for a thesis in clinical psychology to hold personal meaning to the researcher. Carl Jung’s (1951) idea of the ‘Wounded Healer’ comes to mind - We’re all in this for a reason, right? I think the key is self-awareness; being able to differentiate ‘your stuff’ from ‘their stuff’, and knowing when ‘your stuff’ might be influencing the direction of something. So, to be quite frank, this research was born from ‘my stuff'. The 'stuff' I've taken to therapy. The 'stuff' I carry with me each day. The 'stuff' that makes me so bloody angry that the only thing I could do was to write a thesis about it.

I grew up in a white, middle-class family in Kent. A family that was seemingly perfect from the outside looking in. Our social graces (Burnham, 2012) afforded us a certain level of privilege by definition alone but mental health does not discriminate, and this is what we battled with behind closed doors. It was a battle that led to a very dark period in 2020 when suicidal thoughts became too much for one of us to handle, throwing the entire family into a state of distress. My own observations at this time, and my observations since, informed my thinking when developing this research.

A Moment for Refection

'My Stuff' was incredibly difficult to write as I contended with the notion that this thesis would be available online for anyone to read. I struggled with the idea that the story was not my own to tell, I was not the family member at the centre of the mental health struggles so do I have the right to name our circumstances so openly? Anonymity is a funny thing, to a stranger 'My Stuff' means nothing; but to somebody who knows me/to somebody who knows my family, 'My Stuff' is incredibly meaningful and shares part of a story which feels safer if its hidden.

Insider Researcher. I am an insider researcher, which means that I have direct experience of the phenomena which I am interested in (Brannick & Coghlan, 2007; Hellawell, 2006). I hoped that being an insider researcher would encourage participants to feel comfortable in sharing their stories with me. Insider researchers have been shown to have positive outcomes when engaging their participants; they are able to form therapeutic alliances easily due to the pre-existing knowledge they hold (Smyth & Holian, 2008), which encourages participants to be more open and honest when sharing their stories (Bonner & Tolhurst, 2002). However, the familiarity which exists between insider researcher and participant can also be a challenge. It can cause researchers to unconsciously make the wrong assumptions about a story being told. This is thought to be due to a lack of objectivity (DeLyser, 2001; Hewitt-Taylor, 2002), which can mean a participant's 'true' story may not be heard; impacting the validity of results, and leading to participants feeling dismissed.

As an insider researcher I recognise that I approach this research with a certain level of expertise, and bias. I also acknowledge the fluidity which exists within the insider/outsider researcher positionality, meaning there will be some participant narratives I personally identify with more than others (Almack, 2008; Bukamal, 2022). I attempted to overcome my biases through bracketing, which is a process qualitative researchers go through to help separate their own experiences from what they are studying (Creswell, 2014). I employed bracketing through keeping a reflective journal, engaging with the *Bracketing in Qualitative Research* framework outlined by Tufford & Newman (2012) in facilitated meetings with a colleague external to the research, and consultation [both with Experts by Experience (EbE), and professionals working in the field]. Extracts from each bracketing exercise can be found in Appendix A.

Reflective extracts are embedded in tables throughout this thesis to help the researcher and reader stay connected to the thoughts informing the research process. The extracts also demonstrate bracketing without requiring the reader to refer back and forth to the Appendices.

1.2.2 Theoretical Perspective, Ontology, and Epistemology

To understand the theoretical lens of the researcher is essential to understanding the research itself. The researchers' theoretical lens informs how decisions are made in relation to the research, and how the methodology is executed. It is underpinned by the researchers ontological and epistemological positionality. Ontology has been defined as the "study of being" (Crotty, 2003), and has been described as our individual understanding of the nature of reality (Guba & Lincoln, 1994). Epistemology has been defined as the "theory of knowledge"

(Crotty, 2003), and describes what we as individuals deem to be the truth (Duberley et al., 2012).

This research was conducted from the theoretical perspective of Critical Realism (CR) developed in the 1970/80's by Roy Bhaskar as an alternative to the dominant positivist and constructivist perspectives (Denzin & Lincoln, 2011). CR draws on elements of positivism and constructivism and is typically understood to take an ontological position of realism and an epistemological position of relativism (Stutchbury, 2022). CR argues that ontology is not reducible to epistemology (Fletcher, 2017), believing the knowledge we hold is only one small piece of a larger reality.

Through the lens of CR, knowledge of social phenomena is understood to be subjective, relative and socially constructed by individuals; it is acknowledged that a reality exists outside of ones knowledge of it (Stutchbury, 2022), and that this reality cannot be unproblematically understood (Wynn & Williams, 2012). Applying CR to this research provides a framework to understand the experiences of participants. It encourages the researcher to be critical of the narratives provided, understanding that participants' narratives are personal to them and their specific context.

1.3 Defining Language and Key Terms

The language used when discussing suicide is incredibly important due to the stigma attached to suicide. Decisions around language choices should be sensitive and considered. Internationally, charities are campaigning to change the language around suicide, believing that appropriate language use can save lives (Centre for Addiction and Mental Health, n.d.; Samaritans, 2023). There is more information on the evolution of language around suicide in Section 1.4. Holding the importance of language in mind, this section was developed with the support of an *advisory panel* made up of EbE, and professionals who work in the suicide prevention space. There is more information on the advisory panel in Section 3.5. Table 1 displays language and key terms for this research

Table 1

Language and Key Terms

Language and/or Key Term	**Definition**
Suicide	The term suicide is used when somebody has intentionally ended their own life (O'Connor & Nock, 2014). 'Committed suicide', 'taken their [own] life', 'ended their [own] life' and 'killed themselves' are used interchangeably in society to describe the notion of dying by suicide.
Suicide Attempt	The term suicide attempt describes a non-fatal suicidal behaviour. It is where somebody harms themselves with the intention of dying but does not die as a result of their actions.
Suicidal Behaviour	The term suicidal behaviour describes a set of non-fatal behaviours which are self-directed and potentially harmful. They occur alongside an intent to end one's own life (O'Connor & Nock, 2014).
Suicidal Ideation	The term suicidal ideation describes preoccupation, thoughts, and/or wishes related to taking one's own life (Harmer et al., 2023). This is sometimes referred to as 'suicidality'.
Suicide Note	The term suicide note describes a form of communication that is left by somebody, intended for others to read after they have taken their own life.
Suicide Survivor	The term suicide survivor describes the family/friends/loved ones of somebody who died by suicide.
Stigma	The term stigma describes a social and cultural construct which encompasses disapproval or discrimination towards a certain person/group. Stigma has been defined in literature as being the "*co-occurrence of its components – labelling, stereotyping,*

	separation, status loss, and discrimination" (Link & Phelan, 2001, p.363).
Hidden Population	The term hidden population describes a population of people where no sampling frame exists (Liu & Lu, 2018). It describes a population which society does not always 'see', as membership typically involves some form of stigmatisation which prevents members identifying themselves (Heckathorn, 1997).
Informal Caregiver	The term informal caregiver applies to anybody (e.g., friends, family) who is providing care to another person in an informal capacity, meaning they are not employed to do so. It is caregiving that is typically done out of kindness towards the care receiver.
Loved One	The term loved one is used to describe a close or cherished relationship. It encompasses all forms of relationship, stretching beyond the realms of family and friendship (e.g., to include colleagues, acquaintances etc.).
Unspoken Narrative	The term unspoken narrative references a story, or set of feelings, that exist but are not explicitly spoken about. Unspoken narratives are stories that often have an emotional burden to the beholder, which make them harder to discuss openly (Frie, 2023).

1.4 Situating the Research in Context

1.4.1 A Brief History

The word suicide is thought to originate from the Latin terms 'sui' meaning 'self', and 'caedere' meaning 'to slay'; loosely translated as 'to slay oneself' (Khan & Faud, 2020). The term was first used in 1643 by Sir Thomas Browne[1] in his book Religio Medici. It began to

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[1] An English physician and author.

be used more widely throughout society from the 18th Century. Although the term wasn't in circulation until 1643, the phenomena itself far pre-dates this. It is believed that the act of suicide has been occurring since 70,000 BC which marks the beginning of the first cognitive revolution, when homo-sapiens developed the ability to think and speak, quickly leading to the development of abstract thought and the ability to plan (Harari, 2015). A piece of writing considered to be the first known 'suicide note' is dated 2040 BC, and was written in Egypt (Erman, 1978).

The first references to suicide in the Western World are in writings from Ancient Greece. Philosophers Plato and Aristotle viewed suicide to be negative, a selfish act that places burden on society (Plato, c.340 BC/1926; Aristotle, c.330 BC/2000). However, this was challenged by the philosophical school of Stoicism who viewed suicide as permissible in certain circumstances. The Roman Stoic Seneca famously wrote that a man *"lives as long as he ought, not as long as he can"* (Seneca, c.60 BC/1965). In the non-Western World, philosophical views on suicide differed greatly. The uniting principal in the non-Western World was the idea that an act of suicide goes against filial piety[2] (Battin & Mayo, 1980). Throughout history suicide has largely been conceptualised as negative, and was criminalised all over the world.

A Moment for Refection

I was really struck by Seneca's words. To me, Seneca is positioning the person who chooses to end their life as powerful and in control, which feels as though it is in direct conflict with the way suicide is currently conceptualised in the West. In the present day, when someone takes their own life, the common conceptualisation is that they did so <u>*because*</u> *they experienced mental health difficulties. To me, this positions 'mental health difficulties' as powerful, taking the control away from the person. It was helpful for me to think about*

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[2] A concept arising from Confucian thought relating to having respect for parents and ancestors.

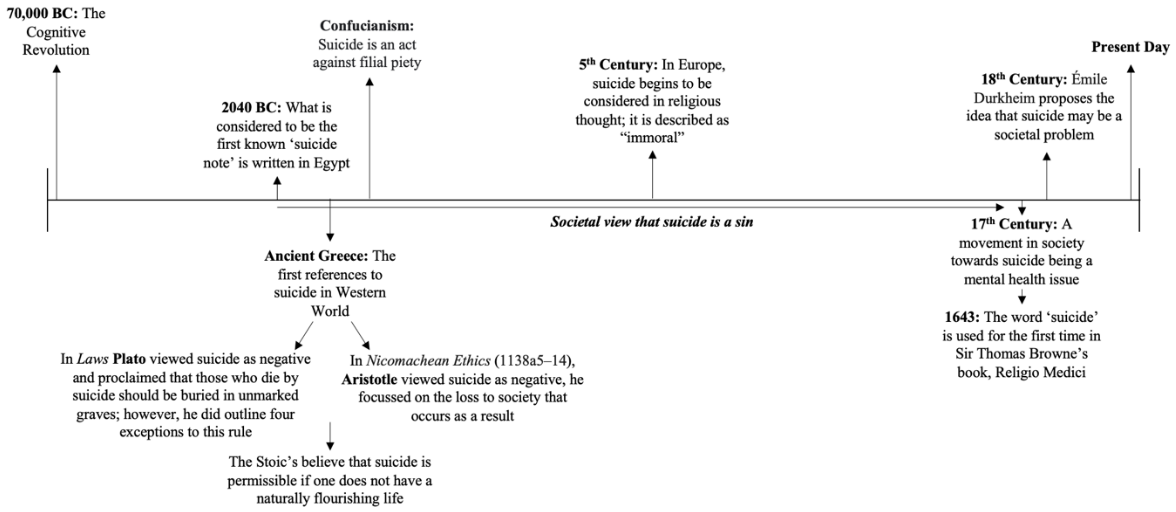
where I position power, and challenge biases which I didn't know I had around the interaction between mental health and suicide.

In Europe, religious writing in the fifth century declared suicide to be *"immoral"* (De Leo, 2011, p.234); *"an affair between the devil and the individual sinner"* (Midelfort et al., 2000, p.1268). French sociologist Émile Durkheim attempted to move Western society away from the idea that suicide was a sin. In the 1800's, he proposed that suicide was a societal issue believing that the way one interacts with society can increase or decrease their risk of suicide (Durkheim, 1897). These ideas were proposed at the same time as suicide was first being proposed as a 'mental illness' by physicians. In recent decades, the medicalisation of suicide as part of a mental illness has become the dominant idea in the Western World.

Figure 1 depicts this brief history on a timeline. The next part of this chapter will focus on the conceptualisation of suicide in the United Kingdom[3] (UK).

Figure 1

A Brief History of Suicide



Timeline not to scale.

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[3] The United Kingdom is made up of England, Scotland, Wales, and Northern Ireland.

Suicide and the United Kingdom. Suicide was a criminal offence in the UK until 1961. The historic criminalisation of suicide reflects the societal narrative of the time, which was largely dictated by religious thought. This began to change during The Enlightenment[4] (c.1680-1820) when religion was questioned openly for the first time. In 1796, The Times[5] advertised attendance to a debate titled "*Is suicide an act of courage?"* which demonstrated a radical shift in thinking (Minois et al., 2001), and a step towards liberation for those being convicted. Yet, prior to the 1961 Suicide Act (Suicide Act 1961, 1961), those who attempted suicide and survived were prosecuted and imprisoned. When a suicide death occurred, the bereaved family often faced a similar fate (The Lancet, 2023).

As mentioned earlier in this section, the dominant conceptualisation of suicide in the West in recent years is to pathologise it as part of a mental illness. This view was adopted by the Church of England in the 1960's. As an institution the Church began to recommend counselling, psychotherapy and, a 'suicide prevention intervention' as opposed to criminalisation when suicide occurs (Board for Social Responsibility Church of England, 1959). This, along with the work of Sir Charles Fletcher-Cooke[6] contributed to the decriminalisation of suicide in the UK.

As the societal view on suicide changed, so did the language around it. Prior to The Enlightenment, suicide was referred to as "committing self-murder" (Laragy, 2013; Lesser, 1980). This language reflects the harsh conceptualisation of suicide as a crime against ones 'Creator' which is punishable by law. This changed from 1643, when Sir Thomas Browne introduced the word suicide. The phrase to "commit suicide", upholding the

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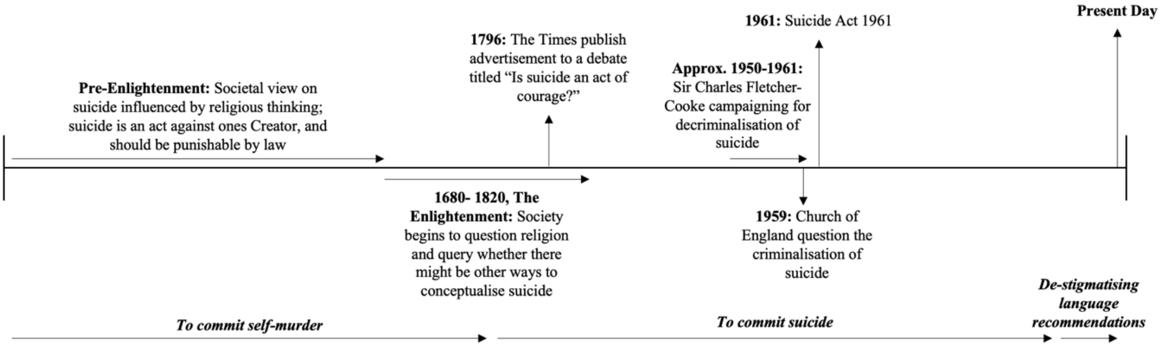
[4] A European intellectual movement which moved thinking away from tradition, towards individualism.
[5] Britian's oldest daily national newspaper.
[6] A British politician and lawyer.

conceptualisation of suicide as a crime, became the dominant way to language a suicide death. To “commit suicide” is still used colloquially in society today. Charities and organisations alike are working hard to deviate from this terminology, advocating for the stigma that is upheld by using the phrase. At present, there is no recommended universal way to language suicide; the uniting principial between various recommendations is simply to not use the word “commit”. Example language guidance can be found in Appendix B. A timeline of changes in the UK can be found in Figure 2.

Figure 2

Suicide and the United Kingdom



Timeline not to scale.

1.4.2 Policy and Strategy

Table 2 provides the Office of National Statistics (ONS) data on suicide for the last five years (2018-2022) across the UK (National Records of Scotland, 2023; Northern Ireland Statistics and Research Agency, 2023; Office for National Statistics, 2023a). It should be noted that the ONS data represents the date of suicide registration, not the date of suicide death (some suicide deaths require a coroner’s inquest before a registration can take place, this can take many months with longer delays since the Covid-19 pandemic).

Table 2

ONS Data, United Kingdom (2018-2022)

Year	Total: Suicide	Average Age-Standardised Suicide Rate Per 100,000 People	Total: Male (%)	Average Age-Standardised Suicide Rate Per 100,000 Males	Total: Female (%)	Average Age-Standardised Suicide Rate Per 100,000 Females
2018	6440	11.7	4854 (75.4%)	19.1	1586 (24.6%)	6.2
2019	6729	12.3	5078 (75.5%)	19	1651 (24.5%)	6.0
2020	6248	12.1	4660 (74.6%)	18.1	1588 (25.4%)	6.4
2021	6572	12.3	4870 (74.1%)	18.7	1703 (25.9%)	6.1
2022	6607	11.7	4891 (74.1%)	18	1716 (25.9%)	5.8

The remainder of this chapter will focus on current policy, strategy, and service provision in England. Table 3 provides the ONS data for the last five years (2018-2022) across England.

Table 3

ONS Data, England (2018-2022)

Year	Total: Suicide	Average Age-Standardised Suicide Rate Per 100,000 People	Total: Male (%)	Average Age-Standardised Suicide Rate Per 100,000 Males	Total: Female (%)	Average Age-Standardised Suicide Rate Per 100,000 Females
2018	5021	10.2	3800 (75.7%)	16	1221 (24.3%)	4.9
2019	5316	10.8	4017 (75.6%)	16.7	1299 (24.4%)	5.1

2020	4912	9.9	3682 (75%)	15.4	1230 (25%)	4.8
2021	5219	10.5	3852 (73.9%)	16	1367 (26.1%)	5.4
2022	5284	10.5	3909 (74%)	16.1	1375 (26%)	5.3

ONS data for 2023 is still being finalised. Provisional data for England collected from quarters 1-3 (January – September) of 2023 has been released (Office for National Statistics, 2023b), and can be found in Table 4.

Table 4

Provisional ONS Data, England (January – September 2023)

Quarter	**Total: Suicide**	**Age Standardised Rate Per 100,000 People**
1: (January – March)	1406	11.4
2: (April – June)	1322	10.6
3: (July – September)	1412	11.2

The statistics shown in Tables 2, 3 and 4 form part of an evidence base informing the development of associated policy and strategy. The UK Parliament have published a webpage outlining their approach to suicide prevention: Suicide Prevention: Policy and Strategy. On the webpage they accurately report England to have had the lowest Age-Standardised Suicide Rate (ASSR) per 100,000 people across the UK in 2022, but inaccurately report this statistic to have been five suicide deaths per 100,000 people. As can be seen in Table 3, the 2022 ASSR per 100,000 people in England was 10.5; the ASSR per 100,000 females in England was 5.3 (or five, as is reported by Parliament, if rounded down). This could be a simple typo, or it could reflect an effort to make suicide deaths seem more insignificant than they are. Suicide is still heavily stigmatised in the UK, and by under-reporting the frequency and not facing the *real* problem, this stigma is maintained.

A Moment for Reflection

I was incredibly shocked when looking at the ONS data and understanding what I believe to be the misreporting of suicide deaths across England in 2022. The underreporting said to me that the Government were trying to brush the issue under the carpet, to hide it away. The accurate ONS data was there if you looked for it, but it was not easily accessible. I made attempts to access equivalent data for suicide attempts. This data is either not collected, or is not accessible to the general public. WHO estimate that for every suicide death, there are 19 suicide attempts (WHO, 2021). I thought about historic narratives around suicide and then queried how much these narratives were really 'historic' considering the amount of data which is hidden from view.

In 2016, the NHS released 'The Five Year Forward View for Mental Health' marking the start of a ten-year plan for service reform (NHS England, 2016). This document reported a commitment to reducing the rate of suicide deaths by 10% by the year 2020, when compared to 2015. In the 2019 follow-up document, 'The NHS Long Term Plan', the authors suggested that the 2016 commitment had been achieved earlier than expected however, there is no statistically significant data to support this claim (NHS England, 2019).

In 2023, the Government announced a £10 million grant fund for 79 third sector organisations[7] working in the suicide prevention space in England, which would be

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[7] Organisations which are not for profit, and are non-governmental.

accessible between 2023 and 2025 (Department of Health and Social Care, 2023a). In March 2024, the Government provided a progress report detailing how the money has been used so far. The report shares that James' Place[8] were awarded £625,000 and have used the money to employ two full-time therapists, and Samaritans[9] were awarded £530,000 which is being used to support its 24/7 helpline. More information on the progress of this grant can be found here: Suicide Prevention VCSE Grant Fund. In September 2023, the Government published a 'Five-Year Cross-Sector Strategy for Suicide Prevention', which included an action plan, with timescales for delivery. The aims outlined in this document are: 1) to reduce the suicide rate over the next five years, 2) to improve support for those who have self-harmed, 3) to improve support provisions for those who have been bereaved (Department of Health and Social Care, 2023c).

Suicide prevention requires action more broadly than just that outlined in the Government initiatives above. A summary of other relevant policy can be found in Table 5.

Table 5

Suicide Prevention, Relevant Policy

Area	Summary of Policy
Healthcare	• In 2021, the Government announced £150 million for mental health crisis services. • In 2023, the Government announced £7 million for new mental health ambulances. • By April 2024, NHS 111 aim to make crisis care universally available across England (NHS England, 2019). • It is anticipated the 2024 Major Conditions Strategy (Department of Health and Social Care, 2023b) will consider an interaction

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[8] A charity (1121891) supporting men who experience suicidal ideation.
[9] A charity (219432) dedicated to reducing feelings of isolation and disconnection that can lead to suicide.

	between mental health and physical health; working towards better collaboration in the suicide prevention space.
Education	• Government funding is available to train mental health teams in school. • Since 2020, 'health education' was introduced as part of school curriculum; mental health is discussed at primary school and secondary school level. • Since 2023, suicide prevention is being considered as part of an ongoing review of the school curriculum (Department of Health and Social Care, 2023c).
Employment	• The Government has called for employers to have professionals trained in mental health first aid, mental health support, and suicide prevention awareness (Department of Health and Social Care, 2023c). • In 2023, the Government announced its 'Back to Work Plan' which aims to assist 1.1 million people with long-term health conditions get back into employment (Department for Work and Pensions, 2023).
Transport	• The Department for Transport has a suicide prevention working group where real time data is analysed and discussed. • The rail industry has a suicide prevention programme, in partnership with the Samaritans and the British Transport Police. • National Highways published a suicide prevention strategy in 2022 (National Highways, 2022).
Prisons	• The Ministry of Justice has provided guidance to prison and probation staff aimed at reducing suicide deaths in custardy (Ministry of Justice, 2020). • The Ministry of Justice has developed 'safety training' for all prison and probation staff which is a learning tool focused on suicide prevention.

	• The Ministry of Justice will fund the Samaritans Listeners Scheme until March 2025 which will be available to prison and probation staff.
Media	• The Samaritans have written guidance on how the media should report on a suicide death. • The Online Safety Act 2023 aims to increase safety online due to increasing concerns about the use of social media. All regulated platforms must protect users from content relating to suicide (Online Safety Act 2023, 2023).
Armed Forces	• The Armed Forces published a suicide prevention strategy April 2023 due to an increase in suicide deaths of those in the forces. • In 2021, the Government launched 'Op Courage' which was developed in collaboration with veterans, as a single point of access service for veterans to access mental health support.

The policies outlined above give only a snapshot of the current policy and strategy within the suicide prevention space in England, building on years of policy and strategy that came beforehand. The ONS data indicates that suicide rates have been stable in England since 1981, which – given the amount of policy and strategy over the years – raises the questions: What is being missed? What needs to change? What could we be doing differently/better? And more importantly, **why** are these questions not being asked by those in power?

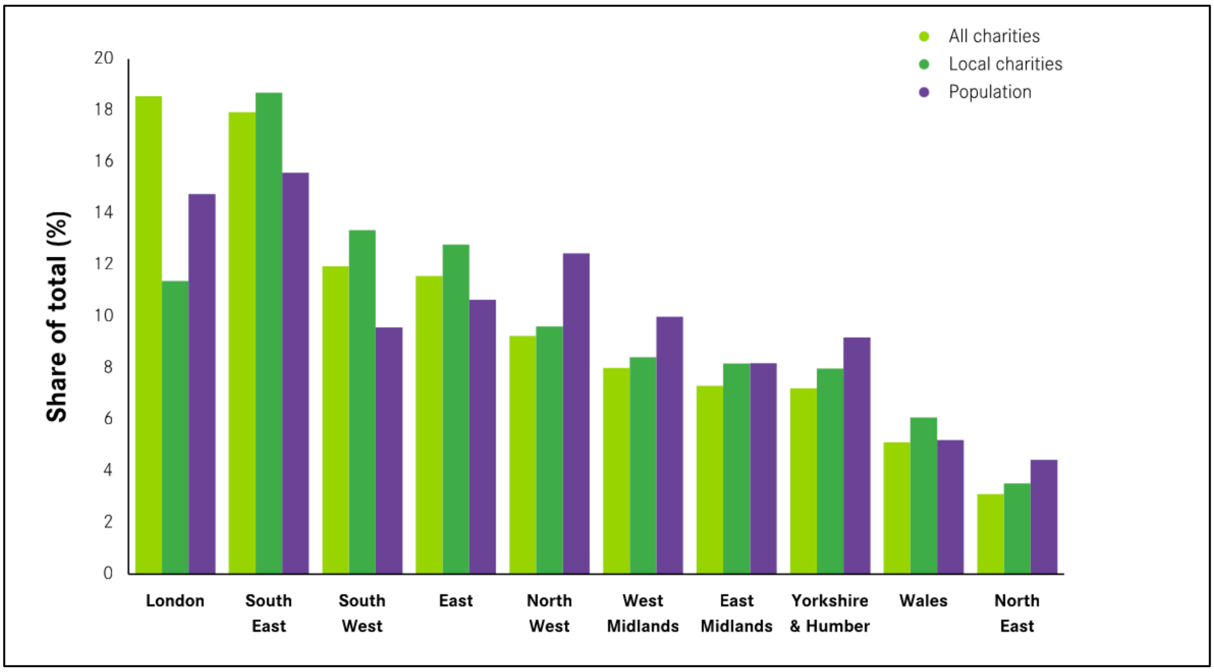
A pronounced area of neglect across Government initiatives relates to informal carers. Throughout various policy documents, there is not a single acknowledgment or consideration given to the informal carers offering support for a loved one following a suicide attempt. Given WHO's (2021) estimation that there are 19 suicide attempts for every one suicide death, it is not irrational to assume that there are *at least* 19 informal carers requiring support and not receiving it as a result of the same statistic. Anecdotally, in a consultation meeting with a member of the National Suicide Prevention Alliance (NSPA; personal communication, March 17, 2023) as part of the development of this research it was acknowledged that informal carers are ignored by public sector, and third sector organisations. The NSPA explained this as there being two options: 1) to channel money/thinking into the already established areas (e.g., support for the suicidal person, support for those bereaved) to improve them and standardise these services across the UK, or, 2) to channel money/thinking into new areas (e.g., support for informal carers) with the acknowledgment that any service developed will not necessarily meet the needs of the population as there is not *enough* money for this to be done meaningfully. Sadly, option one has been chosen time and time again, leaving informal carers with nowhere to turn. These ideas form part of the rationale and add to the value of this research, as it provides a platform for informal carers to be heard.

1.4.3 Service Provision

The service provision when somebody is suicidal differs from county to county across England. Each NHS Trust has developed service provision in line with the wider Government policy and the delivery of this differs from Trust to Trust. Much of the suicide prevention work occurs within third sector organisations; and the accessibility of these differs based on geographical location (Corry, 2020). As shown in Figure 3, there is a clear North/South divide, with charities disproportionately concentrated in the South of England (National Council for Voluntary Organisations, 2023; Office for National Statistics, 2023c).

Figure 3

Geographical Location of Charities Across England and Wales



(Taken from, Johnson, 2024)

The National Institute for Health and Social Care Excellence (NICE) provide guidance, advice and quality standards for health and social care professionals. For example, clinicians working with individuals diagnosed with Paranoid Schizophrenia can type "Schizophrenia" into the NICE website and read guidance on what the service provision should look like. In the case of Paranoid Schizophrenia, clinicians would be advised to do all they can to keep the individual in the community (drawing on crisis and secondary care services), and combine antipsychotic medication with psychological intervention (specifically CBT for Psychosis, a family intervention, or art therapy; NICE, 2014). For "suicide", or words to that effect , no such guidance exists on the NICE website. This is largely because suicidal ideation is viewed as a symptom of other mental illnesses (e.g., depression) as opposed to something 'diagnosable' in its own right, and it is not uncommon for people to 'fall through the gaps' of service provision without a *diagnosable* condition (Bell & Pollard, 2022). The lack of guidance adds to discrepancies in how service provision is set up and offered across different spaces, placing increased pressure on the loved ones of suicidal individuals, who often feel lost, unsupported and uncontained by professional service provision in their attempts to provide care (McLaughlin et al., 2016).

1.5 Situating the Research in Theory

1.5.1 Theoretical Models: Suicide

A Clinical Model of Suicidal Behaviour (Mann et al., 1999). In 1999, Mann and colleagues attempted to understand the generalisability of suicide risk factors across a sample of individuals with different psychiatric diagnoses. Their findings led to the development a stress-diathesis framework to understanding suicidality. The theory dictates when stressors (e.g., psychosocial circumstance and/or psychiatric diagnosis) interact with diathesis[10] (e.g., childhood abuse, head-injury, alcoholism); an individual is likely to experience suicidal behaviour. The model was updated in 2020, and renamed The Brain-Centric Model of Suicidal Behaviour (Mann & Rizk, 2020). The updated model added neurological descriptions to understand diathesis factors (see Appendix C for a visual representation of the model).

Mann's work has been hugely influential in psychiatry and clinical medicine; positioning diagnosis at the core of the model, it fits with current conceptualisation of suicide in the West. The main critiques of the stress-diathesis framework are that it cannot explain why individuals might experience similar stressors and diatheses but not experience suicidal behaviour (Dwivedi, 2012). Or, why individuals can experience suicidal behaviour independent of an interaction between stressor and diathesis. Despite criticism, the stress-diathesis framework remains prominent in the field of suicide prevention, with researchers using it as a foundation to advance theoretical thinking (O'Connor, 2011; Schotte & Clum, 1987; Wenzel & Beck, 2008).

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[10] A term used in medical literature since the 1800's meaning a predisposition.

Interpersonal-Psychological Model of Suicidal Behaviour (Joiner, 2005). Joiner proposed an interpersonal theory of suicidal behaviour. Joiner's model theorises that suicidality occurs subsequent to an interplay between three psychological states. The model dictates that when an individual experiences *perceived burdensomeness* (an assumption that one's exitance places a burden on others), alongside *thwarted belongness* (the feeling of alienation), in the presence of *capability of suicide* (suicidal ideation combined with a reduced fear of death), the risk of suicide increases (see Appendix D for a visual representation of the model). Joiner's model has advanced clinical understandings of suicidality in recent years, marking a move towards 'ideation-to-action'[11] theories of suicide (Klonsky et al., 2018).

A critique of this model it that it overlooks contextual factors (e.g., negative life events, social status, cognitive factors) by suggesting that *only* an interplay between the three psychological states can lead to suicidality. Two systematic reviews and one meta-analysis have been conducted which aim to increase the validity of Joiner's theory (Chu et al., 2017; Ma et al., 2016). Ma et al. (2016) found mixed evidence in support of Joiner's theories hypotheses. The review found strong evidence for a positive correlation between *perceived burdensomeness* and suicidal ideation; however, the idea of an interplay between the three psychological states was less strongly supported. Chu et al. (2017) critiqued the rigor of Ma et al.'s review, building on their work in their own review and meta-analysis. Differing from Ma et al. (2016), Chu et al. (2017) found strong evidence of the interplay between the three psychological states; however, they noted that the effect sizes found were "modest".

The Integrated Motivational–Volitional (IMV) Model of Suicidal Behaviour (O'Connor, 2011). The IMV was developed to synthesise current theoretical literature on

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[11] A way to conceptualise suicidal behaviour; the notion that suicidal ideation leads to suicidal behaviour.

suicide and provide a framework drawing on key theoretical ideas. The IMV is a three-part model comprising of the *pre-motivational phase* (an individual's biopsychosocial context), the *motivational phase* (the factors which contribute to an individual experiencing suicidal ideation), and the *volitional phase* (the factors which govern the transition between suicidal ideation to suicide attempt/suicide death). In line with stress-diathesis work, this model hypothesises that stressors and diathesis must interact to induce suicidality; it also acknowledges the importance of psychological states, hypothesising that states such as *humiliation* and *defeat* increase the likelihood of suicidal ideation (O'Connor, 2011).

A critique of the IMV is the assumption that individuals move through these phases in a linear process. This critique was taken on by O'Connor et al. and, in an updated model, they highlight the cyclical nature of the suicidal experience with bi-directional arrows between the three phases of the model (O'Connor & Kirtley, 2018; see Appendix E for visual representations of the model). O'Connor and Kirtley (2018) reference studies whereby the model has been tested to show support, but acknowledge that most of the supporting studies were cross-sectional in design. The support offered by these studies is therefore limited given the biases which are introduced when conducting mediation analyses using cross-sectional data (Maxwell et al., 2011).

A Moment for Reflection

I thought about the theoretical models and how they give the idea that we can understand suicide, and work alongside it; this felt like a conflict to the ideas put forward in policy which are situated around 'prevention'. I also thought about how these models are incredibly individualistic, positioning suicidality as a fault within the person which can be 'fixed' by working with that person independent of their context. We know that humans are social beings, and we know that when presented with suicide a vast amount of people are impacted (Cerel et al., 2019). After reading about these models, I was left thinking… Why are we not considering this in our models?

1.5.2 Theoretical Thinking: Life After Suicide

When an individual makes a suicide attempt there are two possible outcomes: they die, or they survive. The final part of this section will consider research in relation to the loved ones of those who die by suicide, and the loved ones of those who *almost* die by suicide.

Bereaved by Suicide. Research into suicide bereavement is limited. That which exists indicates that suicide bereavement is different to being bereaved through a more ‘normative’ mode of death (Jordan, 2020). Literature often describes those who have been bereaved by suicide as ‘suicide survivors’ (Jordan & McIntosh, 2011); a phrase with connotations which are not typically seen in bereavement research more widely. Suicide survivors are likely to experience a complex grief reaction (Ali, 2015), and have a higher chance of experiencing Post Traumatic Stress Disorder (PTSD; Mitchell & Terhorst, 2017), especially if they were the one to find the deceased individual (Jordan, 2020).

Clinicians working in suicide bereavement have found that suicide survivors feel an increased sense of guilt and responsibility for the deceased, they experience heightened stigma and shame (Geležėlytė et al., 2020), express an increased desire to make sense of what happened, are more likely to experience social isolation, and in many cases, suicide survivors will experience their own suicidal thoughts (Jordan, 2020).

Researchers have been working to theorise the experience to ensure that the population receive the best support possible (Jordan, 2001; Jordan & McIntosh, 2011; Sveen & Walby, 2008). In 2009, Sands proposed a Tripartite Model of Suicide Grief (Sands, 2009; see Appendix F for a visual representation of the model). The model highlights three different relational stages in the grief process. The first stage, *Trying on the Shoes: Understanding Relationship* relates to the process of the bereaved individual coming to terms with the intentional nature of the suicide; the second stage, *Walking in the Shoes: Reconstructing*

Relationship relates to how the bereaved individual attempts to reconstruct the narrative surrounding the suicide, focusing on the pain their loved one felt in life and death; the final stage, *Taking off the Shoes: Repositioning the Relationship* relates to the bereaved individual being able to separate the suicide from their love for the individual, grieving continues as they move forward with an enthused commitment to living. At present, this model has not been tested in a treatment study.

Almost Bereaved by Suicide. Research into the notion of being *almost* bereaved by suicide is more-or-less non-existent. As mentioned at the beginning of this chapter, suicide research focuses predominantly on the individual deemed as 'suicidal', with little academic thought given to their loved ones. In the instance of a suicide death, academic interest shifts towards the experience of loved ones; but in the instance of an *almost* suicide death, interest remains solely focused on the suicidal individual.

Referring back to Sands' model of suicide grief, it has been theorised that a bereaved individual will first work to come to terms with the *intent* behind the suicide (Sands, 2009). *Intent* is present regardless of whether a loved one has been bereaved or not, *intention* occurs at the point the suicide attempt is made, not at the point of death. In the second stage of Sands' model, a loved one begins to consider the *pain* felt by the suicidal individual. This *pain* was felt prior to the suicidal attempt, it did not occur as a result of the death. Finally, in the third stage of Sands' model, the bereaved individual begins to move forward as they can *separate* the action of suicide, from their love for the suicidal person. This *separation* is required regardless of a suicide death. Suicide death is a by-product of the suicide attempt, and by virtue of this the experiences of the bereaved, and the *almost* bereaved are incredibly similar.

There is a dearth of literature which explores the experience of the *almost* bereaved. This population are referred to most commonly as 'informal caregivers/carers'. A large proportion of the available research focuses on how caregivers experience the services around the suicidal individual (e.g., how they found the hospital staff engaged with the suicidal individual at the point of the attempt), highlighting how caregivers often feel excluded, and how they wish services to be improved going forward to better meet the needs of their loved one (Cerel et al., 2006; Inscoe et al., 2022; McLaughlin et al., 2014). There is a small amount of research available focusing on the carer experience of supporting a suicidal individual after a suicide attempt. This research indicates that caregivers experience an emotional burden when supporting their loved one (Dempsey et al., 2019; Inscoe et al., 2022; Roach et al., 2021), many caregivers desire to engage with personal support provisions to help with the burden but are not often afforded this luxury (McLaughlin et al., 2014; Wayland et al., 2021).

1.6 Rationale for Systematic Literature Review

Lavers et al. (2022) published *A Systematic Review of the Experiences and Support Needs of Informal Caregivers for People who Have Attempted Suicide or Experienced Suicidal Ideation*. This review revealed that caregivers experience varying levels of psychosocial stressors in their role, and that they desire to engage with support services to help with these stressors. Recommendations from this review indicated that further research was needed to understand the caregiver experience, and intervention studies were needed to understand how to best support the population. The SLR, presented in Chapter 2, was developed in response to Lavers et al.'s (2022) recommendations. It aimed to consolidate existing literature referencing the experience of informal caregivers when seeking and engaging with support provisions (both for themselves, and for their loved one). The SLR builds on Lavers et al.'s (2022) work by responding to the recommendations made, and differs to it by looking at the specific experience when seeking and engaging with support provisions (both for themselves, and for their loved one) as this was not covered in the last review. It was hoped that understanding this would give valuable insights into the experience of the population, and help academics and clinicians make recommendations for targeted change in service provision.

Chapter 2: Systematic Literature Review

2.1 Chapter Overview

The SLR presented in this chapter aims to address part of the research gap identified by Lavers et al. (2022). The research question is: *What is the experience of informal caregivers seeking and engaging with support provisions when caring for somebody who has experienced suicidal ideation and/or has made a suicide attempt?* This chapter will describe how the researcher has attempted to answer this question. Firstly, the chapter outlines the methodology employed in the SLR (focussing on question development, search strategy and search process), before sharing the results of a thematic synthesis (Thomas & Harden, 2008). The chapter closes with a short discussion, highlighting clinical implications and making actionable recommendations for the future.

2.2 Methodology: Development Stage

2.2.1 Question Configuration

The research question for this SLR was developed using the PICo question format. PICo is a useful format when developing questions for qualitative reviews seeking to analyse a human experience (Stern et al., 2014). The PICo question breakdown is presented in Table 6.

Table 6

PICo Question Configuration

Acronym	Question Configuration
P: Population	Informal caregivers
I: Phenomena of Interest	Seeking and engaging with support provisions
Co: Context	Caring for somebody who has experienced suicidal ideation and/or has made a suicide attempt

2.2.2 Scoping Exercises

Scoping exercises were conducted using Google Scholar to identify relevant articles, detect any possible duplication, and test the validity of the proposed question (Tawfik et al., 2019). Scoping exercises highlighted the stark lack of research in this area. Initial searches aimed to look at UK articles only, experimenting with date restrictions to detect any changes pre/post 1961; when suicide was decriminalised in the UK. It became clear that there were not enough articles published with a UK population to complete a review of this nature. The decision was then made to open the review up to allow for international studies, this also meant the ringfence around the year was removed as international laws on suicide differ.

PROSPERO was reviewed to ensure there were no pre-registered ongoing reviews investigating the same question. A PROSPERO protocol was created and published, protocol number: CRD42023445806.

A Moment for Refection

When completing the scoping exercise, I was initially surprised to see how much research was available for informal carers supporting a loved one with a physical illness (e.g., cancer, dementia, HIV). I think my initial surprise was linked to my assumption that carers would be being neglected across the board however, when I reflected on this a little bit further and thought about the socio-political climate around physical health and mental health, my surprise that physical health research had more traction than mental health research lessened.

2.3 Methodology: Search Strategy

The search strategy was developed in line with the SPIDER search tool (Cooke et al., 2012). SPIDER is an extension to the PICo question format and is generally considered to be the most effective search strategy for qualitative reviews, due to having the greatest specificity by comparison (Methley et al., 2014). A thesaurus was used to enhance the search terms. The search terms were combined using Boolean connectives ‘AND’/‘OR’, asterisks were used as truncation symbols, and quotation marks were used to search words as a collective. The SPIDER search strategy used can be found in Table 7.

Table 7

SPIDER Search Terms

Acronym	Searches
S: Sample	Carer* OR "caring for" OR caregiver* OR famil* OR friend* OR spouse* OR partner* OR parent* OR sibling* OR child* OR grand* OR "loved one*" OR relative*)
	AND
P: Phenomenon of	Suicid* OR "suicide-attempt" OR "suicidal-ideation" OR "surviv*"
	AND
I: Interest	Support OR intervention* OR service* OR therap*
	AND
D: Design	Interview* OR "focus group*" OR observation* OR "case stud*" OR questionnaire
	AND
E: Evaluation	Experience* OR stor* OR narrative* OR view* OR belei* OR perception*
	AND
R: Research Type	Qual* OR "mixed methods" OR "mixed-methods"

Initial searches were conducted in August 2023. The bibliographic databases searched were Scopus, PsychARTICLES, PubMed (incl. MEDLINE), EBSCO, Social Care ONLINE, and Elsevier. These platforms were chosen as collectively they provide a comprehensive overview of academic work focused on public health, education, health sciences, physical sciences, and social sciences. The researcher looked at previous suicide prevention related reviews to help gather the list of appropriate databases (e.g., Lavers et al., 2022). Databases were accessed using licences obtained by the University of Hertfordshire. Further searches were conducted on Google Scholar and identified articles were added under the heading ‘References from Other Areas’. The searches were repeated in February 2024 to capture recently published research, no further articles were identified.

Grey literature was not included in this review due to the increased risk of bias and inaccuracies. For example, it has been observed that public health related evaluations (considered grey literature) are often conducted by the same practitioners who developed and delivered the intervention, meaning there is an inherent conflict of interest in the work (Adams et al., 2016).

Inclusion/exclusion criteria were applied to the searches. The criteria, and justification for them, can be found in Table 8.

Table 8

Inclusion/Exclusion Criteria

Criteria	Justification
Inclusion	
Articles/studies published in the English language	Only articles published in the English language are accessible to the researcher.
Published in peer reviewed journal	Grey literature is not being included in this review as it is more prone to inaccuracies, bias, and incomplete information. There is also a lack of guidance on how to include grey literature in reviews.
Excision	
Articles/studies published in any language other than English	As above.

Published anywhere other than a peer reviewed journal	As above.

2.4 Methodology: Search Process

The searches were downloaded into Covidence[12] (Groove, 2023). 3676 articles were downloaded, 1207 were removed as they were duplications. This left 2469 articles to be screened through a two-phase screening process. In phase one, the title and abstract of all 2469 articles were screened against the inclusion/exclusion criteria first by the lead researcher (thesis author), and second by a colleague referred to from now on as the 'secondary researcher'. The screening process revealed 74 conflicts, equating to 97% agreement between researchers, and a Cohen's kappa[13] of 0.53 (moderate agreement). The conflicts largely related to human error (e.g., one of the researchers pressing the wrong button on Covidence). Each conflict was discussed, a final decision was made in collaboration with supervisors. The Cochrane Handbook and Covidence support the notion of involving a third party (e.g., supervisors) in the discussion of conflicts until a decision is made (Groove, 2023; Higgins et al., 2023). Fifty-two articles were progressed into phase two. In phase two, the full text of all 52 articles were screened against the inclusion/exclusion criteria by the lead researcher, and secondary researcher. The screening process revealed 18 conflicts, equating to 64% agreement between researchers, and a Cohen's kappa of 0.11 (slight agreement). The conflicts largely related to differences in the perception/judgement of the phenomena being discussed (e.g., differences in what the term 'support provision' could encompass). Each conflict was discussed, and a final decision was made in collaboration with supervisors.

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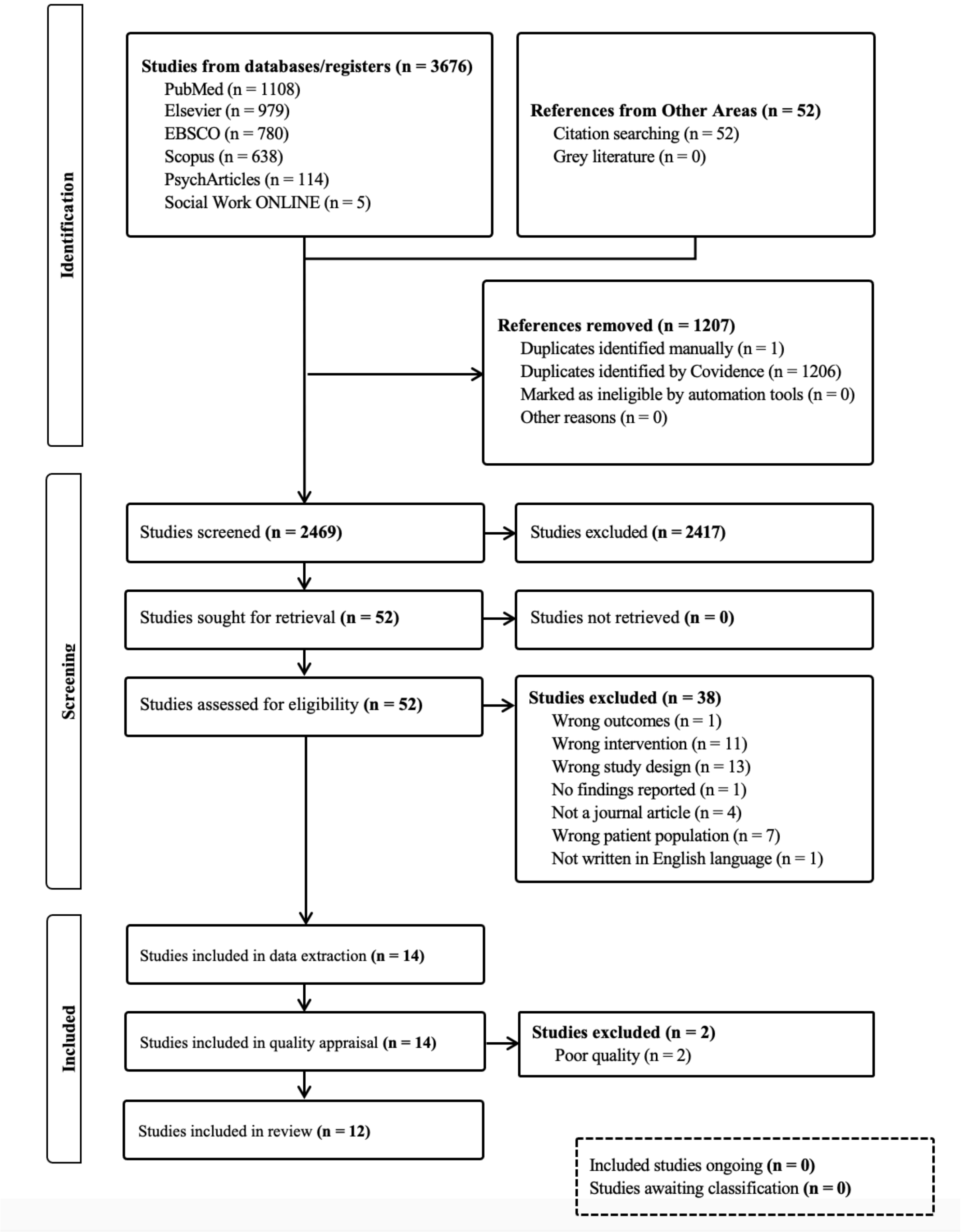
[12] A software designed to support the completion of systematic reviews.
[13] A measure of inter-rater reliability.

Fourteen articles were included in the next stage of the SLR: data extraction, and quality appraisal. The reference lists of the final 14 articles were reviewed, and relevant articles were checked against Covidence; all were found to be duplicates.

Figure 4 presents the search process in a PRISMA diagram (Page et al., 2021).

Figure 4

PRISMA Search Process



2.5 Methodology: Data Extraction

Data was extracted from the 14 identified articles in two phases. In phase one, data extraction was completed independently by the lead researcher. Evidence suggests that data extraction is more efficient when it is duplicated; specifically, studies have found that there are less errors when data is independently extracted by two researchers (e.g.,.Buscemi et al., 2006). The Cochrane Handbook directs that any information which involves *subjective interpretation* should be extracted by two researchers (Higgins et al., 2023). As such, for phase two of data extraction, the lead researcher and the secondary researcher independently extracted the *Results/Outcome*, *Strengths and Limitations*, and *Clinical and Practical Implications/Recommendations* from each of the articles. This process resulted in four conflicts, equating to 89% agreement between researchers, and a Cohen's kappa of 0.60 (substantial agreement). The conflicts largely related to human error (e.g., one researcher not pulling through *all* strengths/limitations). Each conflict was discussed, and a final decision was made in collaboration with thesis supervisors.

A brief synthesis of extracted data is provided in Table 9.

Table 9

Data Extraction Table

Country of Origin	Aims and Objectives	Study Design / Methodology	Sample and Participant Demographics (incl. Caregiver Relation)	Results	Strengths and Limitations	Clinical and Practical Implications
1. The experiences of attempt survivor families and how they cope after a suicide attempt in Ghana: a qualitative study (Asare-Doku et al., 2017)						
Ghana	To understand the experience of 'coping' within families where someone has made a suicide attempt, when existing in a land where the social-cultural climate forbids suicidal behaviour.	This research employs a qualitative methodology. Participants were recruited from the Psychiatry Department of Korle-Bu Teaching Hospital (KBTH); all suicidal presentations at KBTH receive automatic referral to Psychiatry. The sampling method used was purposive and convenience	The sample size was 10 adults; comprised of six males, and four females. The sample consisted of four fathers, two mothers, one brother, one husband, one aunt, one sister. The mean age of the sample was 41.	Overall, the study found three themes: 1) experiencing shame and stigma, 2) reactive affect, 3) surviving the stress of attempt. With regards to the RQ in this SLR, the findings revealed that participants sought support through: 1) religion/spiritual means, 2) having people visit them, 3) confiding in family	Strengths: This was the ground-breaking research in Ghana, it was the first of its kind and marked the beginning of conversations in a very sensitive area. Limitations: The authors report that they were time bound and that this impacted on their recruitment	The authors suggest that individualised psychotherapy following a suicide attempt may not be the most appropriate method of treatment, they suggest leaning into systemic thinking and placing a focus on dysfunctional interpersonal patterns to alleviate

		sampling. Data was collected through semi-structured interviews; the interview guide was developed following a review of literature outlining contextual factors associated with suicidal behaviour. Data was analysed using Interpretive Phenomenological Analysis (IPA).		and friends. Some participants felt that shame prevented them from seeking support; and some chose to isolate and not seek support from others.	strategy and introduced bias to the recruitment method. The sample size is small, which impacts its generalisability.	symptoms of suicidality. There is a recommendation to upskill families, communities, and religious groups in suicide literacy through adopting a 'Train the Trainer' approach.
2. Mothers living with suicidal adolescents: a phenomenological study of their experience (Daly, 2005)						
Canada	To understand the experience of mothers who care for their suicidal adolescent	This research employs a qualitative methodology, it uses a phenomenological method. Participants were recruited through	The sample size was six adults; comprised of six females. The sample consisted of six mothers	Overall, the study found six themes: 1) failure as a good mother, 2) the ultimate rejection, 3) feeling alone in the	Strengths: This was the first study of its kind with the specific population. The authors provide a	The results indicate a need for support groups, specifically for mothers. The authors suggested that nurses should

	children. To develop guidance for health care professionals on how to best support mothers with such caring responsibilities.	paediatric psychiatrists affiliated with a specific health facility; all participants were receiving family therapy. The sampling method used was convenience sampling. Data was collected through unstructured interviews which were audiotaped. Data was analysed using thematic analysis.	The mean age of the sample was 38.	struggle, 4) helplessness and powerlessness in the struggle, 5) cautious parenting, 6) keeping an emotional distance. With regards to the RQ in this SLR, the findings revealed that participants sought support through: 1) support group, 2) family therapy, 3) emotionally distancing from their child. Other experiences associated to the RQ: 1) mothers feel isolated and unable to	detailed methodology which is easy to replicate. Limitations: The results are presented as an overgeneralisation as the sample size is small. The time length of the child's illness was not controlled for, meaning that the experiences of mothers were different. There were sampling limitations as all participants were recruited through	be more ‘validating’ and ‘sensitive’ towards mothers. There is a recommendation for counselling and conflict resolution work as an intervention within the families where the adolescent is presenting as suicidal.

				contact friends with healthy adolescents, 2) stigma associated with suicide stops mothers reaching out to family members / stops family members wanting to speak to them.	the same psychiatrist, from the same clinic.	
3. “Some guidance and somewhere safe”: Caregiver and clinical perspectives on service provision for families of young people experiencing serious suicidal ideation and attempt (Dempsey et al., 2019)						
Australia	To explore the reflections and perspectives of clinicians and caregivers on the service provision for family members of young people	This research employs a qualitative methodology. Participants were recruited from a Youth Mood Clinic. The sampling method used was convenience sampling. Data was collected through	The sample relevant to the RQ was eight adults; comprising of one males, and seven females. The sample consisted of seven mothers, and one father. The mean age of	Overall, the study found caregiver needs across four domains: 1) initial needs, 2) crisis needs, 3) discharge needs and, 4) general caregiver challenges. With regards to the RQ in this SLR, the findings	Strengths: The first study of its kind to evaluate the Youth Mood Clinic in this way. Limitations: The sample size was small and there was a gender imbalance in the	The results indicated that caregivers require specific support systems in place, and suggest there would be benefit in peer forums, information evenings, printed

	who attend clinic for moderate-severe mood disorder.	semi-structured interviews. Data was analysed using thematic analysis.	the sample was 52.	revealed that participants sought support through: 1) reassurance, 2) mentoring, 3) family support, 4) peer support, 5) information/psycho-education.	sample meaning that there are limits to the generalisability of the results.	information, web-based support, a named person to contact with concerns relating to their child.
4. Coping in the Aftermath of Youth's Suicidal Behaviours: A Comparison of Black Mothers and White Mothers (Doyle et al., 2021)						
United States	To understand Black mothers' and White mothers' qualitative reactions to their adolescents' hospitalisations following a	This research employs a mixed-methods methodology. Participants were randomly selected from data collected for a previous study. The previous study consisted of 288 participants who were mothers of	The sample size was 40 adults; comprised of 40 females. The sample consisted of 40 mothers. The mean age of the sample was 43.	Overall, the study found four themes: 1) mothers' emotional distress, 2) mothers' coping, needs, and supports, 3) mothers' perceived need for increased monitoring, and 4) improved mother–child relationships. With	Strengths: This was the first study of its kind in the way it explored the experiences of Black mothers' and White mothers'. The authors provide lots of clinical implications and	The authors recommend further research into the same topic as they felt this study was limited as the mothers all came from the same geographical area. They also highlight how more research

	suicide attempts.	adolescents who had been hospitalised at one psychiatric hospital in America. The sampling method used was random sampling. Data was collected through semi-structured interviews which took place one month after the adolescent was hospitalised. Data was analysed using Grounded Theory.		regards to the RQ in this SLR, the findings revealed that participants sought support through: 1) prayer/faith, 2) supportive relationships, 3) escaping. Other experiences associated to the RQ: 1) Mothers expressed a need for better resources.	suggestions for future research. Limitations: The sampling techniques did not fit the method for data analysis. The authors report that they made a lot of assumptions as they were unable to disentangle race and socio-economic status. There were geographical limitations in the sample.	is needed to look at the interaction between religion and suicidal behaviour. In terms of clinical implications, the authors discuss how mental health support for mothers should be more than just an afterthought; at a minimum, pamphlets and information should be provided. The results indicated that discharge planning should involve managing

						conflict, and, that clinicians need to be more attune to different ways distress presents across race.
5. Help-Seeking in Suicidal Situations: Paramount and yet Challenging. Interactions between Significant Others of Suicidal Persons and Health Care Providers (Dransart & Guerry, 2017)						
Switzerland	To understand how ‘significant others’ experienced the suicide attempt of their partner. To understand what led them to seeking help (or not seeking help) for both	This research employs a qualitative methodology. Participants were recruited from Swiss institutions and associations which support mental health. The research was advertised in two newspapers and a poster was placed on a billboard. The	The sample size was 18 adults; the sex makeup of the sample was not provided. The sample consisted of five spouses/partners, three children, three mothers, three sisters, two ex-spouses/partners,	Overall, most participants repeatedly sought support for their loved one and themselves. The help-seeking process was difficult, and often unsuccessful on the first attempt. Two-thirds of the participants were dissatisfied with the	Strengths: This was the first study of its kind. The aims were relevant to the Swiss context where assisted suicide has been legal since 1941, suggestive of more liberal views. Limitations: The	The authors recommend that when someone presents as suicidal the contact details of their significant other should be kept, and confidentiality should be waived. They recommended that significant others

	themselves and their partner.	sampling method used was volunteer sampling. Data was collected through semi-structured interviews which were audiotaped. Data was analysed using qualitative content analysis.	and two friends. The mean age of the sample was 41.	care provided to their loved ones. Half of participants faced challenges in their cooperation with professionals. With regards to the RQ in this SLR, the findings revealed that participants sought support through: 1) therapy and professional support, 2) actively choosing not to seek help. Other experiences associated to the RQ: 1) participants described a lack of empathy in the personal support they	sample size was small for a content analysis. The sample was restricted to a specific geographical and cultural area. The authors disclosed that many participants had their own mental health issues which were not controlled for.	should be trained in suicide risk screening. With regards to professionals, there should be specific education on how to positively comminate and collaborate with significant others.

				received, 2) participants felt as though professionals did not take them seriously.		
6. Family involvement, patient safety and suicide prevention in mental healthcare ethnographic study (Gorman et al., 2023)						
United Kingdom	To explore how families can be involved in supporting a loved one accessing crisis mental health services.	This research employs a qualitative methodology, it was an ethnographic investigation. Participants were recruited by healthcare staff who reviewed a sample of consenting persons medical records against their inclusion/exclusion criteria for the study. Family members were	The sample relevant to the RQ was eight adults; the sex makeup of the sample was not provided. The sample consisted of four 'family members', two partners/spouses, and two parents. The mean age of the sample us unknown.	Overall, the study found three themes: 1) how family involvement helps patients, 2) challenges of involving families when delivering a home-based service, 3) how organisations can promote effective family involvement. With regards to the RQ in this SLR, the findings revealed that	Strengths: A strength of this study was the inclusion of multiple viewpoints from patients, carers, and healthcare professionals. The research was conducted by a multidisciplinary research team which encouraged ideas from	The authors recommended involving families more in discharge planning. The findings indicated that healthcare professionals must initiate explicit discussions about consent and carer involvement, to enable carers to be present during

		contacted via the consenting person. The sampling method used was purposive sampling. There were multiple methods of data collection: 1) review of organisational documents, 2) observations of interactions between patients, family members and healthcare professionals, 3) case-note review and 4) semi-structured interviews with patients, family members and		participants sought support through: 1) the internet, 2) support group. Other experiences associated to the RQ: 1) Caregivers felt isolated from others.	multiple perspectives. Limitations: The recruitment was hindered by Covid-19. The sample size was small for the data analysis method. The authors disclosed bias in the recruiting as staff chose who to invite.	clinical interactions.

		healthcare professionals. Data was analysed using Framework Analysis.				
7. Significant others of suicide attempters: their views at the time of the acute psychiatric consultation (Magne-Ingvar & Öjehagen, 1999b)						
Sweden	To investigate 'significant others' views on why their loved ones made a suicide attempt and consider the needs of significant others in relation to help-seeking. The evaluate whether information	This research employs a mixed-methods methodology. Participants were recruited from Lund University Hospital between 1993 and 1994. The sampling method used was unclear. Data was collected through semi-structured interviews. Data was analysed using Content Analysis.	The sample size was 81 adults; comprising of 40% males, and 60% females. The sample consisted of 24 partners, seven former partners, 30 parents, 12 grown-up children, two siblings, and six friends. The mean age of the sample was 39.	Overall, the study found that significant others can provide valuable information to help develop packages of care around their loved one. Significant others felt that loneliness and a lack of self-confidence led to their loved one making the suicide attempt. With regards to the RQ in this SLR, the findings	Strengths: The study was the first of its kind in Sweden and provided recommendations for better treatment. Limitations: The authors do not make their process or method of data analysis clear. Participants were all interviewed at	The authors recommend that significant others should be involved in care planning from the point of assessment.

	from significant others was helpful in the assessment of the suicidal person. To understand more about the wellbeing of significant others in a suicide crisis.			revealed that participants sought support through: 1) professional support, 2) someone to turn too, 3) counselling.	different stages in the caregiver journey.	
8. One-year follow-up of significant others of suicide attempters (Magne-Ingvar & Öjehagen, 1999a)						
Sweden	To explore the reflections and opinions of 'significant others' of those who have made a suicide	This research employs a mixed-methods methodology. Participants were recruited from Lund University Hospital between 1993 and	The sample size was 84 adults; comprising of 34 males, and 50 females. The sample consisted of 37 parents, 23	Overall, the study found significant others require information and support following their loved one's suicide attempt.	Strengths: This is a follow-up study; the sample were looked at over a longitudinal scale. Limitations: The authors do not	The authors recommend that significant others should be involved in the treatment prescribed for their loved one, as this

	attempt, one year after the suicide attempt.	1994. The sampling method used was unclear. Data was collected through semi-structured interviews, conducted over the phone. Data was analysed using Content Analysis.	partners, 10 adult children, five ex-partners, two siblings, four friends, and three professional colleagues. The mean age of the sample is unknown.	Significant others felt that joint counselling would be helpful to move forward interpersonally. All significant others wanted to be considered in treatment planning. With regards to the RQ in this SLR, the findings revealed that 80% of significant others had had at least one person to talk to after their loved ones' suicide attempt, 20% had not talked to anybody about the event. 46% would have liked	make their process or method of data analysis clear. It is unclear how recruitment took place.	will mean better outcomes for the suicidal person.

				professional counselling together with their loved one, 29% stated they had needed individual professional support.		
9. Caring for a Family Member with Psychosis or Bipolar Disorder Who Has Experienced Suicidal Behaviour: An Exploratory Qualitative Study of an Online Peer-Support Forum (Marshall et al., 2022)						
United Kingdom	To understand the experience of carers who have a family member diagnosed with psychosis or bipolar disorder and who experience suicidal behaviour.	This research employs a qualitative methodology. Data generated by forum users between April 2016 and June 2018. The sampling method used was unclear. This was a secondary analysis of forum posts collected as part of a randomised controlled trial to	The sample size was 29 adults; comprised of three males, and 26 females. The sample consisted of 11 partners, nine mothers, three daughters, two siblings, and four unspecified family members. The mean age of	Overall, the study found three themes: 1) suicide as the ultimate threat, 2) bouncing from one crisis to another”, 3) it definitely needs to be easier to get help. With regards to the RQ in this SLR, the findings revealed that participants sought support through: 1)	Strengths: The study had good reliability and replicability. Limitations: The study was not generalisable, as it was a UK-based largely white female population. A large number of posts included in	The authors suggest that carers should be included in the care provision for suicidal family members from the point of assessment. The authors suggest that there should be “carer-inclusive” information

		evaluate the REACT intervention. Data was analysed using thematic analysis.	the sample is unknown.	engaging with the peer support forum.	the data analysis were written by a small amount of users.	planning when care planning for suicidal individuals.
10. The unmet support needs of family members caring for a suicidal person (McLaughlin et al., 2016)						
United Kingdom	To explore the support needs of family members of a suicidal person.	This research employs a qualitative methodology. Participants were recruited through a media call (no further information provided). Data was collected through semi-structured interviews. Data was analysed using thematic analysis.	The sample size was 18 adults; the sex makeup of the sample was not provided. The sample consisted of seven children bereaved by suicide, and 11 family members currently living with a suicidal person. The mean age of the sample was 51.	Overall, the study found one theme: 1) Family members of suicidal people have unmet needs; with four subthemes: 1) having practical support, 2) respite and advice, 3) feeling acknowledged and included, 4) having someone to turn-to; and consistency of support. With regards to the RQ in this SLR, the findings	Strengths: This study addresses an identified gap in literature. This study has good replicability as it shares a rigorous method. The authors included information on inter-coder reliability and triangulation to reduce bias in the findings reported. Limitations:	The authors suggest that the “Good Practice Report” should be revisited in healthcare settings, as there are specific recommendations around navigating confidentially which include keeping the family involved from the earliest point of contact.

				revealed the following about the participants experiences of seeking support: 1) there was no support available to them from professionals, 2) they would have valued practical support, 3) they felt as though they had no one to turn too.	There was limited information given about the demographics of the sample which makes the results hard to contextualise. The authors provided no real clinical implications or direction for future research.	
11. The burden of living with and caring for a suicidal family member (McLaughlin et al., 2014)						
United Kingdom	To explore the experience of living with a suicidal person.	This research employs a qualitative methodology. Participants were recruited through a media call via local newspapers. The	The sample size was 18 adults; comprised of four males, and 14 females. The sample consisted of seven children	Overall, the study found one theme: 1) “Hard work for the whole family”; with four subthemes: 1) family burden, 2) competing pressures,	Strengths: This work gave research focus to the experience of caregivers which is often forgotten in literature.	The authors suggest that mental health workers need to work hard to eradicate the stigma associated with suicide

		sampling method used was volunteer sampling. Data was collected through semi-structured interviews. Data was analysed using thematic analysis.	bereaved by suicide, and 11 family members currently living with a suicidal person. The mean age of the sample was 51.	3) secrecy and shame and 4) helplessness and guilt. With regards to the RQ in this SLR, the findings revealed the following about the participants experiences of seeking support: 1) participants felt prevented from seeking support by the suicidal person, 2) participants felt abandoned by support services.	Limitations: The authors acknowledge that the sample that come forward will not necessarily give the experience of all caregivers, as this is a taboo area, and many caregivers will not come forward to share their stories.	however, they provide little direction in how this might be achieved. The authors also highlight the importance of psychological support for carers.

12. The psychosocial needs of parents of adolescents who attempted suicide (Ngwane & Van Der Wath, 2019)

South Africa	To explore the psychosocial needs of	This research employs a qualitative methodology, using a	The sample size was 10 adults; comprised of ten	Overall, the study found one theme: 1) psychological needs;	Strengths: This was the first study of its kind in	The authors recommend the health care

	parents of adolescents who have recently made a suicide attempt.	descriptive phenomenological approach. Participants were recruited by psychiatric nurses from the public district hospital in a rural area of South Africa. The sampling method used was purposive sampling. Data was collected through semi-structured interviews. Data was analysed using thematic analysis.	females. The sample consisted of ten mothers. The mean age of the sample was 44.	with three subthemes: 1) post-traumatic experiences, 2) regret, self-blame and guilt, and 3) fear and anxiety. With regards to the RQ in this SLR, the findings revealed the following about the participants experiences of seeking support: 1) participants unable to seek support from their social network.	South Africa. Limitations: The authors highlight that the participants who came forward will likely report on things differently than those who did not come forward. The results are limited to just one cultural group.	professionals should address the barriers which prevent "family centred care" when appropriate. The authors highlight the need to family to be involved in the care planning of a young person.
13. Family's experience in caring for clients with suicidal risk in Indonesia (Nova et al., 2019)						
Indonesia	To explore and understand the perspectives of	This research employs a qualitative methodology.	The sample size was six adults; comprised of six	Overall, the study found five themes: 1) suicide attempts is a	Strengths: This was the first study of its kind in	The authors recommend that families should be

	family members caring for someone who presents with suicide risk.	Participants were recruited method was unclear. The sampling method used was purposive sampling. Data was collected through in-depth interviews. Data was analysed using the Colaizzi method.	females. The sample consisted of grown-up children, siblings, partners, and cousins (the frequency of which is unknown). The mean age of the sample was 54.	complex burden for families, 2) behavioural changes as a suicide sign, 3) concern as a form of family and community support, 4) family perceptions about the causes and consequences of attempted suicide, 5) coping strategies of families overcoming the impact of attempted suicide. With regards to the RQ in this SLR, the findings revealed that participants sought support through: 1)	Indonesia. Limitations: The sample size was very small; the results are not generalisable.	included in the care planning for their suicidal loved one and acknowledge that family members will be able to pick up on subtle changes which professionals will not be able too. The authors recommend that nurses should take on a counselling role to improve the wellbeing of patients and their families, the suggest that this role could include

				family support, 2) prayer.		health education, family therapy, stress management, and the facilitation of self-help groups.
14. Parent experience during and after adolescent suicide crisis: A qualitative study (Weissinger et al., 2023)						
United States	To explore the impact on parents and families when someone in the family system experiences a suicide crisis.	This research employs a qualitative methodology. Participants were recruited via social media flyers, posters in public areas, and community outreach initiatives. The sampling method used was purposive sampling. Data was collected through semi-structured interviews conducted	The sample size was 18 adults; comprised of one male, and 17 females. The sample consisted of 16 mothers, one father, and one grandmother The mean age of the sample was 48.	Overall, the study found five themes: 1) Trauma of the Experience (subtheme: Feelings of Failure); 2) Living in Fear; 3) Alone and Seeking Connection; 4) Lasting Impact; 5) A New Normal (subtheme: Turn the Pain to Purpose). With regards to the RQ in this SLR, the findings revealed that	Strengths: This was the first study of its kind to look at this area in the United States. Limitations: The aims talk about parents but there are only mothers' views represented in the study. The sample does not reflect the diversity of the United States.	The authors recommend that nurses should employ a trauma-informed approach with adolescents and families. They advise that discharge plans should include an assessment of the family, including the parental mental health needs.

		via a teleconferencing platform. Data was analysed using thematic analysis.		participants sought support through: 1) support groups, 2) speaking with friends, 3) starting peer support groups, 4) therapy.	The authors acknowledge there were barriers for caregivers seeking support which were due to the Covid-19 context and perhaps were not typical.	

2.5.1 Summary of Extracted Data

Country of Origin. Twelve of the studies were conducted in the Global North, distinctions between the Global North and Global South are being made in line with recommendations by Odeh (2010). Articles included from the Global North include: one article from Canada (Daly, 2005), one article from Australia (Dempsey et al., 2019), two articles from the United States (Doyle et al., 2021; Weissinger et al., 2023), one article from Switzerland (Dransart & Guerry, 2017), four articles from the United Kingdom (Gorman et al., 2023; Marshall et al., 2022; McLaughlin et al., 2014, 2016), two articles from Sweden (Magne-Ingvar & Öjehagen, 1999b, 1999a), and one article from South Africa (Ngwane & Van Der Wath, 2019). Two of the studies included in the SLR were conducted in the Global South. Articles included from the Global South include: one article from Ghana (Asare-Doku et al., 2017), and one article from Indonesia (Nova et al., 2019). The Ghanaian study is the only one completed in a context where suicide has not been decriminalised.

Aims and Objectives. The 14 articles broadly aimed to explore and understand the perspectives of family members supporting somebody who has made a suicide attempt. Two articles looked at the impact of a suicide crisis on parents and families (Ngwane & Van Der Wath, 2019; Weissinger et al., 2023). Eight articles looked at the experiences of different groups of family members in relation to caregiving (Daly, 2005; Dransart & Guerry, 2017; Magne-Ingvar & Öjehagen, 1999b, 1999a; Marshall et al., 2022; McLaughlin et al., 2014, 2016b; Nova et al., 2019). Two articles looked at coping in the aftermath of the suicide attempt of a loved one (Asare-Doku et al., 2017; Doyle et al., 2021). Two articles looked at how the experience of caregiving could be better for families (Dempsey et al., 2019; Gorman et al., 2023).

Study Design / Methodology. Eleven of the studies employed a qualitative research design. Three of the studies employed a mixed-methods research design (Doyle et al., 2021;

Magne-Ingvar & Öjehagen, 1999b, 1999a), only the qualitative results were included in this SLR.

Sample and Participant Demographics (incl. Caregiver Relation). The sample sizes across articles ranged from six participants (Daly, 2005; Nova et al., 2019), to 84 participants (Magne-Ingvar & Öjehagen, 1999a). The mean average sample size was 25.3. Ten of the 14 articles included a frequency breakdown of male/female ratio, four article did not include this information (Dransart & Guerry, 2017; Gorman et al., 2023; Magne-Ingvar & Öjehagen, 1999b; McLaughlin et al., 2016). The ten articles which included this information, each presented a sample heavily weighted towards females. Combined, the ten studies consisted of 229 participants; 49 of these were male (21.4%), and 180 of these were female (78.6%). All 14 studies included a participant sample with an adult population. There was a mixture of caregiver relationships in the sample, these included fathers, mothers, siblings, aunts, children, partners, and friends. The biggest proportion of caregiver relationships across the 14 samples was mothers (at least, 40.6%; six of the studies did not make a mother/father distinction when categorising 'parents').

Results. All 14 articles highlighted how caregivers experienced negative impacts from the caregiving role, largely in that they felt unsupported by those around them (including friends, families, and professionals). A summary of how the results answered the research question for this SLR will be described in Section 2.8.

Strengths and Limitations. All 14 articles had strengths in that they were the first of their kind to investigate a gap in literature with a specific population. Twelve articles described limitations in relation to the sample; five of these related to the sample size (Asare-Doku et al., 2017; Daly, 2005; Dempsey et al., 2019; Gorman et al., 2023; Nova et al., 2019), four related to the geographical stretch (Doyle et al., 2021; Dransart & Guerry, 2017; Marshall et al., 2022; Ngwane & Van Der Wath, 2019), and three related to a gender imbalance (Dempsey et al., 2019; Marshall et al., 2022; Weissinger et al., 2023). Three authors noted limitations based on the recruitment method, disclosing recruitment biases subsequent to time restrictions, and contextual factors (Asare-Doku et al., 2017; Gorman et al., 2023; Weissinger et al., 2023).

Clinical and Practical Implications. All 14 articles included clinical implications aimed at improving the experience for caregivers. Recommendations for clinicians to change the way they practice to be more inclusive of care givers were given by 11 of the authors (Daly, 2005; Dempsey et al., 2019; Doyle et al., 2021; Gorman et al., 2023; Magne-Ingvar & Öjehagen, 1999a, 1999b; Marshall et al., 2022; McLaughlin et al., 2016; Ngwane & Van Der Wath, 2019; Nova et al., 2019; Weissinger et al., 2023). Four of the authors made references to psychological interventions which were needed for caregivers (Asare-Doku et al., 2017a; Daly, 2005; McLaughlin et al., 2014; Nova et al., 2019). One author described the need for education for caregivers (Dransart & Guerry, 2017).

2.6 Methodology: Quality Appraisal

Included articles were quality appraised using the Critical Appraisal Tool Programme (CASP) tool for qualitative research (Critical Appraisal Skills Programme, 2023). The CASP tool is supported by the Cochrane Collaboration, and the World Health Organisation, as an effective tool to critically appraise qualitative research (Hannes & Macaitis, 2012; Noyes et al., 2022). The tool comprises of 10 questions, with each answered by: '*Yes*', '*Can't Tell'*, or '*No*', weighted ('*Yes*': 1 point, '*Can't Tell'*: 0 points, '*No*': 0 points; Boeije et al., 2011). A system was developed accounting for total points per article (0-3 points: poor quality, 4-6: fair quality, 7-10: good quality; Hanks et al., 2020) with scores presented in Table 10. The 14 articles were quality appraised by the lead researcher and secondary researcher, separately. This process revealed 23 conflicts, equating to 84% agreement between researchers, and a Cohen's kappa of 0.66 (substantial agreement). The conflicts largely related to differences in the way the CASP question was perceived [e.g., there were differences in how ‘the relationship between researcher and participant’ (Q6) had been understood]. Each conflict was discussed, and a final decision was made in collaboration with supervisors. A table with a sample outlining the specifics of how each question was answered can be found in Appendix G. There is a full written summary in Appendix H.

Table 10

CASP Scoring

Article No.	**Q1: Was there a clear statement of the aims of the research?**	**Q2: Is a qualitative methodology appropriate?**	**Q3: Was the research design appropriate to address the aims of the research?**	**Q4: Was the recruitment strategy appropriate to the aims of the**	**Q5: Was the data collected in a way that addressed the research issue?**	**Q6: Has the relationship between researcher and participants been adequately considered?**	**Q7: Have ethical issues been taken into**	**Q8: Was the data analysis sufficiently rigorous?**	**Q9: Is there a clear statement of findings?**	**Q10: How valuable is the research?**	**Rating**
1	✓	✓	✓	✓	✓	X	-	-	✓	✓	7/10 (Good)
2	✓	X	✓	X	X	X	✓	-	✓	-	4/10 (Fair)
3	✓	✓	X	✓	-	X	-	-	✓	-	4/10 (Fair)
4	✓	-	-	✓	✓	✓	X	✓	✓	✓	7/10 (Good)
5	✓	✓	-	✓	✓	X	✓	-	✓	-	6/10 (Good)
6	✓	✓	✓	✓	✓	-	✓	-	✓	-	7/10 (Good)
7	✓	-	-	✓	✓	-	-	X	-	X	3/10 (Poor)
8	✓	-	-	✓	-	X	-	X	X	X	2/10 (Poor)
9	✓	✓	✓	✓	✓	-	-	✓	✓	-	7/10 (Good)

10	✓	✓	-	-	✓	X	-	✓	✓	-	5/10 (Fair)
11	✓	✓	✓	✓	✓	-	✓	X	✓	-	7/10 (Good)
12	✓	-	✓	✓	✓	X	✓	✓	✓	X	7/10 (Good)
13	✓	✓	✓	-	-	X	-	-	✓	-	4/10 (Fair)
14	✓	✓	✓	✓	✓	-	-	✓	✓	✓	8/10 (Good)

*(**Scoring Key:** Yes (1): ✓, Can't Tell (0): -, No (0): X)*

A Moment for Refection

I reflected on the use of the CASP, and how it is a Western tool. The CASP was initially developed in 1993 in Oxford, UK. I thought about how it would have been designed with Western academic standards in mind, and thought about how academic standards would differ internationally, particularly between the West and the rest of the world. I considered my non-Western papers and how they were not written with the academic standards of the West in mind, and how the ratings may had differed it a more culturally appropriate tool was available.

Following quality appraisal, to maintain the rigor of the review, two articles were removed due to their 'poor' quality (Magne-Ingvar & Öjehagen, 1999a, 1999b), leaving a total of 12 articles included in the review.

2.7 Methodology: Synthesis Strategy

The method of data synthesis chosen for this SLR was thematic synthesis (Thomas & Harden, 2008). Other methods of data synthesis were considered (e.g., narrative synthesis and meta-ethnography) however, thematic synthesis was most suitable as its principals are closely aligned with thematic analysis, which was the most common method of data analysis used across the 12 articles included. Thematic synthesis worked as a tool to explore repeated patterns and recurring themes across the 12 participant samples to answer the research question: *What is the experience of informal caregivers seeking and engaging with support provisions when caring for somebody who has experienced suicidal ideation and/or has made a suicide attempt?*

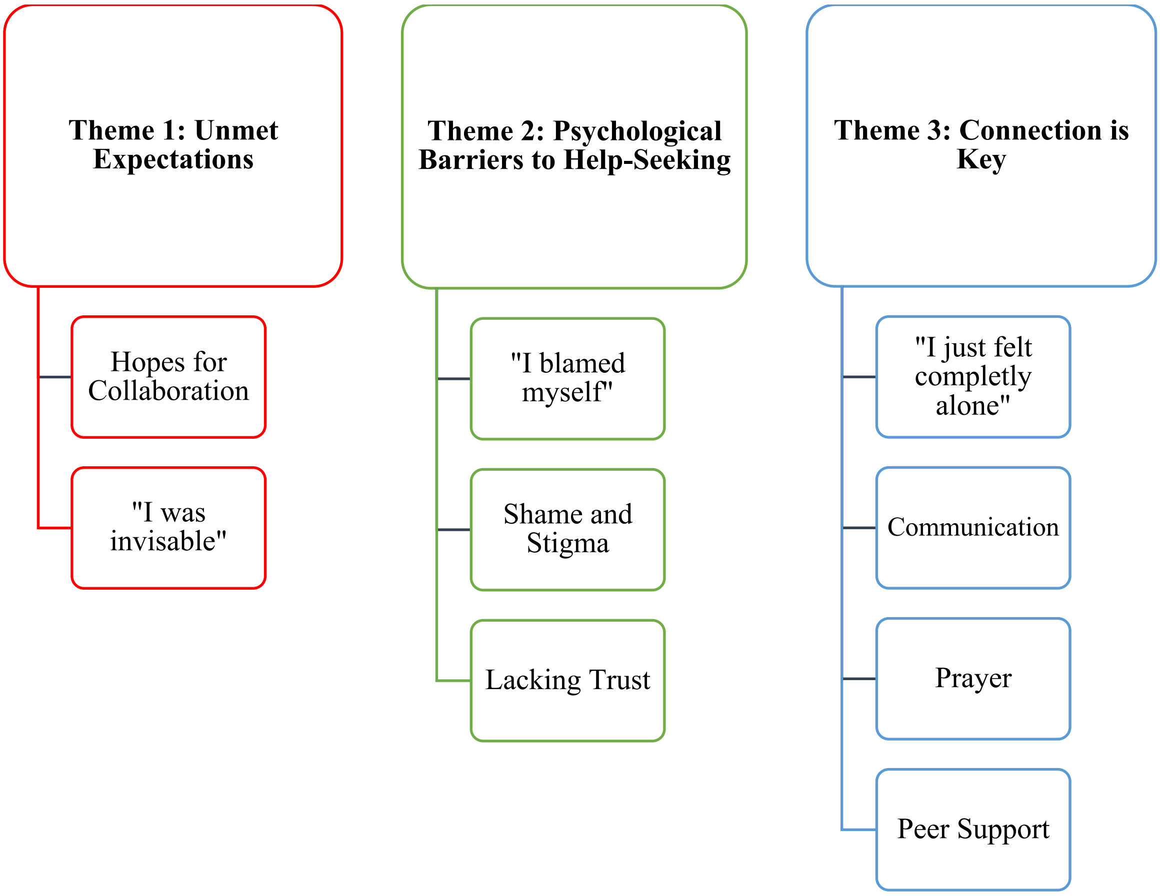
Thematic synthesis uses the principals of thematic analysis to analyse and synthesise qualitative studies (Thomas & Harden, 2008). All 12 articles were reviewed for the researcher to become familiar with the content of each text (Braun & Clarke, 2006, 2013, 2019). Following this, the techniques outlined by Thomas and Harden (2008) were applied to synthesise the studies: 1) code each text line-by-line, 2) develop descriptive themes, and 3) generate analytic themes. Once analytic themes had been developed, they were discussed with supervisors to ensure themes were aligned to answer the SLR question.

2.8 Findings: Thematic Synthesis of Results

Thematic synthesis revealed three main themes with relevant subthemes (Figure 5). Further tabulation was completed to depict the source of each theme (Appendix I).

Figure 5

SLR Findings, Themes and Subthemes



2.8.1 Theme 1: Unmet Expectations

In all but one study (Asare-Doku et al., 2017), participants described an expectation to cooperate with healthcare professionals and work alongside them as a means of seeking and engaging with support for their loved one. Given the expected allyship, participants anticipated that healthcare providers would check-in with them personally to assess how they were coping in their capacity as carers, offering support and guidance if required. Across the 11 studies, these expectations were largely unmet; and as such, a collective feeling of *frustration and anger [..] was very evident* (McLaughlin et al., 2015, p.214).

Hopes for Collaboration. In nine studies (Daly, 2005; Dempsey et al., 2019; Doyle et al., 2021; Dransart & Guerry, 2017; Gorman et al., 2023; Marshall et al., 2022; McLaughlin et al., 2014, 2016; Nova et al., 2019), participants described how they felt healthcare providers did not value them as carers, and did not seem to share the same desire to work collaboratively to support their loved one: "*Significant others often felt that professionals had very little interest in and did not take into account the information and opinions that were shared with them regarding the issues concerning the suicidal person or suicide attempter and his/her care"* (Dransart & Guerry, 2017, p.8). Participants described how their hopes for collaboration were found to be unrealistic from the first point of contact, through to their loved one's eventual discharge (Dransart & Guerry, 2017; Marshall et al., 2022), which led to a shared feeling of frustration, isolation and confusion (Daly, 2005; Doyle et al., 2021; Dransart & Guerry, 2017; Gorman et al., 2023; Marshall et al., 2022; McLaughlin et al., 2014, 2016; Nova et al., 2019). This feeling was articulated through a direct quote from a participant in Gorman et al.'s 2023 study: *"I felt shut out actually and I didn't know what was going on"* (p.7). Ultimately, the notion that healthcare providers did not want to work alongside carers, led to carers viewing them to be: "*insufficiently considerate of the role of the carer"* (Marshall et al., 2022, p.6).

"I was invisible". In 10 studies (Daly, 2005; Dempsey et al., 2019; Doyle et al., 2021; Dransart & Guerry, 2017; Gorman et al., 2023; Marshall et al., 2022; McLaughlin et al., 2014, 2016; Ngwane & Van Der Wath, 2019; Weissinger et al., 2023), participants described feeling overlooked, unsupported, and ignored by the healthcare professionals supporting their loved one, whom they had expected would provide a level of support and guidance to them in their caregiver role. Some participants hoped that support would be provided without directly having to ask for it: *"Even when the lady came I thought she might speak to me, but she didn't speak to me"* (Gorman et al., 2023, p.7). Whereas, others hoped that support would be provided once they asked: *"I said to the doctors 'but me, I need help, I need help', and I was crying and I didn't have any tissues and nobody offered me any, and then, everybody was watching me cry, nobody said anything"* (Dransart & Guerry, 2017, p.8). Despite the method of seeking support, the outcome was overwhelmingly similar in that support was not routinely provided: *"I got no help or support. They knew that I was there but I didn't seem to matter to them"* (McLaughlin et al., 2014, p.239), *"I was invisible to them and so were my parents and my sister. We were all invisible to them"* (McLaughlin et al., 2016, p.214).

2.8.2 Theme 2: Psychological Barriers to Help-Seeking

Psychological barriers to help-seeking permeated through all 12 articles. Participants spoke of difficulties with seeking and engaging in support for themselves, in relation to their caregiver role. They largely expressed a desire to engage with personal support provisions however, internalised feelings of blame and shame, societal stigma, and difficulties trusting others appeared to prevent them from reaching out.

"I blamed myself". In eight studies (Daly, 2005; Doyle et al., 2021; Gorman et al., 2023; McLaughlin et al., 2014, 2016; Ngwane & Van Der Wath, 2019; Nova et al., 2019; Weissinger et al., 2023), carers blamed themselves for their loved ones suicidality. This feeling of self-blame prevented them from reaching out for support:

> *"I felt very guilty about things and I blamed myself and I needed help too. She [the nurse] was very nice and I know she would have felt like talking to me but I didn't want to tell people... [...] I didn't want to talk to other people but I think I wanted to…. I don't know... To hide it really."* (McLaughlin et al., 2014, p.239)

For many participants, it was not explicitly clear how this feeling had developed but, for others, particularly where the participant group identified as parents (Daly, 2005; Doyle et al., 2021; Ngwane & Van Der Wath, 2019; Weissinger et al., 2023), the feeling of self-blame appeared to be linked with societal norms, roles and expectations (e.g., it is a parents responsibility to keep a child safe). One mother described how the language used by healthcare professionals supported the idea that she was to blame: *"When the sister asked me, 'What did you do to the child?', then I told myself that it means there is a negative role that I have played"* (Ngwane & Van Der Wath, 2019, p.377). Overwhelmingly, examples such as this upheld the sense that participants *caused* the suicidality of their loved one, which prevented them from feeling as though they could reach out for support.

Shame and Stigma. In 10 studies (Asare-Doku et al., 2017; Daly, 2005; Doyle et al., 2021; Gorman et al., 2023; Marshall et al., 2022; McLaughlin et al., 2014, 2016; Ngwane & Van Der Wath, 2019; Nova et al., 2019; Weissinger et al., 2023) participants expressed how internalised feelings of shame, and an awareness of societal stigma, worked to prevent them from seeking and engaging with personal support. The dataset was saturated with participants naming feelings of shame. For some, shame was linked to the act of suicidality itself: *"Actually I was ashamed, when it happened. That's why I find it very difficult… To tell you. I have never ever told any of my family people…"* (Asare-Doku et al., 2017, p.3). For others, shame led them to fear the reaction of others: *"I could not talk to anyone and had to keep it secret. I had no one to talk to as I was afraid [...] what others would think. I was ashamed"* (McLaughlin et al., 2014, p.239). And for those who had already experienced the impact of shame from others, they did not want to experience this again: *"The family doesn't want to talk about it. They think it's shameful. [...] They didn't want to hear about it or talk about it, so I felt completely cut off from that group. They didn't even want to try to understand."* (Daly, 2005, p.381).

Shame was heavily linked with stigma across 10 articles, with many participants using the words almost interchangeably. Many felt unable to tell anybody what was going on due to the stigma attached to suicide (Asare-Doku et al., 2017; Ngwane & Van Der Wath, 2019). One participant described stigma as a *"huge barrier"* to reaching out for support and shared a story which solidified this as fact for her *"[Stigma's] a huge barrier. Being able to even pull people around you in as support, because a lot of them disappear on you… I had friends that disappeared on me because they're like 'she's nuts you don't want to be around her."* (Weissinger et al., 2023, p.921).

Lacking Trust. In five studies (Asare-Doku et al., 2017; Daly, 2005; Dempsey et al., 2019; Dransart & Guerry, 2017; Ngwane & Van Der Wath, 2019), participants described how they did not have enough trust in their family to reach out to them for support. Participants had concerns regarding what family members might do with the information, notably fears were around "*gossiping"* (Asare-Doku et al., 2017, p.5; Ngwane & Van Der Wath, 2019, p.377) and weaponising the information to use it to *"insult"* them at a later date (Asare-Doku et al., 2017., p.5). This lack of trust in family members to sensitively hold the information, prevented participants feeling as though they could reach out for support.

2.8.3 Theme 3: Connection is Key

Across the 12 articles, connection was found to be the distinguishing factor as to whether carers described a 'positive' or 'negative' experience of seeking and/or engaging with personal support provisions. Where connection was present, participants used connotations suggestive of a 'positive' experience; and where connection was missing, participants used connotations suggestive of a 'negative' experience.

"I just felt completely alone". In nine studies (Daly, 2005; Doyle et al., 2021; Dransart & Guerry, 2017; Gorman et al., 2023; Marshall et al., 2022; McLaughlin et al., 2014, 2016; Nova et al., 2019; Weissinger et al., 2023), participants reported how, without a sense of connection with others, they felt alone in their caregiver role. The feeling of aloneness was linked to a lack of connection with professionals, as well as those in their more informal social networks (e.g., family and friends; Daly, 2005). Without connection, the experience of help-seeking was experienced as negative, as carers felt others were *"not open to acknowledge their feelings and to offer emotional support"* (Dransart & Guerry, 2017, p.8). When trying to make sense of this, many carers drew on the stigma associated with suicide: "*Lack of understanding and knowledge from others, including health care professionals, and the stigma associated with suicide contributed to their isolation, until they felt this problem was theirs alone"* (Daly, 2005, p.26).

For one carer, even though they had people to talk too, they still felt alone: *"I just felt completely alone. I felt like, even though I had my friends to talk to and everything… I just felt like I was on an island alone"* (Weissinger et al., 2023, p.920). This suggests that feeling connected and supported is *more* than simply having someone to talk too. However, for many carers, having someone to talk too would have been one step in the right direction (Daly, 2005; Doyle et al., 2021; Marshall et al., 2022; McLaughlin et al., 2016).

Communication. In all 12 studies, some participants described how communicating with others was experienced as a positive support provision. There were varying methods of communication across the articles, largely related to talking with friends: *"I talk to my friend… every day… she can make me feel a little better"* (Doyle et al., 2021, p.83), family: *"I discussed with dad, siblings, and nephew" (Nova et al., 2019, p.461)*, and/or communicating with a therapist: *"I think that the therapy really helped [it] gave me just [a] tremendous amount of understanding"* (Weissinger et al., 2023, p.922). Some carers, felt as though even the space provided to them by the researcher to communicate openly was beneficial to them: *"As I'm talking to you I feel relieved so I need it…"* (Weissinger et al., 2023, p.921).

For a small group of carers, communication expanded further than verbal communication to connecting with people and material through online resources (Dempsey et al., 2019; Marshall et al., 2022).

Prayer. In three studies (Asare-Doku et al., 2017; Doyle et al., 2021; Nova et al., 2019), prayer was experienced as a beneficial support provision for carers. It seemed as though connecting with faith worked as a method of coping, which in-turn led to carers feeling more supported: *"Praying… made me feel better. The major one is my involvement in religious activities"* (Asare-Doku et al., 2017, p.6). As well as praying themselves, some carers felt supported from the idea that others were praying for them (Doyle et al., 2021; Nova et al., 2019). Through prayer, carers felt connected to their culture and elders in their community (Nova et al., 2019).

Connecting to God allowed some carers to feel supported without experiencing the stigma they may have experienced if they spoke with another person: *"I pray too, as for prayer, prayer is the key. I tell my God, I don't tell human being. That is what we have been taught to do. They said we should talk to our God"* (Asare-Doku et al., 2017, p5). This allowed the suicide attempt to remain a secret from the community, whilst also allowing the carer to feel as though they had shared their burden.

Peer Support. In six studies (Daly, 2005; Dempsey et al., 2019; Gorman et al., 2023; Marshall et al., 2022; Ngwane & Van Der Wath, 2019; Weissinger et al., 2023) peer support, via support groups and online forums, was found to be a positive support method for carers. Largely, the feeling across all six articles was that peer support lifted feelings of aloneness, as carers mixed with other people experiencing the same feelings they were: *"Relief that I am no longer feeling so alone and isolated dealing with my son"* (Marshall et al., 2022, p.8), *"Support groups are great because you feel like you're not the only person there that is experiencing this"* (Weissinger et al., 2023, p.920).

Support groups also provided space for carers to learn from each other and ask questions they have previously been unable to ask others: "*Access to a carers group provid[ed] the opportunity to receive support and also to learn from others about how best to support the patient"* (Gorman et al., 2023, p.6), *"I have literally just joined [the online peer support forum] and already feel such relief that I have somewhere to ask these questions and find information"* (Marshall et al., 2022, p.5). Peer support appeared to fill the gap which had been previously left by the healthcare professionals, and friends and family.

2.9 Discussion

2.9.1 Summary of Findings

This SLR aimed to understand the experience of informal caregivers seeking and engaging with support provisions when caring for somebody who has experienced suicidal ideation and/or has made a suicide attempt. The thematic synthesis found three themes which demonstrated shared challenges for participants in this context *(Theme 1: Unmet Expectations; Theme 2: Psychological Barrers to Help-Seeking)* and provided insight into what is needed for participants to find the experience of seeking and engaging with support provision as both meaningful and beneficial *(Theme 3: Connection is Key)*.

2.9.2 Relating Findings to Existing Literature

Carers expected to work alongside professionals to deliver high quality care for their loved one, whilst simultaneously receiving a level of personal support and guidance from them. This expectation was not met, and instead participants felt "*shut out*" (Gorman et al., 2023, p.7) and "*ignored*" (McLaughlin et al., 2016, p.214). Participants did not place the same expectations on informal support provisions (e.g., family, friends), which differs from carers in other contexts (e.g., carers for those with dementia) who heavily rely on their personal networks for support (Rodríguez-Madrid et al., 2021; Roth, 2020). This possibly speaks to the stigma which surrounds suicide working as a silencing weapon, leading carers to feel as though they can only seek support from those who are employed to provide it.

Shame, blame, and a mistrust of others flooded the participant experience, operating as psychological barriers to help-seeking. Similar to above, these feelings link with the stigma surrounding suicide. The impact of stigma swamped the carer experience in each of the articles, which provides an international picture of how widespread stigma is. Eleven studies were conducted in a context where suicide had been decriminalised, whilst one study (Asare-Doku et al., 2017) was conducted in a context where suicide was still a criminal act. Despite the difference in suicide law, there were many shared themes between the Ghanaian sample and the 11 other articles which perhaps speaks to the stigma which surrounds suicide, regardless of the legal context (Geležėlytė et al., 2020).

The review included 12 articles which span two decades, and it is noteworthy that all 12 articles provide actionable clinical implications to either improve the carer experience [e.g., psychological support offered to carers (McLaughlin et al., 2014, p.239)] and/or reduce stigma [e.g., educate communities to become suicide literate (Asare-Doku et al., 2017, p.8)]. Despite the actionable outcomes, there is little evidence of change over time. It is possible that conversations around improving support for informal caregivers is happening in small pockets with small change arising in specific contexts subsequent to the articles; however, more widespread change in a broader context appears limited.

Reflections on what has been helpful for carers when seeking and engaging with support provisions linked to feeling connected. Carers appeared to long for someone to connect with and found safety in prayer and support groups. In this context, support groups may have bridged the gap between professional support, and personal networks. The group held expertise in a subject that was tricky for participants to speak to their personal networks about, developing an in-group/out-group divide and increasing the appeal of peer support

(Tajfel & Turner, 1979). Similarly, prayer operated as a space for carers to share their feelings with a greater power who offered complete confidentiality, offloading a burden and offering a sense of connection. Prayer and support groups offered a non-judgemental space whereby participants could step outside of the stigma momentarily, overcoming psychological barriers to help-seeking.

2.9.3 Strengths and Limitations

Strengths. This SLR was the first of its kind to look at the specific experiences of caregivers who have supported somebody through a suicide crisis, and it specifically addressed part of the gap in literature outlined by Lavers et al. (2022).

A strength of this review was the rigorous methodology. The search process, a large proportion of the data extraction, and the quality appraisal were carried out by two researchers, increasing the validity of the decisions made to include articles in the final review (Jeyaraman et al., 2020). Equations of inter-rater reliability (Cohens kappa) were conducted, and the results yielded showed varying degrees of agreement between researchers at different points in the research process. All conflicts were agreed sufficiently during discussion. To scrutinise the Cohen's kappa results fits with the paradigm of statistical positivism (Chirkov & Anderson, 2018). Through the lens of CR, variations in inter-rater reliability are expected as it is accepted that each researcher will engage with the information presented to them differently (Fletcher, 2017).

Limitations. Sample limitations impact the applicability of results to the wider population. Firstly, females - specifically mothers - were over-represented across the 12 articles which may have led to a bias in the findings. Secondly, the review failed to consider the ethnicity of the participants in each sample which means that important demographic intersections were not accounted for in the findings. This review was unable to include this information as it was not adequately reported on by the articles included.

Another limitation is that the review did not control for context, specifically the decriminalisation of suicide, allowing the inclusion of the Ghanaian article (Asare-Doku et al., 2017). The findings of this SLR failed to consider how the experience of the Ghanaian participants were influenced by the context of caring for a loved one who had committed a crime. Secondly, the Covid-19 pandemic provided a context for four of the 12 studies (Doyle et al., 2021; Gorman et al., 2023; Marshall et al., 2022; Weissinger et al., 2023). The findings of this SLR did not consider how the challenges healthcare provisions faced during the pandemic would have impacted the experience of the four samples.

2.9.4 Clinical Implications and Invitations for Future Research

Clinical Implications. The findings of this review highlight a desire from carers to be involved in the care and treatment of their loved one. Carers would like to collaborate with healthcare professionals to achieve positive, effective outcomes for the care receiver. Healthcare professionals should aim to upskill themselves in systemic modalities, to begin thinking about patient care through a less individualistic lens (Boyd et al., 2011; Tomlinson & Åstedt-Kurki, 2008). Healthcare providers should acknowledge carers and recognise the role they play in treatment. Staff should facilitate conversations with the ‘patient’ around confidentiality, considering the extent of carer involvement from the offset. These conversations should be dynamic, with regular check-ins to consider any changes in circumstance. If the ‘patient’ opts to not include the carer for any reason at all, healthcare professionals should aim for transparency around this so that carers understand why there are limits to what can be shared with them.

The Care Act 2014 entitles all carers to an assessment of their needs. The NHS and local authorities have a duty to offer these assessments to all carers they come into contact with (NHS England, 2017). A combined NHS/local authority audit found that between 2021 and 2022, 380,725 carers were offered an assessment in the UK (NHS England, 2017). Yet, the 2022 UK census estimated that there are 10.6 million carers in the UK (Carers UK, 2022). Statistically, this means that between 2021 and 2022 only 3.6% of carers received an assessment of their needs. There will be a variety of reasons for this, one being that carers assessments are not routinely being offered. Healthcare professionals working in settings whereby people present with suicidal ideation (e.g. crisis teams, CMHT) should work hard to routinely seek to identify carers and offer carers assessments, when taking any 'patient' on for care and treatment.

Invitations for Future Research. Given the over-representation of females/mothers in this review, future research might look specifically at the experiences of male carers (e.g., fathers and/or brothers) to understand the experience more broadly.

This SLR highlighted how the experience of informal caregiving in the context of suicidal ideation/attempts is extremely complex, with carers feeling isolated, alone, and as if they cannot share their stories/seek support for a variety of reasons. Qualitative studies are needed to better understand the intricacies of the caregiver role with the hope that, from this, support provision can be developed to meet the needs of the population.

2.10 Discussion: Critical Appraisal

The CASP tool for systematic reviews (Critical Appraisal Skills Programme, 2023) was used to quality appraise this SLR. The CASP was completed in conjunction with the secondary researcher, and reviewed by a colleague external to the research to reduce risk of bias. Each answer was scored using the same system as described in Section 2.6 ('*Yes*': 1 point, '*Can't Tell'*: 0 points, '*No*': 0 points; Boeije et al., 2011). The CASP score for this review was 9/10 (see Table 11).

Table 11

Quality Appraisal of SLR

CASP Criteria	Quality Appraisal	Rating

(incl. description)		
Section A: Are the Results of the Review Valid?		
Did the review address a clearly focused question? ***Consider:*** *1) The population studied, 2) The intervention given, 3) The outcome considered*	✓ The SLR addressed a specific question, information on how question was developed (incl. breakdown of population, intervention, and outcome) can be found in Chapter 2 (Section 2.2)	1
Did the authors look for the right type of papers? ***'The best sort of studies' would:*** *1) Address the review's question, 2) Have an appropriate study design (usually RCTs for papers evaluating interventions)*	✓ The SLR aimed to understand the *experience* of carers, thus qualitative articles were included (and mixed-methods articles, looking at qualitative section only) ✓ The results of this SLR appropriately answer the research question × It is possible that there are carer experience surveys using quantitative data which could have deepened the understanding of the carer experience if included in this SLR	1
Is it Worth Continuing?		
Do you think all the important, relevant studies were included? ***Consider:*** *1) Which bibliographic databases were used, 2) Follow up from reference lists, 3) Personal contact with experts, 4) Unpublished as well as published studies, 5) Non-English language studies*	✓ The author has outlined all databases included in this study Chapter 2 (Section 2.3) ✓ The author has included detail around searching references lists Chapter 2 (Section 2.4) ✓ The author discussed re-checking the databases later on in the SLR process for newer published papers × The researcher did not have contact with experts in the field as part of this SLR × Unpublished articles were not included in this SLR however, rationale was given as to why this was Chapter 2 (Section 2.3)	0

	× Non-English language studies were not included in this SLR however, rationale was given as to why this was Chapter 2 (Section 2.3)	
Did the review's authors do enough to assess quality of the included studies? ***Consider:*** *The authors need to consider the rigour of the studies they have identified*	✓ All studies included in the SLR were quality appraised using the CASP tool for qualitative research; two articles which did not meet the CASP criteria were removed following quality appraisal (Magne-Ingvar & Öjehagen, 1999b, 1999a) to ensure a strong rigor	1
If the results of the review have been combined, was it reasonable to do so? ***Consider:*** *1) Whether results were similar from study to study, 2) Whether results of all the included studies are clearly displayed, 3) Whether results of different studies are similar, 4) Whether reasons for any variations in results are discussed*	✓ The results are similar from study to study, this has been explained through the thematic synthesis ✓ The results of each study are clearly outlined in the data extraction table Chapter 2 (Section 2.5) ✓ Variations are discussed by outlining how many studies supported with each subtheme in the thematic synthesis, expected variations are also discussed (e.g., with reference to the different legal contexts)	1
Section B: What are the Results?		
What are the overall results of the review? ***Consider:*** *1) If you are clear about the review's 'bottom line' results, 2) What these are (numerically if appropriate), 3) How were the results expressed (NNT, odds ratio etc.)*	✓ The results are clearly expressed as you would expect for a qualitative review; results are also reiterated in the discussion section	1

How precise are the results? ***Consider:*** *1) Confidence intervals, if given*	✓	The results are as precise as qualitative results can be, there will always be a level of subjectivity due to interpretation biases; the researcher has included reflections throughout the SLR to demonstrate work completed to manage biases	1
Section C: Will the results help locally?			
Can the results be applied to the local population? ***Consider:*** *1) Whether the patients covered by the review could be sufficiently different to your population to cause concern your local setting is likely to differ much from that of the review*	✓	Although the sample is international, the results have implications for local samples; the findings of this review are relevant to anyone working in the suicide prevention space	1
Were all important outcomes considered? ***Consider:*** *1) Whether there is other information you would like to have seen*	✓	All important outcomes appear to have been considered	1
Are the benefits worth the harms and costs? ***Consider:*** *1) Even if this is not addressed by the review, what do you think?*	✓	There are huge benefits to this review as there is such little research in the area, this SLR collectively shows a need for change	1
			Total Rating
			9/10

2.11 Conclusion

This SLR aimed to build on the previous work of Lavers et al. (2022), consolidating and critically appraising existing literature to understand the experience of informal caregivers seeking and engaging with support provisions when caring for somebody who has experienced suicidal ideation and/or has made a suicide attempt. This SLR aimed to amplify the voices of an under-represented population in the literature. Better understanding their experience can give valuable insights to help academics and clinicians make recommendations for targeted change/adaptations to existing services, and for the development of new services to better supports carers. This SLR found that carers desire to work alongside healthcare professionals, that there are psychological barriers that prevent carers feeling as though they can reach out for support, and that connection is vital for a positive carer-experience of seeking/engaging with support. Recommendations are made as to how carers can be supported by professionals to overcome some of the psychological barriers to support experienced, and to enable professionals to work better alongside carers, suggesting directions for future research.

2.11.1 Rationale for Current Study

The current study was developed in line with the *Invitations for Future Research* outlined in Chapter 2, Section 2.9: *"Qualitative studies are needed to better understand the intricacies of the caregiver role".* The SLR results highlighted how much of the wider experience of informal carers supporting a loved one following a suicide attempt is unreported. This is in part due to the *Psychological Barriers* (outlined in *Theme 2)* which lead to carers feeling silenced, and as if they cannot share their stories openly. The empirical study which occupies the remainder of this thesis was developed holding this in mind, and a specific focus was put onto what has been unreported in literature so far. The empirical study focuses on the *unspoken narratives* of informal caregivers supporting somebody following a suicide attempt. A specific focus on the *unspoken* was developed with the aim of opening up conversations hidden by the *psychological barriers.* What has previously been *unspoken* and what has previously been *unreported* are comparable, as if a narrative has not been shared before, it could not have been reported on.

Aims and Research Question. The current study aimed to explore the following research question:

What unspoken narratives exist for informal caregivers who have supported a loved one following a suicide attempt?

Chapter 3: Methodology

3.1 Chapter Overview

The purpose of this research is to identify and explore the unspoken narratives which exist for caregivers who have supported a loved one following a suicide attempt, shedding light on the experience of this hidden population. This chapter begins with a statement on positionality, reminding the reader of the lens through which the research was conducted. The chapter then moves on to describe the research process, focusing on research design, ethical considerations, consultation, recruitment strategy, and participants.. Methods of data collection and analysis are presented. The chapter ends with a quality appraisal, and a statement on researcher reflexivity.

3.2 Theoretical Perspective, Ontology and Epistemology

As discussed in Chapter 1, this research was conducted from the theoretical perspective of CR which is situated within a realist ontology, and a relativist epistemology (Stutchbury, 2022). The methodology employed aims to facilitate an understanding of the shared experiences that are the unspoken narratives of caregivers who have supported a loved one following a suicide attempt. Any data that is presented in this research will not be presented as the *truth* but instead as my interpretation of the shared, subjective experiences of the participants. My interpretation is influenced by the various lenses I wear (e.g., age, race, gender), and the various positions I occupy (e.g., student, research team member, insider researcher); as such, I have opted for a methodological approach which values the subjective experience of the researcher, as oppose to one that makes attempts to neutralise it (Braun & Clarke, 2006, 2019).

3.2.1 Positionality

As discussed in Chapter 1, I approach this research as an insider researcher meaning that I have direct experience of the experience that I am researching. My position as an insider researcher was shared with the participants through the participant information form, it was not discussed with the participants outside of this context.

I hoped that my insider researcher position would be advantageous in that participants would feel more at ease sharing their stories with me due to shared/similar experience. Shared experiences between researcher and participant has been shown to build trust in qualitative interviews (Roberts & Chisholm, 1988). However, I was also mindful that shared experience could lead to assumptions not being challenged, ‘obvious’ questions not being asked (Hockey, 1993), and ‘norms’ not being explicitly articulated (Platt, 1981).

Bracketing. A major criticism of the insider researcher position is the inherent subjectivity which exists subsequent to the pre-existing knowledge the researcher holds. The position of the insider researcher is often viewed on a continuum based on the amount of characteristics shared between researcher and participant (Griffin, 1985). I entered this research with an awareness that my own story would be more closely aligned with some participants than others, and that this may influence my interactions. I employed bracketing to help keep a conscious awareness of my own internal process and biases throughout the research process (Tufford & Newman, 2012). A breakdown of my engagement with bracketing in this research can be found in Chapter 1, Section 1.2.

3.3 Design

3.3.1 Qualitative Methodology

The qualitative method aims to explore the subjective phenomena that is the human experience (Austin & Sutton, 2014). The method leans into the idea of ‘intersubjectivity’, a concept encompassing the way individuals construct and attach meaning to specific social or human problems (Creswell, 2014; Todd et al., 2004). Qualitative research has a rich history in advancing the study of human behaviour (Agius, 2013). Its phenomenological approach encourages exploration into the intricacies and nuances that are *simply* being human, whilst respecting and valuing individual difference (Hedge, 2021).

Qualitative research falls within the philosophical paradigm of ‘interpretivism’ (Schwandt, 2005), which takes an ontological position of ‘experienced world’ (Habermas, 1978; Lather, 1991) and an epistemological position of ‘multiple truths’ (Habermas, 1978; Lather, 1991). These positions fit with the lens of CR through which this research was conducted (Archer et al., 2016; Bhaskar, 2008, 2015). CR does not claim an objective truth, but instead accepts multiple truths through the understanding that the knowledge we have as individuals is subjective, subsequent to personal interpretations and perceptions that have been developed through our own experienced worlds (Stutchbury, 2022).

Rationale for Qualitative Design. The qualitative method was deemed the most appropriate design for this piece of research as the research question seeks an understanding of the human experience, as opposed to searching for a quantifiable answer which is typically associated with quantitative methodologies (Rana et al., 2021).

The topic area for this research is sensitive, and the population of interest are not often given space in academic literature to share their experiences. This further informs the rationale for the research design, as qualitative methodologies provide safe spaces for these stories to be told, with a wealth of literature outlining therapeutic benefits for participants who choose to take part (Dennis, 2014; Hebenstreit & DePrince, 2012; Lowes & Gill, 2006). The semi-structured interview structure employed provided a framework, with boundaries which had additional benefits for both participant and researcher; as both were prepared for the remits of the conversation, allowing them to plan for the types of conversations which would arise (Corbin & Morse, 2003).

3.3.2 Reflexive Thematic Analysis

Reflexive thematic analysis (RTA; Braun & Clarke, 2006, 2013, 2019) was chosen as the qualitative analytic method. RTA is an approach to qualitative data analysis which helps researchers identify, analyse, and report on themes across a dataset through a six-step method (Braun & Clarke, 2006).

RTA respects the power of the researcher in the data analysis process, and with this acknowledges researcher subjectivity. Instead of trying to minimise subjectivity, RTA invites the use of reflexivity to transform it into a tool which can be consciously and actively utilised (Devine, 2021). Reflexivity is a conscious awareness of the researcher's role and the lens' they bring to the research process; it involves delving into one's personal experiences, pre-existing knowledges, and positionality (Haynes, 2023). Braun and Clarke (2006, 2013, 2019) encourage researchers to "*critically interrogate*" how their subjectivity may be interacting with, and influencing on, the data analysis process (Devine, 2021). Given the researchers position as an insider researcher, reflexivity throughout the research process was crucial in ensuring credibility of any results yielded (Saidin, 2016).

Strengths and Limitations of Reflexive Thematic Analysis. Table 12 details some of the strengths and limitations of RTA.

Table 12

Strengths and Limitations [or Opportunities and Challenges (Braun & Clarke, 2022)] of RTA

Strengths (Opportunities)		Limitations (Challenges)	
Flexibility / Theoretical Freedom	• RTA has been described as having 'theoretical freedom' as it is not tied to a specific theoretical framework, meaning that it can be adapted to suit the needs of the researcher, and the research being conducted (Braun & Clarke, 2006; King, 2004; Nowell et al., 2017).	Flexibility / Theoretical Freedom	• Although 'theoretical freedom' can be described as a strength, it can also lead to inconsistencies and a lack of coherence when developing themes (Holloway & Todres, 2003). • The broad applicability subsequent to the flexibility of method can be overwhelming and lead to "analytic paralysis" in newer researchers (Braun & Clarke, 2022).
Transparency	• Due to the value placed on reflexivity, RTA is an extremely transparent form of qualitative data analysis (Harper & Thompson, 2011). This means that other researchers can scrutinise the steps taken by the primary researcher (Kiger & Varpio, 2020), increasing the overall reliability of results.	'Too Simplistic'	• RTA has been viewed as 'too simplistic' as it does not include space for the researcher to consider the language practice and semantics of the participants (Braun & Clarke, 2006; Nowell et al., 2017).
Accessibility	• RTA is user friendly. Its step-by-step guide ensures that it is accessible to researchers at any stage in their career (Braun & Clarke, 2022).	Reporting Contradictions	• The development of themes across a dataset means that it can be difficult for the researcher to accurately capture any contradictions or

- RTA themes (or results) are reported in a way that is accessible to the general public (Braun & Clarke, 2022).	differences in opinion between individual participants, particularly in larger samples (Braun & Clarke, 2022).

Alternative Methods. Other qualitative analytic methods were considered for this research however, RTA was deemed the most appropriate. Table 13 details why other analytic methods were not chosen.

Table 13

Rationale for Choosing RTA

Qualitative Analytic Method	Description	Reason for Rejection
Interpretative Phenomenological Analysis (IPA; (Smith & Osborn, 2003)	• A theoretically bound approach, epistemologically underpinned by phenomenology and hermeneutic inquiry (Breakwell et al., 2012). • IPA views individuals as 'self-interpreting beings' (Taylor, 1985), and is centred around understanding the human lived experience.	• Samples are typically small (e.g., 5-8 participants; Smith & Osborn, 2003). • IPA focuses on the individual characteristics of participants, making it unsuitable for this research.
Narrative Analysis (Bamberg, 2012)	• An approach that focuses on the stories that individuals tell, or the account they give. • There is a focus on how the story has been organised as a way of making sense of a lived experience (Riessman, 2007). • There is an interest in the way certain stories are privileged over others (Wells, 2011). • The participant is encouraged to engage with full reflexivity in their story-telling (Breakwell et al., 2012).	• The aim of this research was not to gain an extended account of individual experiences, but to instead gain an understanding of shared experiences.

Template Analysis (King, 2004; King et al., 2018)	• A form of thematic analysis that is theoretically flexible. • The analytical process centres around the development of a 'coding frame', or 'template'. • Reflexivity is acknowledged and encouraged. • Themes are organised into a hierarchy.	• The final themes are presented as descriptive summaries (or topics) as oppose to an interpretation of the dataset (Braun & Clarke, 2022). • The codebook (or template) felt limiting to rich, meaningful theme development.

3.4 Ethical Considerations

This research received favourable ethical opinion from the University of Hertfordshire Research Ethics Committee (protocol number: LMS/PGR/UH/05362; Appendix J). The research was conducted in accordance with the British Psychological Society's Code of Human Research Ethics (British Psychological Society [BPS], 2021a) which supplements the general ethical principles outlined in the Society's Code of Ethics and Conduct (BPS, 2021b).

The following ethical considerations were outlined in the participant information sheet and were also discussed at the beginning of each interview.

Informed Consent

A brief description of the research project was sent to the participants initially through the advertisement poster at the point of recruitment, and then through the participant information form at the first point of contact. Participants were asked to sign a consent form prior to the interview being conducted.

Confidentiality

All participants were assured that any data obtained from them would be kept confidential, they were reminded of their right to refuse to disclose any information which was private to them. The researcher ensured that all data obtained respected the dignity and autonomy of the participants, and did not violate their interests (Bos, 2020). Participants were also informed of the limits to confidentiality, and assured that if confidentiality needed to be broken, this would be done in accordance with the BPS Code of Conduct (BPS, 2021b).

The right to confidentiality in research is recognised under European General Data Protection Regulation (GDPR, effective 2018). The consent forms, interview recording, and transcript were stored on the University OneDrive which is encrypted for the purposes of data protection.

Anonymity

In qualitative research, anonymity has been described as the degree to which participants are identifiable (BPS, 2021b). Participants were informed that their data would be stored anonymously. Any personal information (e.g., demographics) was saved electronically on the University of Hertfordshire OneDrive under a ‘participant number’, separate to where the interviews were saved. Interview transcripts were anonymised with identifiable information (e.g., names, places) removed prior to them being shared with the research team (supervisors and secondary researcher).

Right to Withdraw

Participants were advised of their right to withdraw from the research at any point up until their interview took place. Participants who took part in the study were reminded that they had the option to withdraw their data from the research, without justification, up until two weeks after their interview date. Any data obtained and then withdrawn would be destroyed.

Psychological Distress

Protection of the Participants. A distress protocol was developed to help manage any emotional distress which arose during the interview. The protocol (Appendix Ki) instructs the researcher to offer a break, draw on therapeutic skills, remind the participant of their right to withdraw, and check-in with the participant before they leave the interview. In the case of extreme distress, the research supervisor would be contacted. At the end of each interview, regardless of distress level, participants were provided a debrief sheet (Appendix L).

Protection of the Researcher. A second distress protocol was developed (Appendix Kii). The protocol instructed the researcher to ensure that the supervisors were aware of the date and time of each interview, and were contactable. It also advised de-brief sessions to take place after each interview, facilitated by the secondary researcher.

3.5 Consultation

Consultation was invited and encouraged at every stage of the research process (Table 14). Together, seven consultants formed an advisory panel; details on this are interwoven throughout this Chapter. All consultation occurred via the Microsoft video conferencing platform, MSTeams.

Table 14

Engagement with Consultation

Research Stage	Task	Who?
Scoping Exercise	• To advise on gaps in service provision. • To advise on ways to access and effectively engage the population. • To advise on the use of language around suicide, and help develop key terms table with definitions.	16 informal network meetings (Please see, Section 3.6)
Methodology	• To review the consent form.	‘Advisory panel’:

	• To review the participant information from. • To review the de-brief form. • To review the interview schedule. • To review the advertisement poster.	• **Invited:** Three charities, four EbE • **Attended:** One charity, three EbE
Data Collection	• Pilot Interview	One EbE
Data Analysis	• To discuss/review codes. • To discuss/review themes.	• **Invited:** Three charities, four EbE • **Attended:** None - There was no response to the invitations
Discussion	• To discuss themes in relation to existing literature.	• **Invited:** Three charities, four EbE • **Attended:** None - There was no response to the invitations
Dissemination	• To advise on effective methods of dissemination. • To advise on any challenges that might arise in relation to dissemination / accessing the population of interest.	• **Invited:** Three charities, four EbE • **Attended:** None - There was no response to the invitations

Notably, there was huge interest in consultation initially, but this became more challenging with time. It is not uncommon in research for this pattern to occur. An investigation into public health research specifically found that when research becomes more ‘academic’ (possibly as it did in this study when consultation opportunities included reviewing codes and themes) consultants can feel ill-equipped and opt to step away from the role (Graham et al., 2001).

A Moment for Reflection

I was quite upset when the consultation dropped out of the research process. As much as I understand that these things do happen in research, I also considered my role as a researcher and whether I could have done anything differently. I think initially I was making a lot of effort to set up networking opportunities, and perhaps took these connections for granted once they had been made. There was a fair period of time between Data Collection and Data Analysis – Longer than I had anticipated at first – I wonder if I should have made more effort to stay in contact with the consultants and give regular updates on progress to keep the relationships more active. I also wonder if being more pro-active in researching patterns of consultation earlier on would have been helpful; if I had been aware of Graham et al.'s (2001) study earlier on I would have made more concerted efforts to break down the consultation tasks/offer training so that consultants felt more supported.

3.6 Recruitment

3.6.1 Recruitment Strategy

It was hypothesised that recruitment to this research could be challenging due to the area of interest being sensitive; participants may be hesitant in coming forward to share their stories due to the psychological barriers, highlighted in Chapter 2. A detailed recruitment plan was developed to assist in considering and overcoming challenges (Kristensen & Ravn, 2015).

The first step in a successful recruitment strategy is to become familiar with the population of interest (Coyne et al., 2019). As such, Google was used to find local and national charities and services which support individuals who have been affected by suicide. Thirteen charities were contacted through their websites, 11 Instagram profiles (consisting of four charities and seven individuals) were contacted via direct message, one professional academic, and one professional suicide prevention lead were contacted via email. Initial contact messages shared information about the research, and invited individuals to get in contact with the lead researcher via email if they wanted to hear more. Sixteen responses were received: 14 responses from charities, one response from the professional academic, and one from the professional suicide prevention lead. Following meetings with various individuals from different charities and services, three (two charities, and the professional suicide prevention lead) agreed to advertise the research on their platforms; a further three charities agreed to be involved in the research through a consultation capacity. The first step in the recruitment plan provided awareness of what was ‘out there’ already for the participants in terms of support services. It also provided space for vicarious learning from passionate individuals who had worked in the field for many years, and were willing to offer advice on how to effectively engage future participants.

Subsequent to the emails and messages sent, the research attracted a lot of attention from professionals and those with lived experience of suicide (otherwise referred to as EbE) who offered their support in a consultation capacity. As well as the three professionals mentioned above, four EbE were recruited to be consultants in the research. Two of the EbE approached Dr Farah Dauhoo (secondary thesis supervisor) in her workplace; and a further two were recruited from one of the charities supporting the research. Together these seven individuals formed the advisory panel (mentioned earlier).

The next step in the recruitment strategy involved inviting the advisory panel to review draft versions of the research advertisement poster, consent form, participant information form, debrief form, and interview schedule. Following this meeting, suggested changes were made in line with the recommendations made. The suggested changes related to the terminology used around suicide (advising against “completed/non-completed” suicide terminology as this can feel as though there is a pass/fail element to the act), considerations around how to open the interview (advising against opening the interview with asking about the relationship between carer and suicidal person, as it can feel intrusive/blaming to begin this way), and the colour of the advertisement poster (advising on the use of blue and purple as this is associated with suicide awareness).

3.7 Participants

3.7.1 Sampling

The sampling techniques used were convenience sampling and snowball sampling. Convenience sampling is a form of non-probability sampling in which data is collected from participants who are readily available, and accessible to the researcher (Golzar et al., 2022). Snowball sampling was used as a secondary method of sampling to aid recruitment. Snowball sampling has benefits when the population is 'sensitive' or 'hidden' (Naderifar et al., 2017); participants are invited to share the research and encourage further participation from others whom they believe would be suitable to take part (Biernacki & Waldorf, 1981).

In step three of the recruitment strategy, poster advertisements were sent to the relevant charities/services for them to post to their platforms (Appendix M). Advertisements first went live in early-July 2023 and were re-circulated in late-August 2023.

3.7.2 Participation Criteria

The inclusion and exclusion criteria for participation are shown in Table 15.

Table 15

Recruitment – Inclusion and Exclusion Criteria

Participant Inclusion Criteria	Participant Exclusion Criteria

• To be over the age of 18 • To be a resident in the UK. • To be English speaking. • To have experience of supporting someone a laced one, following a suicide experience. • The suicide attempt must have taken place more than six months ago (this allows for an extended period of 'watchful waiting'; NICE, 2018). • The participant must have had the belief that their loved one's intention was to die.	• The 'loved one' has made multiple suicide attempts. • The participant, or 'loved one', are personally known to the researcher.

3.7.3 Participant Demographics

Participants expressed interest in the research by emailing the lead researcher via the email address given on the advertisement poster. Once expression of interest was received, the lead researcher sent the participant information form (Appendix N) and asked potential participants to review the information and get back in contact should they wish to participate. The participant information form detailed the inclusion criteria, and participants were asked to check their eligibility against this.

Twenty-three people expressed interest in participating in the research and were sent the participant information form. Sixteen participants agreed to take part in the research after reading this, three declined (two reported to not meet the eligibility criteria, one reported to be incapacitated), and four never responded (a follow-up email was sent three weeks after the initial email and gave a further two weeks for individuals to respond before their place would be given to someone else).

Sixteen participants were scheduled for interview and were sent the interview schedule (Appendix O) so that they knew what to expect on the day. Participants were also sent the consent form (Appendix P) and asked to return this prior to the interview date. Two participants withdrew from the research prior to their interview taking place (one reported to no longer have the time to take part, and one reported that they had re-reviewed the inclusion criteria and discovered they were not eligible). The final sample was 14. Participant demographic information, as well as details on their relationship to their 'loved one', are presented in Table 16.

Table 16

Participant Demographic Information

Pseudonym	**Age**	**Gender**	**Ethnicity**	**Geographical Location (Within the UK)**	**"The loved one was my…"**	**Approx. how long ago did the experience occur?**
Abigail	52	Female	White Caucasian	South-East	Uncle	20 years
Elizabeth	49	Female	White British	South-East	Son	7 years
Harry	60	Male	White Irish	South-East	Friend	1 year
Jane	50	Female	White British	Midlands	Daughter	4 years
Noah	52	Male	White British	South-East	Girlfriend	10 years
Alice	65	Female	White British	North-West	Sister	29 years
Camila	48	Female	White European	East Midlands	Daughter	8 years
Harper	26	Female	White British	South-East	Brother	7 years
Ruby	57	Female	White British	East	Son	2 years
Grace	55	Female	White Irish	South-West	Daughter	6 years
Daniel	41	Male	White British	Midlands	Friend	15 years
Quinn	53	Female	White British	North	Husband	5 years
Sofia	77	Female	White British	North-East	Son	25 years
Evie	60	Female	White British	South-East	Son	5 years

3.8 Data Collection

3.8.1 Resources

All 14 interviews were scheduled to take place online, via MSTeams. Due to technical issues on the day, two interviews ended up being conducted via telephone. Of the 12 interviews conducted using MSTeams, 11 participants opted to have their video on, one opted to have their video off. All 14 interviews were recorded using MSTeams. For the two interviews which were conducted over the phone, MSTeams was running in the background to record the audio. All recordings were saved on the University of Hertfordshire OneDrive and encrypted for data protection purposes. The interviews were transcribed verbatim on Microsoft Word (transcript extract, Appendix Q). NVivo 14 (QSR International, 2023) was used in analysis of the transcripts.

3.8.2 Interview Schedule

Interview Schedule Development. A semi-structured interview schedule was developed in conjunction with the secondary researcher. Semi-structured interviews allow flexibility in the interviewer’s line of questioning, encouraging the researcher to explore and “go deep for discovery” through the discussion of different topics (Dempsey et al., 2016). This flexibility often leads to free-flowing conversation between the interviewer and participant, making the interview itself feel more informal and less structured, which has been found to be beneficial when discussing sensitive topics (Smith et al., 2022).

The interview schedule was broken down into four sections: 1) relationship to person, 2) experience of suicide attempt, 3) unspoken narratives and, 4) support. The sections were developed to help facilitate a well-rounded, coherent interview experience for each participant whilst ensuring that the research question was being answered meaningfully and effectively. The decision was made to end with questions focusing on support as these felt less intrusive to participants comparably; the questions bought a strengths focus, asking about what was helpful during the experience. The drafted interview schedule was shared with the research supervisors, and suggested changes were made relating to the order and wording of questions.

The final step in interview schedule development was sharing it with the consultants. A meeting with the advisory panel was facilitated by the lead researcher and secondary researcher where the interview schedule was discussed and reviewed. The panel made suggested changes (described in Section 3.6) which were followed. The interview schedule was then sent the ethics committee where it was approved to use in the research.

Pilot Interview. A pilot interview was conducted with one of the EbE consultants. The pilot interview allowed the researcher to become familiar with effective and skilful interviewing (Dempsey et al., 2016), whilst also gaining feedback on how the questions were landing with participants. It also gave a sense of timings, and some thought was given to different prompt questions. There were no further changes made to the interview schedule following the pilot interview.

3.8.3 Interview Procedure

The researcher joined the MSTeams link 5 minutes prior to the time the interview was set to begin to ensure there were no technical issues. The participant was kept in a virtual waiting room until the time of the interview.

When the participant was let out of the waiting room, introductions were made, and the participant was given the opportunity to ask any questions or share any worries/anxieties they had. The consent form was reviewed to ensure everything had been understood. Anonymity, confidentiality, and participant right to withdraw were re-explained to the participant. The recording was started, and participant demographic information was taken before formally starting the interview.

Before closing the interview, the interviewer checked all questions had been asked, and gave the participant space to offer anything they felt was relevant but had not disclosed. All participants were thanked for their time, asked whether they would like to be kept updated with the research process, and sent a de-brief form. All participants opted to be kept updated on the interview process and consented for the email addresses used on their consent forms to be stored on the University OneDrive to contact them in future. The following update emails were sent:

- To let participants know when all data had been collected.
- To outline the themes which had been developed from the dataset.
- To outline the clinical and practical implications which have been recommended in the write-up.

A further email will be sent with information on dissemination when these plans have been secured (e.g., with specific publication details).

3.9 Data Analysis

The anonymised transcripts were analysed using RTA (Braun & Clarke, 2006, 2013, 2019) using NVivo 14 (QSR International, 2023). The data analysis was carried out in accordance with the six-step framework set out for effective RTA (Braun & Clarke, 2006, 2013), and a breakdown of this can be seen in Table 17.

Table 17

Six-Steps to RTA (Braun & Clarke, 2006, 2013, 2019)

RTA Phase	Researcher Role
Phase 1: Data Familiarisation	The researcher listened to each interview audio recording and read each interview transcript a number of times to become immersed in the data. Transcripts were printed, and for each interview the researcher recorded initial thoughts, ideas, and trends. These annotations were developed

	into ‘familiarisation doodles’ (Braun & Clarke, 2013); a sample of these doodles can be found in Appendix R.
Phase 2: Generating Initial Codes	Each transcript was coded by the lead researcher using NVivo 14 (QSR International, 2023), transcripts were read verbatim and initial codes and code labels were developed (Appendix S). The lead researcher aimed to code all words and phrases related to the research question. Initial codes were shared with the secondary researcher to who facilitated a reflective session to highlight any possible biases. The lead researcher then randomly selected four audio recordings, and second coded these transcripts whilst listening along to the recording. Following the completion of a second coding period, 198 codes had been developed.
Phase 3: Generating Themes	The 198 code names were written onto post-it notes. As they were being written, the associated quotes were reviewed to see how the code/quote related to the research question. Any codes/quotes that did not relate to the research question were removed. Following this process, 129 codes remained. The 129 post-it notes were then grouped in ways that demonstrated shared meaning/patterns across the dataset. Thematic maps were developed (Appendix T), which led to the generation of six themes, each with subthemes. These were shared with thesis supervisors for consultation.
Phase 4: Reviewing Potential Themes	Over time, distinct themes were constructed from the data. The lead researcher, and the secondary researcher, reviewed and discussed the themes and subthemes at length. Each theme was discussed in relation to the research question, their coherence, and their ability to represent meaning.
Phase 5: Refining, Defining and Naming Themes	The lead researcher, in consultation with the secondary researcher, refined, defined, and named themes. Each theme was organised and named in relation to the quotations it was representing, and quotations were reviewed to ensure each theme had a coherent narrative. These themes were then presented to thesis supervisors for consultation and review. At this point, the six themes described in *Phase 3* had been collapsed into five themes, not all of which had subthemes.

Phase 6: Write-Up	A lot of thought was given about how to represent the themes visually, as it felt important to not represent themes as a linear process. It was decided to use a metaphor which was used by one of the participants to help visually depict the themes in a way which felt meaningful, and accurately represented the journey of participants.

A Moment for Reflection

My biggest challenge throughout this entire thesis was the write up of results – Both the SLR results and the main study results. For a long time, I believed this was because it was a different style of writing, and that the writing style just didn't fit with the way my brain works, but the more I thought about it, I wondered if this was more to do with my position as an insider researcher. I recognised where I related to the themes and the quotes, and also where I did not relate. I recognised that I was sharing my own story through the words of others, and I also recognised that I struggled to want to write the stories where I did not relate/connect to the themes. This realisation forced me to take a step back and take time away from the research for a short while.

3.10 Quality Appraisal, Validity and Self-Reflexivity

3.10.1 Quality Appraisal

Qualitative research is often critiqued for lacking scientific rigor (Noble & Smith, 2015). The critique is explained through a poor justification of the chosen method, limited transparency in the research with regards to the data analysis process, and the presence of researcher bias in the results (Rolfe, 2006; Sandelowski, 1993). A full quality appraisal of this research, addressing the common critiques can be found in Chapter 5, Section 5.7.

3.10.2 Validity and Reliability

Brink (1993) suggested that the threats to reliability and validity in qualitative research occur in four areas: 1) the researcher, 2) the subjects participating in the project, 3) the situational context, and 4) the methods of data collection and analysis. Table 18 presents an assessment of the validity and reliability, reviewing the qualitative method in the current study against Brink's (1993) criteria.

Table 18

Assessment of Validity and Reliability

Brink (1993) Criteria	Assessment of Validity and Reliability
The Researcher	• Researcher bias was at the forefront of thinking throughout this research, and as discussed at various points in this research study, bracketing was employed throughout the research process to stay conscious of and overcome bias where possible. • Brink (1993) believes that researchers should undergo training to be able to facilitate interviews in an objective way prior to facilitation. To be objective, in many ways, is built into the role of a psychologist thus, clinical skills built over the last 10 years would have assisted the researcher in this area.
The Subjects Participating in the Project	• To increase the validity of responses yielded, participants were given the participant information form and interview schedule prior to interview to ensure they were clear on the nature of the research. • Brink (1993) suggests that *member checking* should be used to increase the validity of results. Member checking was not used as an assessment of validity in this research as the method of data analysis chosen (RTA) is interpretive by nature and views the researcher as an active part of theme construction. Incongruence between the researcher and participant in RTA is not viewed as problematic (Varpio et al., 2017).
The Situational Context	• Participants were given an option as to where the interview was conducted (e.g., virtual, telephone, face-to-face). This was to ensure they felt as comfortable as possible during the

	interview, I hope that this would increase the likelihood of them speaking freely and openly. • Brink (1993) suggests that participant behaviour should be observed and noted during the interview; this was harder to assess as none of the interviews were completed face-to-face.
The Methods of Data Collection and Analysis	• Attempts have been made throughout Chapter 3 to be as transparent as possible with regards to the data collection and analysis process. A full assessment of this can be found in the CASP table in Chapter 5, Section 5.7. • Brink (1993) suggests that *triangulation* should be used to increase validity of results. Due to resource this was not possible; equally, when considering triangulation it was felt that it did not fit with the epistemological position of the research with triangulation fitting with more positivist thinking (Varpio et al., 2017).

3.10.3 Self-Reflexivity

Reflexivity is an ongoing process throughout qualitative research, and includes the ongoing reflection on personal assumptions, expectations, and actions (Finlay & Gough, 2003). I have made attempts to evidence reflexive thinking in the reflective extracts provided throughout this thesis, and through the bracketing exerts in Appendix A. Throughout this research, I felt constantly connected to my insider researcher position, viewing this as the fuel for my passion and positivity towards the project. However, it took me a little longer to connect the dots and recognise that this position also played a part in my challenges. Sometimes the project became too much, and I had to learn to break and take time for self-care. This was particularly important during the RTA process, which required ongoing thought and reflection (Braun & Clarke, 2019). I had to be mindful of giving equal space to the stories/themes I connected with, and the stories/themes I didn’t connect with. Regular supervision, discussion with the secondary researcher, and supervisors helped throughout the research process.

Chapter 4: Findings

4.1 Chapter Overview

This chapter presents the qualitative analysis of the 14 semi-structured interviews, using RTA (Braun & Clarke, 2006, 2013, 2019). Five themes and eight subthemes were developed from the data, and are illustrated throughout the chapter.

4.2 Presentation of Findings

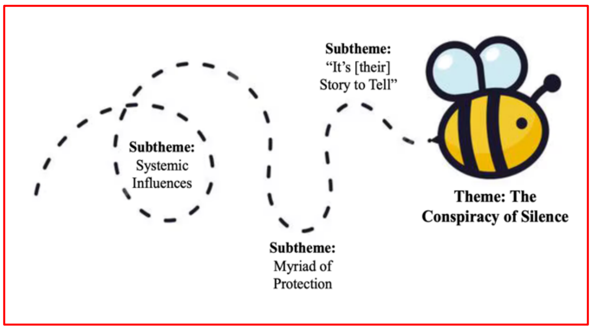
There is no explicit guidance on how the results of RTA should be presented, allowing researchers to be creative with how findings are disseminated (Braun & Clarke, 2006, 2013, 2019). The most common method of dissemination in a thesis is a *thematic table* (e.g., the way themes are presented in Chapter 2, Section 2.8). Thematic tables are useful as they are succinct and accessible; however, to the untrained eye thematic tables may also be understood to demonstrate a linear process; the assumption being that participants move through each theme and subtheme from left to right, following the visual route created by the themes on paper. With this consideration, to present the themes of this study in a thematic table felt like a direct conflict to the themes themselves. Each theme demonstrates part of the unspoken journey which exists for informal caregivers who have supported a loved one following a suicide attempt, and this journey is not linear.

> *"None of this recovery is a straight line, not for them [suicidal person] and not for us [carer]. I call it the flight of the bumble bee, you know. The recovery journey is literally like that, you know. It's like a bumble bee, it's going all over the place."*
> (Harry, friend)

Using Harry's metaphor, each theme and their corresponding subthemes will be presented through the "*flight of the bumble bee*". Please see Figures 6-10.

Figure 6

Theme: The Conspiracy of Silence



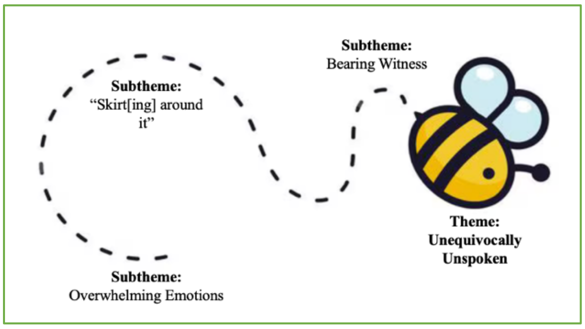
Subtheme: "It's [their] Story to Tell"

Subtheme: Myriad of Protection

Subtheme: Systemic Influences

Figure 7

Theme: Unequivocally Unspoken



Subtheme: Bearing Witness

Subtheme: "Skirt[ing] around it"

Subtheme: Overwhelming Emotions

Figure 8

Theme: A Sense of Responsibility

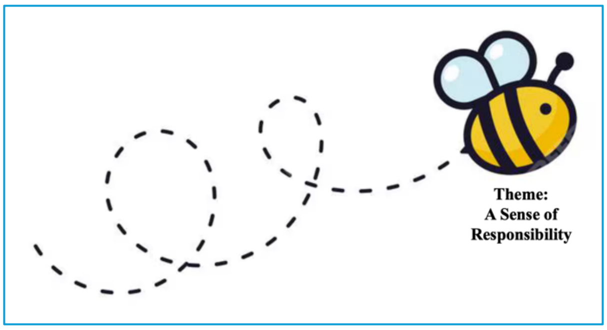


Figure 9

Theme: Making Comparisons

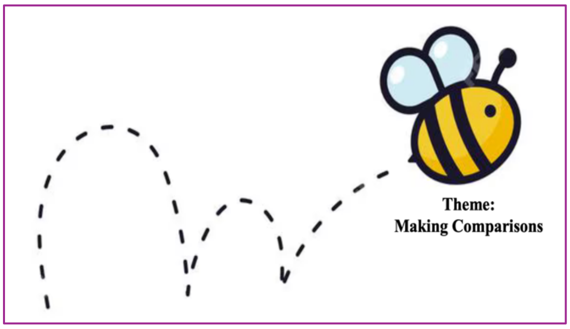
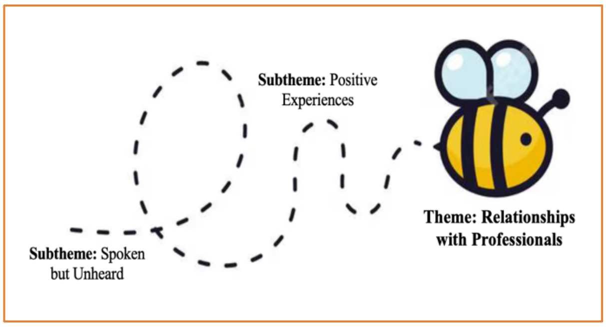


Figure 10

Theme: Relationships with Professionals



Subtheme: Positive Experiences

Subtheme: Spoken but Unheard

4.2.1 Theme: The Conspiracy of Silence

This theme captures the competing ideas, concepts, and influences which participants felt contributed to their experiences being 'unspoken'. Through three subthemes, this theme aims to give the reader their first insights into the unspoken narratives which exist for the participants, whilst simultaneously providing an overview of their perceived reasons as to why silence is upheld, and unspoken narratives exist.

The theme name was inspired by a participant who used the exact terminology, "*conspiracy of silence*". The word 'conspiracy' is defined as *"a secret agreement made between two or more people or groups to do something bad or illegal that will harm someone else"* (Cambridge Dictionary, 2024a). This reveals how participants make sense of the fact their narratives are unspoken, suggesting that participants feel as though the ideas, concepts, and influences outlined through this theme intentionally work together to ensure their narratives remain unspoken.

> *"...So, it's like a* ***conspiracy of silence****, I am being silenced."* (Evie, mother)

Subtheme: "It's [their] Story to Tell"

This subtheme explores unspoken narratives around story ownership, and subsequent feelings of powerlessness. Participants universally described how they felt they did not have ownership of the experiences which involved them stepping into the carer role, and acting in a carer capacity. Participants believed that the experiences belonged to the person who made the suicide attempt, and as such, carers did not feel as though they had the right to share any of what they had experienced with others.

> *"I know why it's hidden, and it's because [my husband's] still alive. And he wants to have a normal life. And it happened to him. So, he chooses what he wants to say… But if I say anything publicly and honestly. I'm telling his story. So, there's instant censorship there."* (Quinn, wife)

> *"I kept it to myself. I kept it in really, to be honest. […] I was probably… I feel like it's not my place to say anything. That's why, yeah. It's her journey and it's her story to tell. It's not mine as such."* (Daniel, friend)

Alice described how she would have felt if she had shared the experience with others. In the first quote, Alice is considering if she were to speak informally with friends, and describes this action as *"break[ing] their confidence"* and *"deceitful"*. In the second quote, Alice refers to a time where she spoke to professionals about her experiences and describes this as a "*betray[al]*". In both quotes, there is a sense of how deep-rooted these ideas around not owning the experience runs for carers, and the impact it would have on them if they were to share the story they did not own.

> *"I think the trouble is with/when someone like [my sister] tries to kill themselves... It's very difficult for people around to talk about it because you don't want to… You don't want to break their confidence, you know. They've entrusted you with what's theirs, their vulnerabilities, and if you share that… Then it's/you feel deceitful."* (Alice, sibling)

> *"I feel like I did betray her there. And it got me nowhere."* (Alice, sibling)

It is possible that ideas around story ownership link with ‘the medical model’, which has been the dominant lens through which mental health has been viewed in the West for centuries. The lens of the medical model is individualistic, placing the person deemed as ‘unwell’ at the centre of the story and therefore, provides them ownership of the experience. This was further exemplified when participants described how they interact with their own lived experiences of mental health. When participants themselves were deemed as ‘unwell’ they felt they had story ownership and therefore could share openly.

> *“It was easier for me to talk about my depression with people/with friends than it was to talk about anything that was happening with [my son]. Because that was/it… Because my talking about it was a direct choice that I was making.”* (Sofia, mother)

> *“No, I’ve never disclosed it [the carer experience] […] It’s only ever about my own issues.”* (Daniel, friend)

Not having ownership/control over their experiences likely left participants feeling powerless. This feeling of powerlessness was evidenced when some participants described how their loved one asked them to share falsehoods to hide the suicide attempt. The belief that this was their loved one’s story, meant that participants felt obliged to disseminate it in a way that their loved one saw fit.

> *“[My daughter] didn’t want people to know. So, we had... Obviously, once she got through it and we found out she was ok, you know, physically. We had to... Well, I had to concoct a make-believe story of why she was admitted, and why she was in high dependency for so long and everything else.”* (Camila, mother)

> *"And so, she went home, and literally within weeks, she was back at work and she told work that she'd had a tummy upset/a bad dose of food poisoning. So, to come on to discussing it afterwards, I... I just went with that, a tummy upset. It was very difficult because it was like I knew she didn't want me to [tell the truth], she wanted to just not look back, just go on."* (Alice, sibling)

Camila shared more details relating to the falsehoods, she uses the word *"had"* – she *"had"* to do this, she *"had"* to do that - further demonstrating the powerlessness that carers feel. It wasn't her story, and so she *had* to share only what the story owner would allow.

> *"We* ***had*** *to... Well, I* ***had*** *to concoct a make-believe story of why she was admitted, and why she was in high dependency for so long and everything else. So, I* ***had*** *to come up with the weirdest thing. So, we came up with… It was a very weird, mysterious viral infection! […] Yeah, and I* ***had*** *to put something on Facebook to tell all the family."* (Camila, mother)

Camila finished by touching on the emotional impact of not owning the experiences, the felt sense of powerlessness, and how these things combined uphold the *conspiracy of silence*.

> *"So again, you couldn't even tell somebody what you had gone through as a parent… That thing of how you nearly lost your child… And the turmoil, and the emotional hell that you go through because you've* ***had*** *to make a story up."* (Camila, mother)

Subtheme: Myriad of Protection

This subtheme considers unspoken narratives around protection. Each participant described a distinct need to protect either themselves, their loved one, and/or people they are in conversation with from distress which might be caused from sharing experiences related to caregiving (e.g., details of the suicide attempt). This unspoken desire to protect, worked to uphold the *conspiracy of silence*.

Participants collectively explained how they chose not to speak about their experiences directly with their loved one, believing that doing so would cause their loved one untoward distress. Carers described how they felt their loved one had been through enough without holding the added context of the carer's experiences.

> *"And I didn't want to bring it up because I didn't want to cause him pain."* (Abigail, niece)

> *"I'm not gonna bring up… I'm not gonna add any extra guilt or weight to what he's been through."* (Elizabeth, mother)

The carers desire to protect their loved one extended beyond direct conversations with them, to conversations with others. When in conversation with others, participants described how a desire to protect their loved one's reputation, and a desire to protect their loved one from the potentially problematic views of others, led to further silencing of their experiences.

> *"It was important to me that he wasn't seen as some sort of loser. […] Because I knew that would make it even harder for him. I didn't want to make anything harder than it already was."* (Evie, mother)

> *"I just felt I couldn't really talk much about it because she knew a lot of our friends. […] I didn't want them to see her differently. […] I was trying to protect her from what other people might think of her."* (Alice, sibling)

When reflecting on whether there was any form of *self-protection* involved in upholding the *conspiracy of silence,* some participants considered if they were protecting themselves from having to face what was *really* going on. These participants thought about how sharing their experiences with others would have led to them connecting with the difficult feelings they were experiencing; thus, by not sharing, they were protected from that.

> *"Maybe there is a fear that there's this huge reservoir of emotion, and that I'll unleash the floodgates and… You know, like I'm finding talking to you, there's a lot to be said, you know. And a lot to be processed, and maybe there is a bit of a fear of the feelings that are under there. They're quite huge, you know. And maybe I'm not ready."* (Alice, sibling)

For Harper, this extended a little bit further. Not only was she protecting herself from connecting with her "*sadness",* but she was also protecting her identity as she was worried about the impact of people finding out what she described as her *"dirty little secret".* An unspoken desire to self-protect prevented participants, such as Harper, from sharing their experiences.

> *"I just didn't want it to be who I was, I just so did not want that to be my identity, so I was really hesitant about, like, telling people. Because I'd had managed to build up a version myself, which was like, really fun loving and like always up for a laugh like*

> *all this stuff, like always going on the nights out, you know? And I didn't want to lose that. I didn't want to be the serious Harper, who has the sad life. [...] So, it was like the worst thing in my head that could happen was that my like dirty secret would come out that I was actually really sad, and then everyone wouldn't want to like hang out with me anymore, and then I'd be lonely..."* (Harper, sibling)

An awareness of the societal view and stigma around suicide, and how these contexts work to inform peoples thinking led to participants pre-empting that other people would respond in a way they would find offensive if they were to hear about some of the carer's experiences. Carers explained how a desire to protect themselves from these anticipated responses stopped them from talking to others.

> *"[You] don't know what people's attitudes are to suicide, and a lot of people think, even now, that it's selfish, it's wrong and you're inflicting pain on others. And I didn't… I never felt that about [my sister]. I never felt 'oh you've dragged me into your suffering!' I never felt that, so I wouldn't have wanted to hear from someone else… 'Oh, I think your sister's being selfish'. [...] I would have hated that if I'd had that reaction from someone."* (Alice, sibling)

> *"And explaining that to an outsider is… People's normal reaction is 'well, why are you still there?'. You know, 'why haven't why haven't you run away from this situation?' And that wouldn't have been helpful to me."* (Sofia, mother)

In both quotes, carers concerned themselves with the possibility of other people verbalising specific, unhelpful responses. Throughout the sample, carers more generally concerned themselves with the idea of non-specific, unhelpful responses. The expectations seemed to be that regardless of what was said, other people would not understand their experiences. Again, carers protected themselves from these expectations, which indirectly shut down conversations.

> *"I don't think anyone - Maybe I'm underestimating people's abilities - But I don't generally… People didn't have like, the emotional literacy to also give me the response that possibly I was seeking."* (Harper, sibling)

> *"This was a relational family thing. And people outside the family unit wouldn't understand it."* (Abigail, niece)

> *"People don't know how to respond. They don't know what to say."* (Grace, mother)

This expectation extended to me, the researcher. Prior to taking part in the research, Ruby sent me an email to ask more about me, and why I'm interested in the area. She justified this decision by alluding to the expectations that she held regarding negative responses from others.

> *"I needed to know where you are coming from as well because there can be insensitivity to this"* (Ruby, mother)

For some participants, expectations around *unhelpful responses* extended to become expectations around *unhelpful reactions.* Participants worried about what the consequence of sharing their experiences might be, assuming that other people would react in a way that impacted how they were viewed by the person they were in conversation with.

> *"[It was] easier just to show you the fun side of me, and keep that other bit away for as long as possible, because if people find out that bit then they might not want to be my friend anymore."* (Harper, sibling)

> *"I feel that other people will judge me because actually 'if you were a good enough mother, your daughter wouldn't have wanted to do that'."* (Grace, mother)

The final segment of the *myriad of protection* is the protection of the person in conversation with the carer, the recipient of the information being shared. Almost all participants described a desire to protect the person receiving the information from experiencing distressing emotions.

> *"It was more protection for other people. They don't need that image."* (Jane, mother)

> *"I mean, you don't feel you can really share that with a lot of people, it might really upset them, you know. So, the fear of upsetting people, I think."* (Alice, sibling)

> *"I'm probably protecting other people about… Not wanting them to be shocked by that. It/that might be in a way, a bit traumatic to hear it."* (Quinn, wife)

Subtheme: Systemic Influences

Participants outlined several systemic influences causing them to feel as though they could not share their experiences. All participants alluded to how an awareness of wider societal norms, and societal perceptions of suicide/suicide attempts ensured that their narratives remained unspoken.

> *"Society's judgments as well and stuff like that. It makes you feel… It's like the peer pressure, type thing. Like you shouldn't talk about it. It's like the taboo in the room."* (Daniel, friend)

The societal context in question is the UK. Internationally, cultures are defined by their etiquette and accepted social interaction (Zhang, 2013). British culture dictates a level of courteousness and politeness at all times (Langford, 1997), and it is an awareness of this norm which likely contributed to participants feeling although it was 'inappropriate' for them to voice their experiences.

> *"It didn't ever feel like the appropriate place to like to bring it up."* (Harper, sibling)

> *"I haven't spoken about it particularly. […] I think it's just not appropriate."* (Jane, mother)

British societal and cultural norms appeared to act alongside generational norms. As well as participants feeling as though an appropriate context did not present itself for them to share their stories, they also seemed to feel as though generational norms dictated who it was, and was not, appropriate to share with.

> *"My dad is like the ultimate stereotypical male of that generation […] could not talk about any of it. […] We just can't go there so with him, like he was definitely someone that was like, it was just kind of, out of, almost out of bounds."* (Harper, sibling)

> *"It impacted sort of telling the wider family 'cause I think my Mum and Dad are probably of that generation that… You don't talk about your mental health. […] I just think that generation just don't, don't get it… This sort of stiff upper lip, isn't it? You just carry on regardless."* (Elizabeth, mother)

The 'stiff upper lip' is a metaphor which became popular in Victorian Britain, and is used to describe stoicism in the face of adversity (Boyce, 2012). Quinn attempted to challenge this metaphor, which perhaps indicates that participants did not want their narratives to be unspoken.

> *"My mother and stepfather came to visit me. […] They didn't go and see [my husband] [in hospital] but they managed to be in my kitchen for several minutes after this had happened, without saying anything. Without even mentioning his name. […] They were very middle class, very stoical, very sort of 'stiff upper lip' and massively didn't know how to handle the situation, or emotions generally. They weren't very good at that. And mostly we're all very polite about it, but I remember screaming at them and saying, 'What is the fucking matter with you? This horrible thing has happened' And I said, 'You can say his name, you know' And... 'Can't you just acknowledge it's happened?' And the worst thing, I think, was when people like them in that instance, weren't able to address it at all."* (Quinn, wife)

Quinn provides insight into the distress and anger felt by participants when they are forced to keep their stories unspoken.

For participants who were supporting their loved one through the pandemic, the rules and restrictions imposed by the UK Government acted as another method of systemic silencing. The pandemic meant that participants were not mixing as usual, and therefore, could not share their stories as openly, even if they would have normally chosen to.

> *"I wasn't socialising in the way I would have done before Covid. […] We weren't living our normal lives. We were all living, you know, at home. We weren't going out, you know, to suppers or whatever. All those normal activities where you would say, 'oh, my son's not well/[my son's] not well'."* (Ruby, mother)

All the above, contribute to the stigma existing around suicide, acting as the glue joining the conspiracy of silence. Participants described how the stigma attached to suicide led to them feeling as though they could not share their stories with others.

> *"Suicide has got one of the biggest, biggest stigmas going. It's something people cannot handle. […] They don't want to know it's the biggest killer of children. They just don't want to know. They want to ignore it. They want to just… 'No'… Just, 'That sort of thing doesn't happen'. Just brush it under the carpet."* (Camila, mother)

> *"People say there's no stigma now around mental health. That's rubbish. It's a fear of the unknown. People don't want to know what they can't see."* (Sofia, mother)

4.2.2 Theme: Unequivocally Unspoken

This theme details the parts of the carers stories which are *unequivocally* unspoken. The word *unequivocally* is defined as "*clear and unambiguous*" (Cambridge Dictionary, 2024b). Through three subthemes, this theme shares the carers narratives, which are clearly, and unambiguously, unspoken.

Subtheme: Bearing Witness

The subtheme *Bearing Witness* refers to the suicide attempt itself. For some participants, this refers to what they *actually* saw when they found their loved one; for others who were not present at the time of the attempt, it includes the intimate details of what they know to have happened. This subtheme will not share details on method, as this information is not relevant to sharing the unspoken narratives of the population. Where method has been mentioned in the quotes used, detail has been removed to protect the vulnerability of the person, and the wishes of the participants.

> *"I worry that people would be interested in gory detail, and it's sort of a bit fascinating in the same way that I sometimes watch stuff on TV with a kind of like… 'err' response. We/a lot of people do it, it's why we watch crime dramas and we're also obsessed with murder and gruesome things that we that we don't really want to have any contact with in our day-to-day life. I suppose I wouldn't want ever to think that anybody might be seeing my experiences in that way that they're sort of fascinated, in a gruesome way."* (Quinn, wife)

Quinn described how she did not share information regarding method because she worried that it would be attractive to others for the wrong reasons, touching on a societal interest in true crime documentaries. For some participants, details of method were described as unspoken due to them being aware of just how vulnerable their loved one was in the moment, and not feeling as though this should be shared more widely.

> *"I didn't talk about method with people. […] I wouldn't have gone into detail about what she'd done […] I don't think that's anybody's business."* (Jane, mother)

> *"So, there's things that she said that I just thought… God, where's she gone? So, so odd and… I guess, exposing, isn't it? And similarly, as I say, this whole thing [**reference to method**]. I haven't talked to anyone about that. […] When you think and hope that someone's gonna get better, you don't really want people to know."* (Alice, sibling)

In three of the 14 interviews, detail regarding method was not discussed at all. This ensured the narratives remained unspoken, even from the researcher.

Being aware of the persons vulnerability, and feeling as though this should not be shared more widely also features in Noah's story. Noah's partner struggled with alcoholism, and it is witnessing this that Noah chose to keep unspoken.

> *"What I chose not to share was the alcohol misuse. Because I think a lot of people wouldn't understand why she was alcohol dependent."* (Noah, partner)

When discussing why it was so difficult to talk about method, participants reflected on how talking about the realities of what happened impacted them. For many participants, talking about the realities of what happened put them in touch with the trauma of the experience, which made sharing too difficult to face.

> *"I don't wanna come back to it. Don't wanna keep going over it because every time you tell someone else, it brings it all up again."* (Noah, partner)

> *"I suppose the part that I perhaps might not share with people is… The detail of what he did, and what I saw. […] When I think about, sometimes I/for a while, I never had flashbacks but what I would have been… I would see that image. So not in the sense of thinking I was there, and smelling it, and experiencing it, not re-living. But the image would pop into my head, which I've… I've not really looked into that, but I'm guessing it's a form, you know, it's a form of trauma, a trauma response."* (Quinn, wife)

Participants explained initially how the details described in this subtheme had never been shared with another person. However, throughout each interview it became clear that this was not the case. For almost all participants, the unspoken narratives in this subtheme became unspoken over time. At the point the suicide attempt occurred, shock and adrenaline took over, and at this point, nothing was unspoken.

> *"And I hated my managers [at work], they were horrible people. And I think I told them how he'd done it, and I really regret that. I really didn't want to share that, but… I/At the at the time, I just couldn't believe what had happened, and I was just on auto-pilot sort of giving facts. So, I wasn't in a state of being able to… Filter what might be needed or appropriate.."* (Quinn, wife)

> *"My boss was next to me as well [when hearing the news of the suicide attempt]. So, I just obviously… I can't remember what I did, I just remember sort of… Throwing everything into my bag and just sort of saying to him 'I've got to go… Because [my son] has [**reference to method**].'"* (Elizabeth, mother)

Subtheme: "Skirt[ing] around it"

This subtheme refers to how some participants were observed not to use the word 'suicide', either in conversation with the researcher, or when they were describing interactions with others.

For Abigail, it was noticed that she did not use the word suicide throughout the entire interview. When answering the question early in the interview about her experience, she moved through the story with a pause where one would assume a reference to the suicide attempt might be made.

> *"That led to him to, sadly… [**pause**] Because they've been together 50 years…"* (Abigail, niece)

Harper answered the question about her experience in a similar manner, pausing and referring to when "*it*" happened, without being explicit as to what "*it*" was.

> *"He… [**pause**] So, **it** happened when he was at Uni. He… [**pause**] I guess he always struggled with his mental health."* (Harper, sibling)

Harper reflected on why it was difficult for her, and also her family, to use the word suicide.

She considered if this was because they didn't want to see her brothers suicide attempt for what it truly was, as this would have been too difficult to handle.

> *"I think it's just like to acknowledge it for what it actually was, it was too painful. So, we [family unit] just went for the alternative of... Yeah, '[my brother's] just'... I don't know, 'made a silly mistake, and he didn't mean to do it'."* (Harper, sibling)

Grace and Ruby (both mothers) used the word suicide when discussing the suicide prevention work they were involved in, and suicide prevention policy (Ruby) but did not feel comfortable using the word suicide when discussing the experience of caregiving, or the experiences of their children. Grace who had her own experiences of mental health difficulties used the word suicide to describe her own attempts; she used the word suicide once to describe her daughters, but reflected on how uncomfortable it made her feel.

> *"I would never have thought that she would have contemplated that. Even though I knew that she'd done, you know, even though I knew that she's got mental health issues [...] I never kind of made that, that kind of, link that actually, well you know she may try to commit suicide. I never even… Actually, saying those words is actually quite hard."* (Grace, mother)

Some participants described how the word suicide was unspoken between them and their loved one. For Grace, she chose to "*skirt around it*" and find other language. For Elizabeth, she didn't feel she could use the word until her son had used it first.

> *"I bought it up on/at/on probably about two or three occasions, and I sort of said, and I'd sort of say, 'oh, about that [**reference to method**] situation'. I'd kind of sort of **skirt around it** like that, and she would just knock me down, and say, 'I don't want to talk about it'. It was very much like that."* (Grace, mother)

> *"...And because he's not used the word suicide, I haven't felt as comfortable using it with him."* (Elizabeth, mother)

Subtheme: Overwhelming Emotions

This subtheme explores how the personal feelings of carers are often unspoken. The interviews revealed how carers are often forced to sit with difficult and uncomfortable feelings, which they cannot share with others. Participants described how the difficult feelings arose subsequent to the suicide attempt of their loved one, and often stayed active, with lasting emotional impact, for years to come.

Participants described how the story of their emotions/internal psychological processes were unspoken out of choice at the point the suicide attempt took place. Carers described how they did not feel they could cope with allowing their emotions to have space in the period of time which followed the suicide attempt. The carer's feelings were unspoken/silenced to others, but also unspoken/silenced to themselves whilst the adrenaline kicked in, took over, and helped them cope with the difficult circumstances.

> *"[There was a] barricade to accessing the emotional, as such. I was too busy on guard to be able to connect it to much emotionally really. So yes, it was like robot."* (Daniel, friend)

> *"I tend to be able to do the, that compartmentalising really well, but then once everything calms down that's when I find that I have the emotional response to it."* (Jane, mother)

When describing the feelings which were being hidden, many of the participants (particularly those who were positioned as mothers) expressed self-blame for the suicide attempt taking place. This is likely linked to Western norms attached to what it is to be a mother. Motherhood in the West is a highly individualised role, linked heavily with the unpaid care of one's children (Schmidt et al., 2023). A "good mother" is a mother who has raised happy and healthy children (Pedersen, 2016).

> *"All I wanted for any of my children was to grow up and be happy. [...] I absolutely blame myself for that not happening"* (Grace, mother)

> *"You feel like you're a monster. And. What have you done? [That's] so, so bad that your child wants to, wants to die."* (Camila, mother)

For many of the participants who identified with self-blame, the feeling was closely linked with guilt. These participants described feeling guilty for the suicide attempt happening *because* they felt they were to blame.

> *"And that's why I've not wanted to talk about it because actually, you know, I feel as if I might as well have been... Might as well have [**reference to method**]. Does that make sense? That sounds awful but I think that's, I feel that guilty about it."* (Grace, mother)

Abigail reflected on how the feeling of guilt deepened over time as her family started to notice the positive changes in their loved one, consequent to increased care/attention given. This only cemented the idea that there was blame to be attributed, believing if they had acted differently earlier, then the suicide attempt may not have happened.

> *"I think the guilt deepened for a while over time because when we were all making concerted efforts to visit him regularly, you know, we could see how, how… What a positive effect that was having on him."* (Abigail, niece)

Developing these feelings further, for mothers, self-blame moved through guilt, and into shame. It is possible again, that this links to Western ideals of motherhood, with shame occurring when those ideals are not met (Pedersen, 2016).

> *"I think there's an element of shame as parent, that, that it's come to that. That your child feels that way."* (Jane, mother)

> *"You feel like a failure is as a parent because you should have noticed. And why, why, <u>why</u> has it got to a place where your child is so vulnerable? Surely you failed as a parent. Your whole job is to look after them."* (Evie, mother)

> *"I feel I failed as a mother. Because I failed. […] Because no/no one should ever get to that point. No one should ever get to that point that they're so desperate that they don't want to be here anymore."* (Grace, mother)

Grace described how she believes the feeling of guilt will never go away.

> *"I don't think it'll ever go away. I think it will always be there. I will always feel guilty, and I've just learned to live with that guilt."* (Grace, mother)

A felt sense of fear was active in all interviews. Participants described being fearful of almost every interaction they had with their loved one, worrying that they would say something which would make things worse, and another suicide attempt would occur.

> *"The worry of saying the wrong things as well [...] You do worry... It's like walking... You feel like you're walking on eggshells, as such. You don't know it... Yeah... Don't know if/when next it's going to happen as well."* (Daniel, friend)

> *"All I could say with any certainty is that the common thought that I had, or the commonest fear that I had is saying the wrong thing and making the situation worse."* (Harry, friend)

Although interactions were a pressure point, the fear that a second suicide attempt could occur exceeded the realms of interactions and was present, although unspoken, in almost all contexts.

> *"It's kind of really scared me because I thought if she has tried to do that, like that, and in such a kind of dramatic way. Then the chances of her trying to do it again are there, you know, are much, are much higher than before."* (Grace, mother)

> *"There's huge amounts of worry and concern about it happening again […] Just that overriding anxiety of what if… You know, what if that's… You know."* (Jane, mother)

Feelings of horror and sadness were described by almost all participants. For a long time, participants could not believe what had happened, or what it meant for how their loved one had been feeling.

> *"I'm just terribly sad that he, that he was so… Felt so bad that he did this."* (Abigail, niece)

> *"It was pretty, pretty hard to, well, pretty hard to sort of even think they/he'd even got to that point. I hadn't realised how serious it was… But then, yeah, but he was/when he was opening up, there was a mental health support worker that came in to sort of spend time with him. It just… Broke my heart."* (Elizabeth, mother)

Evie described how a felt sense of sadness never seems to go away.

> *"The note: 'The brush with death means a fall from innocence'. And there's/there was an equivalent with [my son]; that the, this was not my lovely little boy, my first born. This was my boy who had considered, you know, self-destruction. And you can't un-know that. So, it is a cloud. So that, that inner sorrow you feel will never go away again."* (Evie, mother)

Anger was another emotion which appeared frequently across the interviews. Some participants described how they felt angry with their loved one who had made the suicide attempt, and tried to make sense of this.

> *"At the time, I couldn't acknowledge this is what it was, but I felt so angry at him because he was consuming all of my family's energy. And I was going to/all the attention was on him. So, I think I felt angry and probably a bit jealous, like weirdly, that everyone was like just taking notice of him all the time."* (Harper, sibling)

> *"I did talk to the kids about it, mainly because they'd witnessed, they knew something happened. And I think my son had a lot of anger towards her about it, which again I think is quite a natural response like because of the impact and what it/how it had, you know, for the family."* (Jane, mother)

Participants described how experiencing the emotions impacted them both physically, and emotionally.

> *"I think because I'm so close to [my sister], I started to almost feel her symptoms… Not the losing touch with reality, not that. But the anxiety. I mean, I suffered with anxiety for a long time over those years."* (Alice, sibling)

> *"Because we forget that, we forget that the strain on the body of something, dealing with something so catastrophic… It will affect the body, will affect your actual physical health. And it did. I was so ill, and nearly died from that at that point."* (Camila, mother)

Over time, for two of the participants, the experienced emotion became pathologised.

> *"I'm sorry to jump around, but I've recently been diagnosed with complex post-traumatic stress disorder myself. […] I always thought that I had PTSD. I haven't had a lot... They're called flashbacks..."* (Noah, partner)

> *"It's changed me completely, I would say. I've got my own mental health problems now. I've got severe PTSD." (*Camila, mother)

4.2.3 Theme: A Sense of Responsibility

This theme captures the unspoken, felt sense of responsibility experienced by carers. The theme details various different ways that carers experienced a sense of responsibility relating to their loved one, and the care they provided to them following the suicide attempt.

Building on the felt sense of blame described in the previous theme, mothers in the sample felt responsible for their child's suicidality. Given their position as parents, mothers appeared to reflect on their lives to find evidence which positioned them as responsible for their loved one's suicide attempt.

> *"And that's why I blame myself... She had a history of seeing me do it. You know? So, it's like, not… I mean, I've never tried to [**reference to method**], but I have a history of [**reference to method**]."* (Grace, mother)

> *"I think there was an element of guilt for me because of being so poorly when she was little as well. Now I know she had protective factors, and I know that she's now*

> *leading a really productive life… [But] there's always that element of… What if it's hereditary?"* (Jane, mother)

Evie shared this felt sense of responsibility for her son's suicidality. Overtime, this sense of responsibility transformed, and she began to feel responsible for ensuring that her son felt better.

> *"I must have affected his mental health. So, I was/as soon as he was starting to have mental health problems, I blamed myself. And so, when it came to him saying this, […] I thought, 'right I must. I must deal with this'. I/this is, you know. 'I/it's up to me'."* (Evie, mother)

For many participants, responsibility took the form of checking in on their loved one practically, and ensuring that there was nothing in the environment which they could harm themselves with.

> *"I do remember getting home from the hospital and then sort of almost locking up the medicine cabinet and, you know, getting rid of stuff and, moving things away that thought I thought might be, you know, triggering."* (Elizabeth, mother)

> *"I had to move knives out the way, hide the knives. I used to sleep with all the knives. You know, the kitchen knives and stuff like that. Razor… Shaving blades for shavers […] Anything sharp, so anything sharp I had to hide."* (Daniel, friend)

For other participants, it was keeping a practical note of changes in the persons mood and mental state to keep an eye on what was going on.

> *"I'd been writing notes, and I've got the booklets where I was writing it down so that we could monitor his, you know, changes and how he's feeling."* (Quinn, wife)

Or developing 'safety plans' as a means of keeping their loved one safe.

> *"When she came out to live with me for those five months, we had like a plan. And I said, 'look what happens if, you know, you or I have a crisis?'. Because we both have mental health issues."* (Grace, mother)

> *"One thing we did do when he got home from the hospital, when I brought him home from the hospital… We/I sort of sat down on his bed and said 'look, we need to… You know, sort something out that if you ever feel like that again, you let me know'.* (Elizabeth, mother)

Noah described how his awareness/hypervigilance in relation to keeping his partner safe was constant, and until she was asleep, he could not rest. Evie reflected on the hypervigilance but different to Noah, it didn't appear as though she was aware of it in the moment. It took years for her to see the impact/stress caused.

> *"She was always usually asleep very early or in the bedroom very early. And I always thought/felt… Once I've given her medication and I knew she was asleep. I knew she was safe. I knew she was at peace. And I could rest."* (Noah, partner)

> *"I was on the hypervigilance. I was/the possibility of him taking his life was there. I think it represented a level of stress on me that I didn't acknowledge. It was years, but years of it after that. And I found myself very observant of [my son's] life, and like being aware of the things that were happening with him."* (Evie, mother)

Participants described the difficulties involved with taking on such responsibility for their loved one's wellbeing, and described the anguish involved in hearing about their loved one's suicidality.

> *"But he knew he could pick up the phone. It was like an instant counselling service that I was providing for him. And of course, I was happy to do that, why wouldn't I? I wanted to help, you know, save my son. And… But I didn't/I didn't count the toll it took but that's 'cause I'm a Mum, and it sort of goes with the territory."* (Evie, mother)

> *"I ended up being her counsellor, so I ended up being the person she told everything to… Which is difficult when your hearing your child say they want to kill themselves all the time."* (Camila, mother)

Noticing the effect it was having on her, Jane pushed back and tried to implement boundaries around her level of responsibility.

> *"It became a point where I'm quite happy to do this bit of care, but I'm not doing that bit of care 'cause I need to step back because it… Otherwise you'd be worried 24*

> *hours a day you'd absolutely send yourself, you know, bonkers, 'cause you just think about it all the time."* (Jane, mother)

Participants described how the sense of responsibility was not only internal; for many participants, they were positioned as responsible by professional services, and this ensured that the unspoken sense of responsibility was upheld.

> *"There was a massive assumption because of, because I was involved, and I was articulate, and I was able to sort of get involved in things, and I appeared to be doing well, that I would just take on all of the care and responsibility, and that was very convenient for the NHS."* (Quinn, wife)

> *"Now this is a woman that had [**reference to method**], had been on life support for two weeks, and was in a high dependency bed from the November until Christmas Eve, and [the NHS] expected me to look after her on my own with no training, and no support, for three days! So, as you can imagine, I was slightly dubious… To say the very least."* (Noah, partner)

4.2.4 Theme: Making Comparisons

This theme highlights an unspoken sense of unfairness felt by carers in this context. The unspoken narratives in this subtheme are expressed through carers making comparisons to physical illness, sex education, and bereavement.

Evie compared the silencing around suicide to the silencing which used to exist around sex. She suggested that a suicide prevention movement similar to sex/sex education would be helpful in moving society forward, and breaking down stigma.

> *"I think we can see a parallel with sex education. You know that people in the past, 'oh no, don't teach my child about sex because they're going to go get themselves pregnant.' Well, actually the opposite is true. And I think this is, I think there's a very strong parallel between this. I think we've moved on in sex education. We probably need to move/I think we do need to move on in a similar vein with this."* (Evie, mother)

Speaking to the silencing, Sofia made numerous comparisons between mental health and physical health. Sofia linked the silencing she experienced to stigma, and felt that stigma was built from a fear of the unknown; you can't *see* mental health in the same way you can *see* physical illness. Sofia experienced this in her own family, as well as wider society. She used to joke with her son (who she was supporting) about dressing him in bandages, just so his father and sister (who were fearful of mental health difficulties) would feel more comfortable generally, when speaking with him.

> *"If you can see somebody with a plaster on their leg you're comfortable with it because you can see that there are practical things that you can do to help. [...] And [my son]and I used to say the same thing, we used to say/I used to say jokingly to him, 'Oh, why don't you just put a bandage around your head'. And he would say, 'yeah, perhaps that's what I need to do, mum.'"* (Sofia, mother)

> *"Socially, it's much easier to say, 'oh, my mums in a wheelchair'. And people can understand that, than trying to explain, 'oh, my mum's got depression and she's not*

> *coming out the house'. Or whatever. Or 'I've got a brother who has mental health problems.'* (Sofia, mother)

Camila had a friend whose child had cancer at the same time as she was supporting her daughter with suicidality. She observed differences in the ways the two mothers were treated, and this felt unfair. Camila compared her child's suicidality to that of a cancer, tracking her way throughout the health system using the cancer stages and realising that in the case of mental health, it often is too late for treatment to work.

> *"I was jealous of my friend who had her son who had cancer. And that's terrible saying it. But I was jealous. […] Because at least her child was getting help. You know, she was getting support, and her child was getting help… I do describe it as cancer that, you know, by the time [my daughter] actually saw somebody it [had] already been six months, she'd already reached Stage 1. By the time she sees someone else, and she's waited its Stage 2, Stage 2/Stage 3. By time the she finally got help […] it was Stage 4, it was terminal.* (Camila, mother)

Evie also made the comparison to cancer, but instead used it to look at systems more broadly. Evie felt that the lack of an umbrella organisation (e.g., Cancer UK) means that the true extent of suicide remains misunderstood and ignored.

> *"Now, there isn't an overall umbrella organisation […] If now/if you think of something like cancer, which takes fewer young people's lives... There's an organisation, one organisation which you know… And then we hear about the number*

> *of people that die by cancer because it's like a collective of people, all united."* (Evie, mother)

Finally, participants compared themselves to those who had been bereaved by suicide. Elizabeth described how she felt as though her experiences were *less than* by comparison, and when in conversation with those who had been bereaved, she often would not open up. Jane instead used bereavement to highlight the lack of services available for the *almost* bereaved.

> *"...I kind of/I then don't necessarily open up. You know, if they are sharing their loss with me, I don't then necessarily open up to say I've been through something similar because, because I'm not experiencing what they're experiencing, if that makes sense, and it's not fair for me to share that..."* (Elizabeth, mother)

> *"So yeah, you do feel quite alone with it because there isn't anywhere to send that information to, and it wouldn't have fitted into/it wouldn't be no point me going to see a psychiatrist for example. It wouldn't have fitted into any of the pathways we've got currently where you'd have those conversations. And obviously we've got groups for bereaved parents. But perhaps we need to..."* (Jane, mother)

4.2.5 Theme: Relationships with Professionals

This theme explores the unspoken ups and downs/inconsistencies in the relationship between carers and professionals. The term 'professionals' in this theme extends beyond healthcare professionals, to include anyone whom the carer interacted with in a professional capacity. This theme includes two subthemes: *Positive Experiences* and *Spoken but Unheard*.

Subtheme: Positive Experiences

As highlighted in the SLR (Chapter 2), existing literature has demonstrated a common spoken narrative regarding how carers are dissatisfied with the support they receive from professional services. It therefore felt important to shed light on the alternative, unspoken story, which existed for some of the participants in the sample. This subtheme shares positive experiences/interactions between carers and professionals.

For some participants, the way in which professionals were observed to interact with their loved one was a distinguishing factor as to whether the experience was deemed to be positive. Professionals observed to give their time in a caring and compassionate way were valued by participants. The fact that participants could make these observations suggests that they were included in the care provided, which is possibly another factor which made experiences feel more positive.

> *"Took her to A&E. The actual physical health nurse who [**reference to method**] was amazing. Actually, couldn't have faulted her. Was very sympathetic, understanding. A bit mummy-ish like that..."* (Jane, mother)

> *"He just stayed for the day [in hospital]. They were actually really, really good. Couldn't fault them at all... They... Because he was/he was only 15, I stayed with him through all the questioning, and they were very, very gentle with him and very calm with him."* (Elizabeth, mother)

Time given seemed to be a distinguishing factor in all reports of helpful/positive interactions with professionals. For Quinn, she had a particularly positive interaction with a nurse on a physical health ward who gave her time to speak, whilst asking direct questions to help facilitate the discussion.

> *"There was a wonderful nurse on the ward as well. Not the psychiatric, but the sort of second one he went into in the hospital. And it felt like a debrief... But she asked me lots of questions and she was literally just as a junior nurse. She wasn't any kind of psychologist or anything. But actually, it was really helpful having her kind of, give me the space to talk."* (Quinn, wife)

When Ruby shared her story, for a long time, there was a sense that nobody was giving her time, nobody was inviting her into the room with her son, nobody was advising her on how best to support him. This changed when two paramedics attended her home and spent time with her, noticing her distress. This one positive experience stood out throughout the entire interview because they gave her time, recognising that she needed it.

> *"Nobody had really ever explained how to sort out anxiety, or what it was, or even if it was anxiety. And then they [paramedics] said, 'has anyone sat you down and talked to you about this?' And I said 'no'. And so, they sat round the kitchen table, and they gave us some explanations of things."* (Ruby, mother)

Subtheme: Spoken but Unheard

As mentioned, the spoken stories in literature from carers often relate to carers feeling dissatisfied with healthcare professionals; the SLR (Chapter 2) noted reasons for this largely being around *Unmet Expectations* of the support provision provided, leading to carers feeling alone and isolated. This subtheme shares similar challenging narratives around dissatisfaction with professionals, building on the idea of *Unmet Expectations*. The ideas shared in this subtheme relate to times where carers have spoken directly to professionals and have expected to be listened too but were not (or at least, felt they were not).

Participants reflected on conversations they had with professionals at the time of their loved one's suicide attempt. These were times where they had voiced the severity of the attempt, and the concerns they had going forward, but felt as though the severity and the concerns were not heard/taken seriously by professionals.

> *"But the other one [paramedic] said, 'well, if [your son] wants to jump out of the window, just let him'… Wasn't that an extraordinary thing to say!"* (Ruby, mother)

> *"So, she gets seen by CAMHS, and she gets seen by a psychiatrist. She's not well enough that she needs to be admitted, and they basically turned round to her and the Psychiatrist said, 'Oh, that was a silly thing to do, wasn't it? Oh, you're not going to do that again, are you?'"* (Camila, mother)

This led to participants feeling disillusioned by professionals, and indirectly led to them feeling as though they had to take on more of a caregiving role as they did not feel supported by the professional teams. Consequently, Noah felt as though he needed to step back from his employment and attempted to speak to his manager about how he was feeling. Again, he was met by a response from a professional who did not seem to understand the situation he found himself in.

> *"At this stage I had no support from anybody, including my employer, who, my boss… I asked for flexible working. […] And he said to me, 'if you wanna be a carer, you can F-off and be a carer!'"* (Noah, partner)

As time moved on following the suicide attempt, some participants put in complaints to the professional services about the service they had received. It seemed that even when carers spoke their stories in this capacity, they were still not heard/listened to in a way that felt comfortable. Noah received a "*dismissive*" reply quite quickly following the suicide attempt, whereas Camila's complaint has been left outstanding for several months with no sense of urgency attached.

> *"I made a formal complaint in November. It took them six months to answer that. Then they sent a one-page document which was very flippant, dismissive. Saying that all the questions that I have wanted answered had already been answered…"* (Noah, partner)

> *"I think she had about one or two sessions [with a support worker] before we got the CAMHS CBT assessment. Anyway, I went in. And… I've got a complaint against this person's still, and it's still outstanding."* (Camila, mother)

When reflecting on her experience of not being heard or supported, Ruby remembered that she had voiced this to a local GP. Sadly, the response she received was fitting with the experience she had had so far; professionals did not seem to hear her/care about the importance of listening to carers.

“So that GP, and I’ve told him, I said ‘families need support. You should have supported us’. And Doctor B, who was there in the room too, she’s sort of like, it was like, ‘oh, yes’, almost like, ‘oh, we should have thought about that’. It was like, ‘what the hell?’.” (Ruby, mother)

Chapter 5: Discussion

5.1 Chapter Overview

This chapter summarises the five themes and subthemes which were developed from the data, and then discusses each theme in relation to existing theory and literature. The chapter presents the strengths and limitations of the research, before suggesting actionable clinical implications and invitations for future research.

5.2 Research Question

This research aimed to answer the question: *What unspoken narratives exist for informal caregivers who have supported a loved one following a suicide attempt?*

5.3 Summary of Findings

The research question was explored using RTA (Braun & Clarke, 2006, 2013, 2019). Participant stories were rich and emotive, and partially mirrored what already exists in the limited evidence base [e.g. feelings of shame, blame and guilt; difficult interactions with professionals (Chapter 2)], and some of the information was new (e.g., making comparisons). In keeping with the epistemological stance of this research, through the lens of CR, the findings should not be understood as an objective ‘truth’ but instead as an opportunity to gain insight into the experiences of informal caregivers, holding in mind that each experience is specific to the individual participant and their context.

5.4 Relating Findings to Existing Literature

5.4.1 Theme: Conspiracy of Silence

Participants described how they felt silenced and unable to share their experiences with anyone (e.g., their loved one, friends, family) subsequent to a variety of competing ideas, concepts, and influences. The *Conspiracy of Silence* terminology was introduced by Evie (mother) when referencing the silence surrounding suicide. Evie described how stigma *shuts down* conversations around suicide, ensuring that there is no context which permits safe discussion, and thus the 'true' extent of suicide is not fully seen or understood.

As mentioned in Chapter 1, the medical model positions suicide as a symptom of mental health difficulties. Mental health stigma is well studied in literature. The Modified Labelling Theory (Link et al., 1989) is a framework which can be used to help understand some of the experiences described by participants. The model posits that individuals deemed to be 'unwell' are aware of the stigma associated with mental illness, and implement management strategies to cope with the possible discrimination and social rejection which can occur as a result (Ray & Dollar, 2014). In *Subtheme: "It's [their] Story to Tell",* participants described feeling as though they had to make up stories, as directed by their loved one, to cover up the fact a suicide attempt had been made. This fits with one of the key 'coping strategies' in Link's (1989) theory, which is for the person deemed unwell to conceal their mental illness to avoid further labelling and stigma. By sharing false narratives, participants help their loved ones avoid stigma but inadvertently leave themselves unable to seek/access support for their own emotional responses to the upsetting event. The model suggests that as humans we are innately aware of mental health stigma. This can help us understand why participants in the sample anticipated the reaction from others to their loved one's suicide attempt would be negative/harmful to themselves or their loved one (*Subtheme: Myriad of Protection*). Link's (1989) model is helpful in that it helps us understand these experiences however, it is also unhelpful as it endorses the idea of secrecy to protect from stigma. Secrecy only contributes to widespread stigmatisation of mental health, as stories remain unspoken.

An unspoken narrative around powerlessness was found within *Subtheme: "It's [their] story"* as carers felt they did not have ownership/control over their experiences of caregiving. Feelings of powerlessness were observed in a study investigating the emotional journey of family carers and patients across seven London Boroughs (Boudioni et al., 2015). Powerlessness in this context largely related to carers interactions with the healthcare system; however, the authors noted that carer powerlessness likely extended further, and invited researchers to investigate the psychological state in more depth.

A carers desire to protect the care receiver was observed widely as a theme throughout broader carer research. For example, in Boudioni et al.'s (2015) study, participants were observed to be protecting their loved one when interacting with the researcher through *"constant touching, eye contact, or leaning their body toward them"* (p.535). This example, and the examples discussed by participants in the sample (e.g., protect their loved one whilst in conversation with them, protect their loved one's reputation in conversation with others; *Subtheme: Myriad of Protection*) likely links with societal norms around what it means to be a carer, and the subsequent identity that carers resume when they step into the role. A literature review of *Family Caregiver Identity* (Eifert et al., 2015) found that *Role Engulfment* was a common phenomenon for carers. *Role Engulfment* is described as a slow loss of self as the responsibilities and expectations of being a carer become priority. By definition, a carer is expected to look after/protect the care receiver, making protection and its subsequent silencing, a priority as *Role Engulfment* begins.

Systemic Influences (*Subtheme*) were found to uphold the *Conspiracy of Silence*, these included the UK societal and cultural context, the Covid-19 pandemic, and stigma. Part of this subtheme expressed the distress felt by participants when such systemic influences keep their experiences unspoken. Participants described how an awareness of British societal and cultural norms, as well as religious views on suicide meant that they felt they could not share their experiences openly. Phenomena's such as this have been explained in literature using the Spiral of Silence model (Noelle-Neumann, 1974). The model dictates that as human beings we have a natural fear of social isolation which prompts us to constantly monitor for signs of approval/disapproval. To avoid disapproval, we refrain from talking about things perceived to be controversial, such as suicide. One participant spoke about how the practicalities of the pandemic (e.g., lockdown) meant that she was unable to seek support from friends as they were unable to meet up. Although this makes sense to an extent, it is interesting that she did not feel she could reach out remotely (e.g., phone). A lot of the assumptions built into the Spiral of Silence model are unconscious, which leads one to wonder if there was more going on than simply the physical barrier of lockdown which prevented this participant from reaching out. In Chapter 1, current suicide prevention policy was outlined. In Section 1.4 the author considered whether the Governments under/misreporting of suicide deaths in 2022, combined with the non-reporting of suicide attempt data was an effort to conceal the ‘true’ extent of suicide across the UK. The effort to conceal, is a stark comparison to the Covid-19 death data which was provided in daily updates by the Government throughout the pandemic. It is possible that the daily influx of Covid-19 death data contributed to this participant not wanting to share her experiences. Fitting with Noelle-Neumann's (1974) model, the participant many not have shared to avoid disapproval from others; being acutely aware of the pressure on the NHS which had intensified during the pandemic, and not wanting to be perceived as adding to this. It is possible also that the participant was made to feel as though suicidality was not a difficulty by comparison to Covid-19, due to the emphasis placed on the Covid-19 death data as opposed to suicide death data.

5.4.2 Theme: Unequivocally Unspoken

Participants described how some of their experiences were *Unequivocally Unspoken*. A direct choice was made by participants to keep aspects of their experiences silent. Three subthemes explored: the trauma of what had been witnessed by carers, reasons behind an avoidance of the word ‘suicide’, and the emotional experience of caregiving (both short-term and long-term).

A large part of this theme speaks to the trauma, and psychological experiences of the participants from the point they become aware of the suicide attempt (*Subtheme: Bearing Witness)* to years later when they experience ongoing psychological/emotional impact (*Subtheme: Overwhelming Emotions)*. In *Subtheme: Overwhelming Emotions,* participants described the emotional and physical toll that caregiving took on them, with some participants describing how they began to *feel* the symptoms of their loved one. This is explained in literature as experiencing *vicarious trauma.* Vicarious Trauma describes how the trauma of one, becomes the trauma of another; commonly occurring through empathetic bonding (McCann & Pearlman, 1990). There is an apparent gap in literature looking at the emotional impact of caring on carers, as much of the trauma described in this study was not that of vicarious trauma but, instead, simply the carers own trauma as a result of what they had been through.

Some of the key emotions felt by carers in the sample were *shame, blame* and *guilt*. The participants in this study were *almost* bereaved by suicide; bereavement research has shown that shame, blame, and guilt are common reactions for those who are bereaved by suicide. A systematic review of shame, blame, and guilt in bereaved samples found that self-blame, guilt, and shame are commonly experienced by bereaved parents (Duncan & Cacciatore, 2015). This provides further evidence of the similarities between bereaved samples, and almost bereaved samples, building on the discussion of this in Chapter 1, Section 1.5. Duncan and Cacciatore (2015) noted that none of the studies in their samples looked to understand why these psychological states exist, which again is a silencing tool as it keeps rationale and reasons unspoken. Kauffman (1996) argues that shame comes from powerlessness, which is interesting when we consider that powerlessness also came up as an unspoken narrative in this thesis. Kauffman further argues that shame arises from disruptions in relationships, and failure to meet one's own expectations (Duncan & Cacciatore, 2015;

Kauffman, 1996). When we consider this in relation to the carers in this study, the participants each had a role to play for the participant in some capacity prior to the suicide attempt. Given the term 'loved one' used, it can be inferred that this role would have involved caring; it is therefore, possible to assume that due to this, participants *did* feel as though they failed in their expectations when the suicide attempt occurred.

Witnessing a suicide attempt (and the aftermath of it) can have devastating impacts, as described by the participants in this sample. Brent et al. (1993) attempted to evaluate the psychological impact of witnessing a suicide attempt as an adolescent. The results indicated that participants had higher rates of new-onset anxiety disorders and new-onset PTSD when compared to a standardised sample. The results indicated that the symptomology of each diagnosis was stronger, the closer the relationship between the person making the attempt and the person witnessing. It is therefore unsurprising that the participants in this sample reported to experience such diagnoses (*Subtheme: Overwhelming Emotions).* Similar results were found in a sample of prisoners, looking at the experiences of witnessing suicide-related behaviour (Hales et al., 2014). Hales et al. (2014) indicated that more than 50% of the sample experienced negative reactions following witnessing suicide-related behaviour.

Participants in this study were observed to have difficulties interacting with the word "suicide" when describing their experiences. Some participants avoided the word completely, others used other words to verbalise the event, and others were able to reflect on how their interactions with the word suicide had changed over time. An avoidance of the word might be explained through the Modified Labelling Theory (Link et al., 1989), mentioned earlier. This model promotes ideas around *not* using labels as a means of actively reducing associated stigma.

Another way to think about language use would be to consider the anti-stigma movements and language campaigns headed by charities such as Samaritans in recent years, which are working to reduce stigma through language. Interestingly, these campaigns support movements away from words that prefix suicide, as opposed to moving away from using the term suicide itself. Anti-stigma campaigns have advocated to move away from "committed" suicide due to the criminal connotations, and also move away from "completed/non-completed" suicide due to connotations around achievement. These campaigns are supported by research, such as that by Padmanathan et al. (2019), who surveyed 3000 people affected by suicide and found that *"attempted suicide," "took their own life," "died by suicide,"* and *"ended their life"* were preferred terms/phraseology. The advice from anti-stigma campaigns and research does not fit with what was observed from participants, who were often opting to not use the word at all.

The social media platform TikTok recently shared data revealing that suicide was not being used as commonly as it once was, the preferred replacement was "unalive". The hashtag #unalivemeplease has 9.2 million views on TikTok; #unaliving has 6.6 million; #unaliveawareness has an additional 2.2 million. The hashtag #suicideprevention is a frequently used tag on the app, whereas the hashtags #suicide and #suicideawareness do not exist (Tait, 2022). This suggests that similar to the participants in the sample, there is a desire to move away from the word suicide. However, concerns have been raised regarding changing to a word such as "unalive". Deborah Tannen[14] argues that "*coming up with alternate or roundabout ways to say things, in order to avoid saying them outright, sends a message that the meaning is unsayable"* (Tait, 2022). Ultimately, a move away from the word could uphold the silence through promoting avoidance; perhaps work would be better spent on anti-stigma campaigns, research, and education so that the word itself does not hold so much fear and power.

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[14] A linguist from Georgetown University.

The emotions described by participants in *Subtheme: Overwhelming Emotions,* adds further evidence to the consideration reported in Chapter 1 which highlights the similarities between the experience of those who have been bereaved, and those who were *almost* bereaved. Sands' (2009) Tripartite Model of Suicide Greif details how bereaved people will move through emotions associated with *intention,* onto *pain* and then into *acceptance*. The participants in this sample describe a similar pattern as they contend with what has happened, feel the pain for themselves and their loved one, and then make attempts to move forward. As such, the results of this research provide evidence for the adaptation of Sands' (2009) model for the *almost* bereaved population.

5.4.3 Theme: A Sense of Responsibility

Participants described how they connected with an unspoken sense of responsibility when they stepped into the carer role. This felt sense of responsibility took many forms, and in some cases was linked to the nature of the pre-existing relationship between the participant and their loved one. An example of this would be mothers; mothers in the sample hypothesised about hereditary reasons for their child's suicidality, positioning them as responsible. More broadly, participants felt responsible for their loved one getting better, and facilitated this responsibility through adopting a 'hypervigilance' to their loved one's behaviour, or developing safety plans. Participants both positioned themselves as responsible, and felt positioned as responsible by professionals.

In many ways, the sense of responsibility links with the idea of *Role Engulfment* mentioned earlier (Eifert et al., 2015). *Role Engulfment* occurs as the carer takes on more and more responsibilities to ensure the health of their loved one, to the detriment of their own identity. Oudijk et al. (2011) found that in a sample of physical health related family carers the sense of responsibility was linked with a sense of obligation, and that this obligation made participants more inclined to provide care. The authors talk about a "trade-off" relationship between carers and their loved ones, that in many ways carers are "repaying" loved ones for help received in the past; or that this is simply a reflection of traditional social norms around what it means to care for someone.

It is of note here that most of the sample are women. There continues to be a persistent link between women and domestic responsibility, in society and in literature (Doucet, 2000). Throughout history women have *looked after* their loved ones, this is ingrained in Western (and non-Western) society (Ickes, 1993). It is possible that this traditional social norm was playing out in the sample.

5.4.4 Theme: Making Comparisons

Participants were observed to make comparisons between their position as carers for somebody with suicidality, and other phenomena. Participants compared their position to that of those bereaved by suicide, they made comparisons between supporting somebody with suicidality to supporting someone with cancer, and compared the need for a suicide-related anti-stigma movement to the anti-stigma movement which has occurred regarding sex. The unspoken narratives here were interpreted to relate to a narrative around unjust and unfair treatment, these comparisons also highlighted unspoken narratives around isolation and aloneness.

Social Comparison Theory (Festinger, 1954; Wood, 1989) asserts that people assess their self-worth by making comparisons to others. Social comparisons are defined as the process of thinking about information regarding another person(s) or social group, in relation to oneself. The theory has three key elements: 1) acquiring social information, 2) thinking about it in relation to the self, 3) reacting to the social comparisons. Festinger (1954) proposed *upwards social comparison* as the comparison between us and those we perceive as better off than us. The process of comparison between the participants in the sample and those they compare themselves too can be explained through a process of upwards social comparison. The model dictates that initially with upwards social comparison we might feel discouraged but eventually this can work as motivation to get to the place where we perceive the other person to be. For the participants in the sample, many of them are now working in the suicide prevention space. This could be explained as them trying to make the change, as spurred on by upwards social comparison.

Narratives around isolation and feeling alone are not new in carers' literature. This emerged as a subtheme in Chapter 2 where peer support was shown to be positive in building connection, and breaking down feelings of isolation and aloneness, which may underpin thoughts related to comparison. Another possible explanation for participants in the sample making comparisons, is the lack of service provision available to support them. UK service provision does not include support spaces (e.g., peer support) for informal carers, meaning that there is no space provided for carers to meet, feel connected, and rationalise their thoughts around comparison with others. Research suggests that to engage in peer support, people want to feel similar, and for it to play to their strengths (Heath, 2020). For peer support to work with this population, facilitators should take a strengths-based approach, and use connection as a tool to reframe some of the difficult feelings (e.g., isolation, aloneness, unfairness) which will be underpinning thoughts related to making comparisons.

5.4.5 Theme: Relationships with Professionals

Participants described the way in which they interacted with professionals to be an important part of their narratives. As was seen in Chapter 2, literature is heavily weighted towards unfavourable relationships with professionals, with positive experiences appearing in literature more sparsely. This theme included unspoken positive experiences, as well as the *spoken but unheard* side of the negative experiences. The unspoken narratives here related to a desire to feel valued.

Positive experiences with professionals related to two main areas. Firstly, participants described how they, and their loved one, were spoken too, as important factors distinguishing a positive experience. Jane described how an empathic, maternal nature was helpful when observing a nurse interact with her daughter; Quinn described how a nurse being direct with her and offering her a debrief felt acknowledging and helpful. Both examples speak to professionals taking a trauma-informed approach. Trauma-informed practice is a movement which is gaining traction across healthcare services. Trauma-informed approaches are based on promoting the principals of safety, trustworthiness, collaboration, empowerment, and choice (Harris & Fallot, 2001) when interacting with others. Ruby (mother) found that having things explained to her was extremely helpful, as this made her feel more equipped to deal with her son's suicidality, whilst at the same time she felt listened too as professionals awarded her their time. Feeling ill-equipped and needing the support of professionals has been identified in previous studies. Participants felt they needed to be educated by professionals (Dransart & Guerry, 2017), with coping skills proving extremely helpful to carers (McLaughlin et al., 2016).

Negative experiences of carers relationships with professionals are more common in the literature, as seen in Chapter 2. This theme discussed ideas that carers narratives are not unspoken; they are spoken to professionals, but they are <u>unheard</u>. Even though carers are using their voices, they are not being listened to and change is not occurring. A reflective article from a carer for someone with mental illness echoed this sentiment: *"From my experience, carers voices may at times be the loudest in the room but yet remain unheard"* (Daniels, 2023, p.1784). The author ponders whether it is of benefit to professionals to keep carers voices unspoken as the non-acknowledgment of carers increases the responsibility placed on carers and decreases that on professionals. Daniels also comments on how legislation to protect carers voices is inaccessible due to the jargon used, so often carers cannot even use the legislation to back themselves up if they wanted too. Daniels asks for a seat at the MDT table, to be part of discussions, and to be listened to. These sentiments are echoed across carer literature and are named as actionable clinical implications in Table 9 (Chapter 2). Given the support in literature, one wonders why carers are remaining unheard. It is possible that the silencing extends beyond carers, to the researchers who are supporting them. It is possible that research findings are censored by rejection from journals (Clark et al., 2023), or that hard dissemination of research is being limited to only the specific organisations which supported the research (Ravinetto & Singh, 2023). If this is the case, researchers have a role to play in challenging structures (e.g., journals) to amplify the voice of informal carers, and adapting their dissemination strategies to attract wider audiences and initiate widespread change.

A Moment for Refection
I found the process of writing the discussion/making sense of the findings both exciting and frustrating. I felt excited because some of what had been found fitted with what was already out there, meaning that my findings could work alongside previous findings to develop actionable change. I felt frustrated as there is enough literature out there already for actionable change to have been made – So why hasn't it happened already?

5.5 Strengths and Limitations

5.5.1 Strengths

This study addressed a gap in literature which was identified through the SLR (Chapter 2), and had been highlighted by authors previously (e.g., Lavers et al., 2022). Together, with the SLR, this study adds to the evidence base highlighting how carers are involved, and wish to be involved, in the care and treatment of their loved one. If healthcare providers were to capitalise on this desire, it would help with the nationwide staffing crisis across the healthcare sector (British Medical Association, 2024), and potentially free up staff to be reallocated elsewhere (e.g., to offer carer specific support groups), ultimately offering a more effective, holistic care package to those in need. This could be made possible with appropriate training, supervision, support for carers, and funding/benefits to pay for carer time.

The early consultation and consistent reflexivity throughout this research project are strengths. Consultation and reflexivity encouraged consideration of personal biases throughout the research process, and offered regular check-ins with the lived experience population to ensure the research effectively met the needs of the target population.

The research was conducted from the epistemological position of CR which is a strength as it provides a framework for the researcher to develop themes across a dataset, obtaining a collective understanding of how participants experience the aftermath of a suicide attempt (Stutchbury, 2022), whilst simultaneously encouraging the researcher to be critical of the narratives provided, understanding that each narrative has been personally constructed through engagement with different contexts (Wynn & Williams, 2012). This approach meant that, through the findings, the researcher could present overarching themes, whilst respecting the individual participant stories in the process. The research was conducted from an *Insider Researcher* position which acted as a strength as it can encourage participants to be more open and honest when sharing their experience (Bonner & Tolhurst, 2002); ultimately increasing the validity, and authenticity of the findings presented.

5.5.2 Limitations

There was a gender bias in the sample of participants interviewed for the study which is a sampling limitation. Eleven of the 14 participants in the sample were female (78.6%), and three were male (21.4%). It has been consistently found that women are more likely to participate in research than men (Becker, 2017), so much so that the gender effect has been described as a "social phenomenon" that has not yet been conceptually understood in academia (Slauson-Blevins & Johnson, 2016). The gender bias in this study means that the findings are not fully applicable to the wider population as they do not fairly capture the experiences of the people. It has been found that men are more likely to take part in research when there is monetary reimbursement available, in an attempt to overcome gender biases in future research authors might consider offering monetary reimbursement to participants (Otufowora et al., 2021).

The study did not control for the age of the person who had made the suicide attempt. The age of the person receiving care ranged from age 14 upwards, meaning the way participants interacted with the caregiving role was varied. For some participants, the responsibility they felt linked not only to their carer identity but to the legal responsibility they held as a parent to a young person under the age of 18 (UK Government, n.d.). Such contextual influencers could be viewed as a limitation to the generalisability of findings, and could be mitigated in future research by controlling for this information.

The aim of this research was to explore what goes *unspoken* for caregivers supporting somebody who has survived a suicide attempt. A limitation of any research exploring the *unspoken* is that much of the *unspoken* will remain that way. The unspoken narratives which are shared through research and other forums (e.g., peer support spaces), may not be the *true* unspoken narratives. It is plausible to assume that there is a set of unspoken narratives which feel un-sharable and will never be uncovered. These likely exist within the population who choose to participate, and also within the population who choose not to participate but share the same experiences. Psychological barriers , such as those outlined in Chapter 2, and stigma, as discussed in the findings of the study, likely contribute to keeping the unspoken, unspoken. Future research might consider the use of alternative research methods to assist in breaking down the barriers which keep stories unspoken [e.g., photovoice which is considered a social justice tool, empowering individuals to express difficult stories through art (Budig et al., 2018)].

The study accessed a population deemed as "hard to reach" [or more likely, "easy to ignore" (Dodzro, 2023)]. However, reasons for participation in research vary and it is helpful to be critical of this. The most commonly reported reason for participation in research is perceived personal benefit, one of which was access to better treatment in the future (Sheridan et al., 2020). All participants in this study discussed the need for better treatment, both for carers and for the person being cared for. A possible limitation of this study is the reasons participants chose to take part, a desperation for better treatment could influence the authenticity of findings.

A Moment for Reflection

I found it helpful to reflect on how much the research was hard to engage with vs how much the population were hard to engage with. I thought about how we position people as hard to engage, as opposed to contexts (e.g., the research topic). I thought about why we do this, and recognised that I do this, and had been doing this until this point in my research. This thinking allowed me to challenge my biases and move my thinking away from the individualistic lens I had not realised I was wearing.

5.6 Clinical Implications and Invitations for Future Research

5.6.1 Clinical Implications

The research findings support the clinical implications outlined in the SLR, Chapter 2. The results of this study have shown that carers are very much present and involved in the care of their loved one; often to their own detriment (e.g., *Subtheme: Overwhelming emotions)*. Healthcare professionals should work towards thinking more systemically to consider the role of the carer in treatment planning, making use of statutory carers assessments (NHS Carers Assessment) whenever a 'patient' appears to have family/friends involved in their care.

Professional healthcare services need to consider the trauma that carers experience as part of their role and any service which is set up should be through a trauma-informed lens. The findings of this study have shown how, when treated with a trauma-informed approach, participants felt their relationships with professionals were more positive. This lens applies to when statutory carers assessments are completed; these should be completed in a curious and non-blaming manner so that carers feel safe to share their experiences and access the support which they are entitled too (Social Care Institute for Excellence, n.d.).

The development of services/support provisions for carers supporting somebody who has made a suicide attempt is of the upmost importance, requiring urgent thinking in the suicide prevention space. A space should be developed whereby carers feel they can take control of their narratives, and share their experiences in safe and containing spaces. The first step to achieving this could be to implement peer support groups for carers supporting loved ones who have made a suicide attempt. The SLR in Chapter 2 highlighted how meaningful the peer support space can be for carers. Peer support also has wider recognition for being a great support for carers in other areas, such as family carers for people with dementia (Smith et al., 2018).

Better education is needed to help break down the stigma of suicide. As a Trainee Clinical Psychologist, I hold two – nearly three – degrees in Psychology. Across all my years of training, I have not had a single lecture on suicide. If we are not teaching this work to the clinicians that will go and work in our services, who are we teaching this work to? By not teaching and not educating, we are upholding stigma. We are upholding the *Conspiracy of Silence*.

5.6.2 Invitations for Future Research

It is important that researchers continue to amplify the voice this population so that they are finally heard. Research at present has been sporadic, which has likely impacted the way that systems have interacted with the clinical implications suggested in previous research (e.g., those in Table 9, Chapter 2).

This research has specifically looked at the *unspoken narratives* of the population; due to the limited evidence base at present, any future research building on the current understanding of the carer experience will be valuable. In Chapter 1, Sands' (2009) Tripartite Model of Suicide Greif was discussed with hypotheses made around its applicability to the *almost* bereaved population. Research into the applicability of this model to the informal caregiver population would be beneficial. The feeling of powerlessness for carers came up in this research and has appeared as a theme in other research (e.g., Boudioni et al., 2015); to understand more about how a feeling of powerlessness operates, or not, for carers would be incredibly valuable. Additionally, research looking at the positive experiences of caregiving would also be valued as taking a strengths-based approach could help in peer-support development (Heath, 2020).

This research included *friends* in the sample of 'informal caregivers' and future research should continue to do this as more and more we are recognising that the experience of family and friends is incredibly similar (Cerel et al., 2019). To exclude friends from this sort of research would be detrimental and would continue to uphold silence in contexts where there is no need for it. Finally, to understand more about the systems around carers, research investigating the clinician perspective of carers, or the care receiver's perspective would be beneficial.

5.7 Critical Appraisal

For consistency throughout this thesis, the CASP tool (Critical Appraisal Skills Programme, 2023) was used to quality appraise this study. The 10 CASP criteria were applied to this study, and can be found in Table 19. Each answer was scored using the same system as described in Chapter 2 (Section 2.6) ('*Yes*': 1 point, '*Can't Tell*': 0 points, '*No*': 0 points;

Boeije et al., 2011). The CASP was completed in conjunction with the secondary researcher; and reviewed by a researcher external to the research team to reduce risk of bias. This CASP was scored 10/10.

Table 19

Quality Appraisal of Research Study

CASP Criteria (incl. description)	**Quality Appraisal**	**Rating**
Section A: Are the Results Valid?		
Was there a clear statement of the aims of the research? ***Consider:*** *1) what was the goal of the research? 2) why it was thought important?, 3) its relevance.*	✓ The research aims are outlined at the end of Chapter 2 (Section 2.11)	1
Is a qualitative methodology appropriate? ***Consider:*** *1) If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants, 2) Is qualitative research the right methodology for addressing the research goal?*	✓ The qualitative methodology was appropriate to address the research aims which were to *explore* a specific phenomenon ✓ The researcher justifies the reason for employing a qualitative methodology in Chapter 3 (Section 3.3)	1
Is it Worth Continuing?		
Was the research design appropriate to address the aims of the research? ***Consider:*** *1) If the researcher has justified the research design (e.g. have they discussed how*	✓ The research design was appropriate to address the aims of the research; an overview of how the research design was determined can be found in Chapter 2 (Section 3.3)	1

they decided which method to use)		
Was the recruitment strategy appropriate to the aims of the research? ***Consider:*** *1) If the researcher has explained how the participants were selected, 2) If they explained why the participants, they selected were the most appropriate to provide access to the type of knowledge sought by the study, 3) If there are any discussions around recruitment (e.g., why some people chose not to take part)*	✓ A detailed recruitment strategy was developed and is described in Chapter 3 (Section 3.6); The sensitive nature of the topic being discussed, and how this might pose challenges to recruitment were thought about and discussed ✓ The recruitment strategy was robust and ensured that those who came forward fitted the specific participant criteria / had specific knowledge of the area of interest ✓ The researcher has discussed reasons why participants chose not to take part in the research, this occurred at varying stages of the research process	1
Was the data collected in a way that addressed the research issue? ***Consider:*** *1) If the setting for the data collection was justified, 2) If it is clear how data were collected (e.g., focus group, semi-structured interview etc.), 3) If the researcher has justified the methods chosen, 4) If the researcher has made the methods explicit (e.g., for interview method, is there an indication of how interviews are conducted, or did they use a topic guide), 5) If methods were modified during the study. If so, has the*	✓ It is clear how data was collected, and the method of collection was justified in Chapter 3 (Section 3.8) ✓ Participants were offered different interview locations (e.g., face-to-face, virtual, telephone) and their preference was facilitated ✓ The researcher has provided a clear description of how the interview schedule was developed, and how consultation was used in this process; the interview schedule is also located in the Appendix O ✓ The form of data is clear (audio tapes from MSTeams, and subsequent transcriptions)	1

researcher explained how and why, 6) If the form of data is clear (e.g.,. tape recordings, video material, notes etc.), 7) If the researcher has discussed saturation of data	×	The researcher has not discussed data saturation.	
Has the relationship between researcher and participants been adequately considered? ***Consider:** 1) If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location, 2) How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	✓ ✓	The relationship between researcher and participants was constantly considered, please see exerts from reflective journal in Appendix A; these extracts along with the reflection boxes throughout demonstrate how the researcher attended to events throughout the research The researcher discussed positionality as an insider researcher throughout the research to demonstrate how this was constantly considered	1
Section B: What are the Results?			
Have ethical issues been taken into consideration? ***Consider:** 1) If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained, 2) If the researcher has discussed issues raised by the study (e.g., issues*	✓ ✓	The researcher has explained how ethical considerations were discussed with participants prior to taking part (participant information form), and when taking part (discussion at beginning of each interview) The researcher has referenced the relevant ethical standards which the research was conducted in alignment with (British Psychological Society, 2021a, 2021b)	1

around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study), 3) If approval has been sought from the ethics committee	✓ The researcher includes a debrief form which was provided to participants post-interview, and there is a discussion around how this was developed Chapter 3 (Section 3.8) ✓ This research received favourable opinion from the University of Hertfordshire ethics committee, protocol number: LMS/PGR/UH/05362	
Was the data analysis sufficiently rigorous? **Consider:** *1) If there is an in-depth description of the analysis process, 2) If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data, 3) Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process, 4) If sufficient data are presented to support the findings, 5) To what extent contradictory data are taken into account, 6) Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	✓ There is a description of the data-analysis process found in Table 17 ✓ There is evidence of a thematic map which shows how the themes were derived from the data (Appendix T) × It is not clear how the data presented was selected from the original sample ✓ There are sufficient quotations to support each point in the data analysis process ✓ There is some reference to contradictory data, and some specific participant stories are followed to highlight this ✓ An examination of researcher bias is shown through the bracketing exercise (Appendix A), and the reflection boxes throughout	1
Is there a clear statement of findings? **Consider:** *1) If the findings are explicit, 2) If there is adequate*	✓ The findings are explicit, themes are named and discussed under specific headings ✓ Each finding is discussed in relation to existing literature, this includes a discussion of where findings support existing literature	1

discussion of the evidence both for and against the researcher's arguments, 3) If the researcher has discussed the credibility of their findings (e.g., triangulation, respondent validation, more than one analyst), 4) If the findings are discussed in relation to the original research question	and where findings do not support existing literature ✓ Credibility of findings are shown in Table 18, assessment of reliability and validity ✓ Findings are discussed in relation to the original research question, and conclusions are made in this way also	
Section C: Will the Results help Locally?		
How valuable is the research? ***Consider:*** *1) If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research- based literature If they identify new areas where research is necessary If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used)*	✓ The researcher discusses how value the research is when looking at clinical implications and making invitations for future research (Chapter 5, Section 5.6)	1
		Total Rating
		10/10

5.8 Conclusion

The aim of this research was to decipher and explore unspoken narratives that exist for informal caregivers who have supported a loved one following a suicide attempt. Through 14 interviews, numerous unspoken narratives were identified. Some were hypothesised due to the existing literature, and personal lived experience; and others were new, and/or contradicted existing literature, and personal lived experience. Participants discussed: Silencing, narratives which are *unequivocally* unspoken, the responsibility which comes with being a carer, a sense of unfairness, and their turbulent relationship with professionals. Findings are discussed in relation to existing literature to build on the developing evidence base amplifying the voice of a population who have not previously been given space in academic literature. If this thesis (and subsequent publications) achieves only one thing, I hope it is that academics, clinicians, and researchers begin to recognise this population. I hope to have inspired others to want to learn more about informal caregiver experiences in this context so that, one day soon, they are given the space and time in service provision they so desperately deserve.

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Appendices

Appendix A: Bracketing Examples

Ai: Reflective Journal / Extracts

Reflective Extracts: SLR

Date	Title and Extract
09/03/23	**The search process and Covidence** Today I started the *Title and Abstract* review on Covidence. I thought it would feel a bit daunting, as there are so many to get through – And I am aware that I need to get through mine, and then start on Katies – But it doesn't feel like that at all. Perhaps the novelty will wear off, but I am enjoying the process so far! I think this is maybe because it doesn't require HUGE concentration, I can read and have something on in the background, so it feels like I am not alone. I wonder also if it is helpful for me knowing that Katie will also be reviewing mine, so if I miss anything major there is security in that she might pick it up. I have only reviewed the first 100 articles so far, and at the moment I am surprised by how many physical health articles there are for informal carers. I haven't "included" anything in my review yet, so I am a little worried about that! A lot of the articles seem to relate to carers of individuals with HIV, or Dementia. I think this is really interesting, especially with HIV as it has a similar taboo around it as suicide. What has triggered research into carers of people with HIV but not suicide attempters?
15/11/23	**Data extraction** Today I finished my data extraction table and I have HATED EVERY SECOND OF IT. This has hands down, been the WORST task to date. I know that a lot of my hatred here is to do with my hatred of reading and that is something I need to work on! I generally find articles quite inaccessible to read, it's not so much the jargon involved but more the small writing, and the boring text. Why can't we make our papers more

	engaging for readers? Anyway, its done and I am proud of that! I am aware that my table needs cutting down, and that I will need to re-review it to check for typos etc. but I'll give myself a break on that first.
01/04/24	**Write up: Discussion** Today I have been writing up my discussion, I actually really enjoyed it! I really enjoyed thinking about how my findings relate to wider literature, and thinking about what synthesising this knowledge could do for the population. It makes me sad to realise that so many of the clinical implications in the data extraction table are similar. For years researchers have been trying to advocate for informal carers voices, making similar recommendations around the need to involve them in care – Surely that's common sense, why is this not being done as standard!? I am curious as to why with so many clinical implications saying the same thing, that change has not yet occurred. I wonder if it's because these studies are international, and therefore they don't feel like a collective; I also wondered if there was a bigger systemic reason why these implications seem to be being ignored. I was curious about the medical model and how that might be playing a role, the medical model has no place for carers and perhaps it is the power of this that is keeping carers voices away.

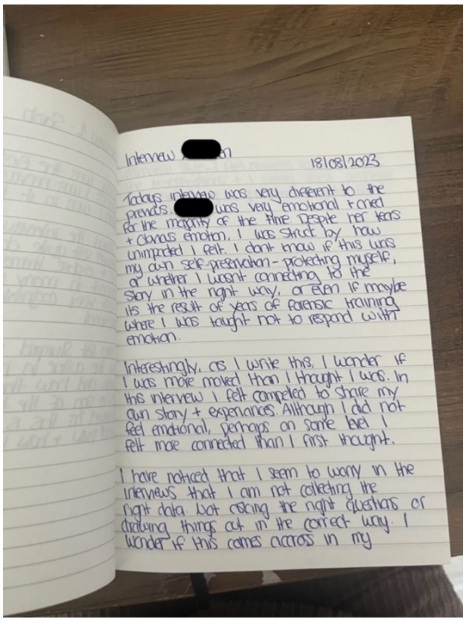
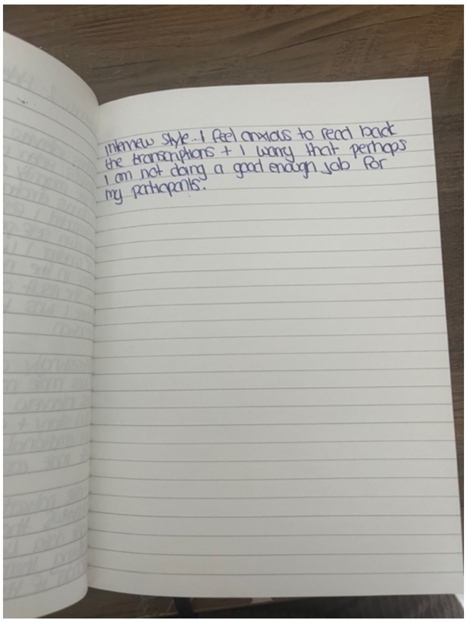
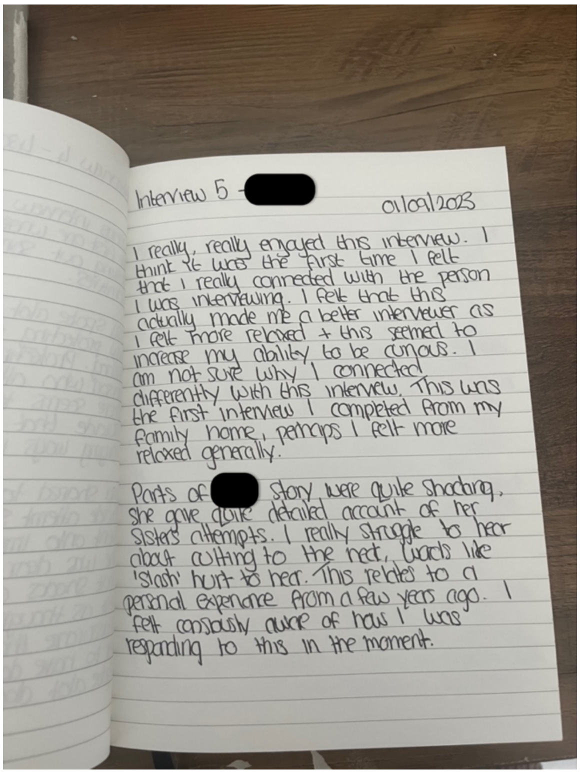
Reflective Extracts: Empirical Study

Date	Title and Extract
	Networking/Scoping Exercises
11/01/2023	**Initial response from third sector organisations** Last week Katie and I spent the day contacting different charities and third sector organisations, just letting them know about the research and being curious as to whether they had the capacity to be involved. Over the last week we have had a huge response, and have set up a few meetings with various charities / people to discuss the research further. I am honestly a bit shocked! And equally honoured, but also feel a bit anxious about the process of meeting with these people who are experts in the field! The

	huge amount of interest says to me that this research is so needed, and I am really proud to be involved because of that alone.

Ethics	
20/04/2023	**Advisory Panel** Today we had our meeting with the advisory panel, it was great! I am so grateful to be running these meetings with Katie, as it feels so much easier to be in this with someone else. It also takes a huge pressure off because if I don't know how to answer a question, she always does! The consultants gave some really helpful advice on our resources which we will be incorporating into our work. Each person we meet with seems to say something along the line of "Lauren, your area is quite niche" which is starting to make me anxious – What if I don't get any participants? If these experts are saying it's going to be difficult, that tells me that it will be difficult! I guess I can only hope for the best and do all I can in the recruitment information to make the process of participation seem as comfortable as possible.
06/07/2023	**Pilot interview** Today Katie and I ran our pilot interviews. We had a lovely morning meeting with two EbE's and then split into two groups to complete pilot interviews. In the meeting, both participants thought they would be more suited to engage with Katies pilot as they had both been bereaved by suicide – This made me anxious again re: recruitment! What if nobody wants to engage with my research?? What was surprising was that one of the EbE's did have the appropriate experience to engage with my pilot, and did so. It was interesting as she had *forgotten* this experience. I am interested to reflect on this a little more, are suicide *attempts* forgettable? What is that about…
27/06/2023	**Ethics**

	Today I got ethics approval, wooooo! This is exciting, although it all feels very REAL now! The charities can now advertise on their platforms, and I am anxious to see if anyone comes forward to take part!!

Data Collection	
18/09/23	**Interview – Elizabeth**  Interview [redacted]n 18/08/2023 Todays interview was very different to the previous. [redacted] was very emotional + cried for the majority of the time. Despite her tears + obvious emotion, I was struck by how unimpacted I felt. I dont know if this was my own self-preservation - protecting myself, or whether I wasnt connecting to the story in the right way, or even if maybe its the result of years of forensic training where I was taught not to respond with emotion. Interestingly, as I write this, I wonder if I was more moved than I thought I was. In this interview I felt compelled to share my own story + experiances. Allthough I did not feel emotional, perhaps on some level I felt more connected than I first thought. I have noticed that I seem to worry in the interviews that I am not collecting the right data. Not asking the right questions or drawing things out in the correct way. I wonder if this comes accross in my  interview style.. I feel anxious to read back the transcriptions + I worry that perhaps I am not doing a good enough job for my participants.
01/09/2023	**Interview – Alice**  Interview 5 - [redacted] 01/09/2023 I really, really enjoyed this interview. I think it was the first time I felt that I really connected with the person I was interviewing. I felt that this actually made me a better interviewer as I felt more relaxed + this seemed to increase my ability to be curious. I am not sure why I connected differently with this interview. This was the first interview I completed from my family home, perhaps I felt more relaxed generally. Parts of [redacted] story were quite shocking. She gave quite detailed account of her sisters attempts. I really struggle to hear about cutting to the neck, words like 'slash' hurt to hear. This relates to a personal experiance from a few years ago. I felt conscously aware of how I was responding to this in the moment.

Data Analysis	
19/11/23	**Transcribing** TODAY I FINISHED TRANSCRIBING!! This feels like the biggest achievement to date – It took AGES! Also, I have finished just in time for my birthday and a week's annual leave, God I feel like I deserve this time off! Transcribing was a long and tedious process, and I found that when I listened to the stories back the emotions in them hit me harder. Even though I knew what to expect, I felt much more impacted by the stories than I did when I was completing the interviews. Perhaps this is because I was just listening and typing, I didn't have an active role as a professional as I did when I was conducting the interviews. The sadness of the stories really started to hit me as I listened.
20/02/24	**Data Familiarisation** I am in the middle of data familiarisation and so far, it's been a really lovely exercise! I have been creating colourful doodles to represent my thoughts and this has been such a valuable task. I feel as I read the hard copies of the transcripts, I am noticing different things / different aspects of the stories are jumping out at me. I almost feel closer to the individual stories in some ways. I am also noticing the transcripts which I am drawn too more than others, and I need to keep a conscious eye on this to ensure I am not finding what I want to find, as opposed to what is actually there. I will discuss in supervision.
23/02/24	**Generating Codes** Today I continued with generating my initial codes on NVivo. I thought I would be enjoying this process a lot more than I am, I am finding it quite exhausting and draining. The first few transcripts were ok but now I am in the middle of them, I am so tired. I am not sure really why this is, I am aware of my position as an insider researcher and have been thinking If the

	stories are just taking a toll on me differently because of this. I feel tired like I need a break, but I am also so aware that time is ticking towards the first draft.
01/03/24	**Generating Themes** Today I started generating my themes. The first step was writing all of my codes onto post-it notes, and then reviewing them / grouping them when codes were similar. I am enjoying this much more than I was when I was generating the codes! This feels like I am building something, and it feels a little bit detached from the transcripts and the individuals stories themselves. I wonder if this is why I am finding it a little bit easier.
04/03/24	**Reviewing Themes** Today we had a supervisory meeting where we presented our themes. I think reading them outload and describing them to Jen made me realise that they weren't quite ready yet. There were a few crossovers that I need to iron out and will work on over the next few days. I am excited to be at this stage, but nervous to start the write up as it means engaging with the stories differently again.
11/03/24	**Refining and Defining Themes** Today we had a thesis meeting where we talked through and reflected on the final theme development (so-far). This was really helpful, and it was also helpful to see how far id come over the last week. Farah held a reflective space which was really helpful in helping me unpick the places where I have been struggling, and think about how this might be relating to my insider researcher position.

Aii: An Extract from a Transcript of a Bracketing Conversation with a Colleague External to the Research (3rd July 2023 – Research Development Stage)

Colleague: Is there anything specific that you think you will find in your data?

Researcher: I think I will find, I think I will find, and actually interestingly I went to say *I hope I will find…* But, I think I will find an unspoken struggle. And I hope that that's where my next steps could come, from uncovering whatever this unspoken struggle is. Yeah.

If that makes sense? I think there is going to be… It feels really quite niche and really quite… Cant find my words… Something… I cant find my words… But it feels like, it feels like I'm going to uncover something.

Colleague: Have you thought about what will happen if you don't uncover what you expect to find?

Researcher: I have wondered about that… And… I don't know, I don't know. I guess… What does it say if no one else is in the position other than [redacted]? What does that say?

Colleague: What does that say about you, or [redacted] in general?

Researcher: Both probably… [redacted]… I am part of it, so id class myself in that. Yeah I have thought about what does it mean if, if not. And I don't know actually. I'm not sure.

Colleague: Is there anything that you wouldn't wish to find, or that would really surprise you?

Researcher: I read a research paper where… So there is a lot around mental health support afterwards and how families don't always feel included by professionals and all things like that. And then there was one I was reading and it was around the relief when somebody is in hospital and then the fear of them coming out of hospital and then thoughts around, would it have been better off if the person died?

Colleague: Interesting

Researcher: And that was difficult, that was a difficult read. And I think to hear that first hand would be quite difficult, particularly if that then became a theme. And that was a shared…

Colleague: Why would that be difficult?

Researcher: It's just quite… It's quite dark isn't it. Yeah. And we never / I never got to that point – I don't know whether [redacted]. But I never got to that point in my thinking. So I guess I would be thinking… How bad did it get in their family? You know, my… [redacted]… Preferred scenario in some respects, how bad was it really? And how much did you really struggle.

Colleague:	It’s interesting that you say, that you view on it from a family perspective because my first thought when you said that was how bad it was for the person, not for the family.
Researcher:	Oh ok, yeah.

Aiii: An Extract from the notes of a Consultation Meeting (20th April 2023 - Review of Documents prior to Ethics)

Attendees: Lauren (lead researcher), Katie (secondary researcher), one charity, 3 EbE’s

Interview question re: relationship:

- The way questions are phrased needs to be inquisitive rather than intrusive, could rephrase to, “can you tell me a little bit about the person we will be talking about?” (rather than asking about their relationship directly); participants can then talk about the person and what they meant to them.
- If choose to leave term ‘relationship’ in - be prepared that participants might ask about why asking about the relationship is important (can create barriers to input due to feeling on the back foot as there may be a prejudice about who they are, what they identify as)
    - **Action:** Think about why the relationship is important to ask about

Terminology: ‘How made sense of event’:

- This assumes that they have made sense of the event and that they have processed and come to a conclusion, which will probably not be the case for a lot of people.
- The term “event” in itself does not sit right; 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?

Terminology: ‘completed/non-completed suicide’

- Not advised, makes it seem as though there is something to be achieved
- A pass/fail
- **Action:** Removed, just say suicide attempt – No need to discuss outcome as it would just be ‘suicide’ if the person had died.

Support:

- When thinking about support ‘what helped’ can include activities, coping mechanisms (as these may be ways of expressing unspoken narrative)
- Make these questions at the end so that there is a more strengths focus towards the end.

Poster:

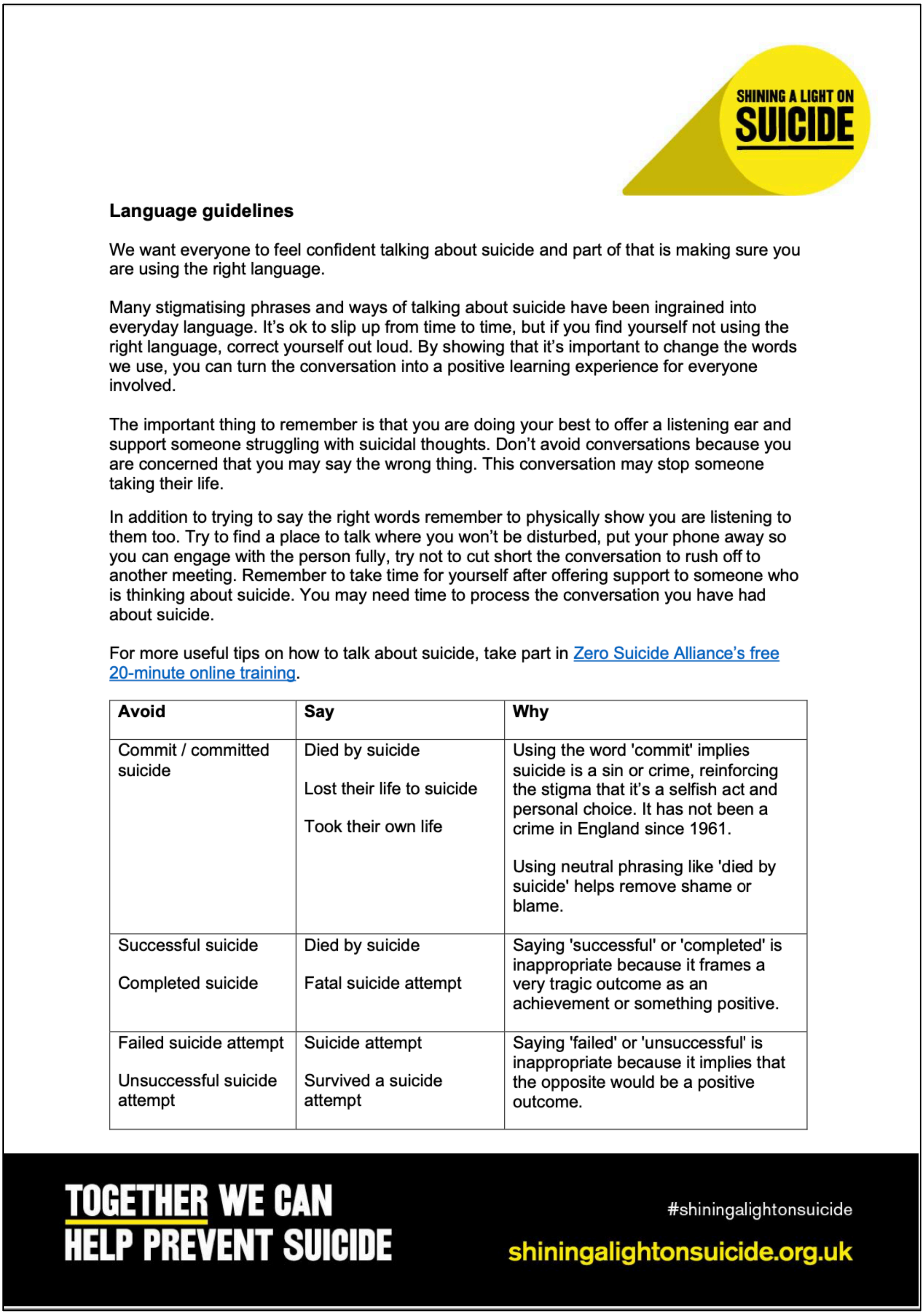
- **Action:** Change colours to match suicide prevention colours.

<u>Other points:</u>

- Ensure interview schedule sent to participants beforehand
- Important to be mindful of what that person wants to share and what the aim of asking the questions are

Appendix B: Language Guidance Examples

Bi: Shining Light on Suicide Language Guidance



SHINING A LIGHT ON
SUICIDE

Language guidelines

We want everyone to feel confident talking about suicide and part of that is making sure you are using the right language.

Many stigmatising phrases and ways of talking about suicide have been ingrained into everyday language. It’s ok to slip up from time to time, but if you find yourself not using the right language, correct yourself out loud. By showing that it’s important to change the words we use, you can turn the conversation into a positive learning experience for everyone involved.

The important thing to remember is that you are doing your best to offer a listening ear and support someone struggling with suicidal thoughts. Don’t avoid conversations because you are concerned that you may say the wrong thing. This conversation may stop someone taking their life.

In addition to trying to say the right words remember to physically show you are listening to them too. Try to find a place to talk where you won’t be disturbed, put your phone away so you can engage with the person fully, try not to cut short the conversation to rush off to another meeting. Remember to take time for yourself after offering support to someone who is thinking about suicide. You may need time to process the conversation you have had about suicide.

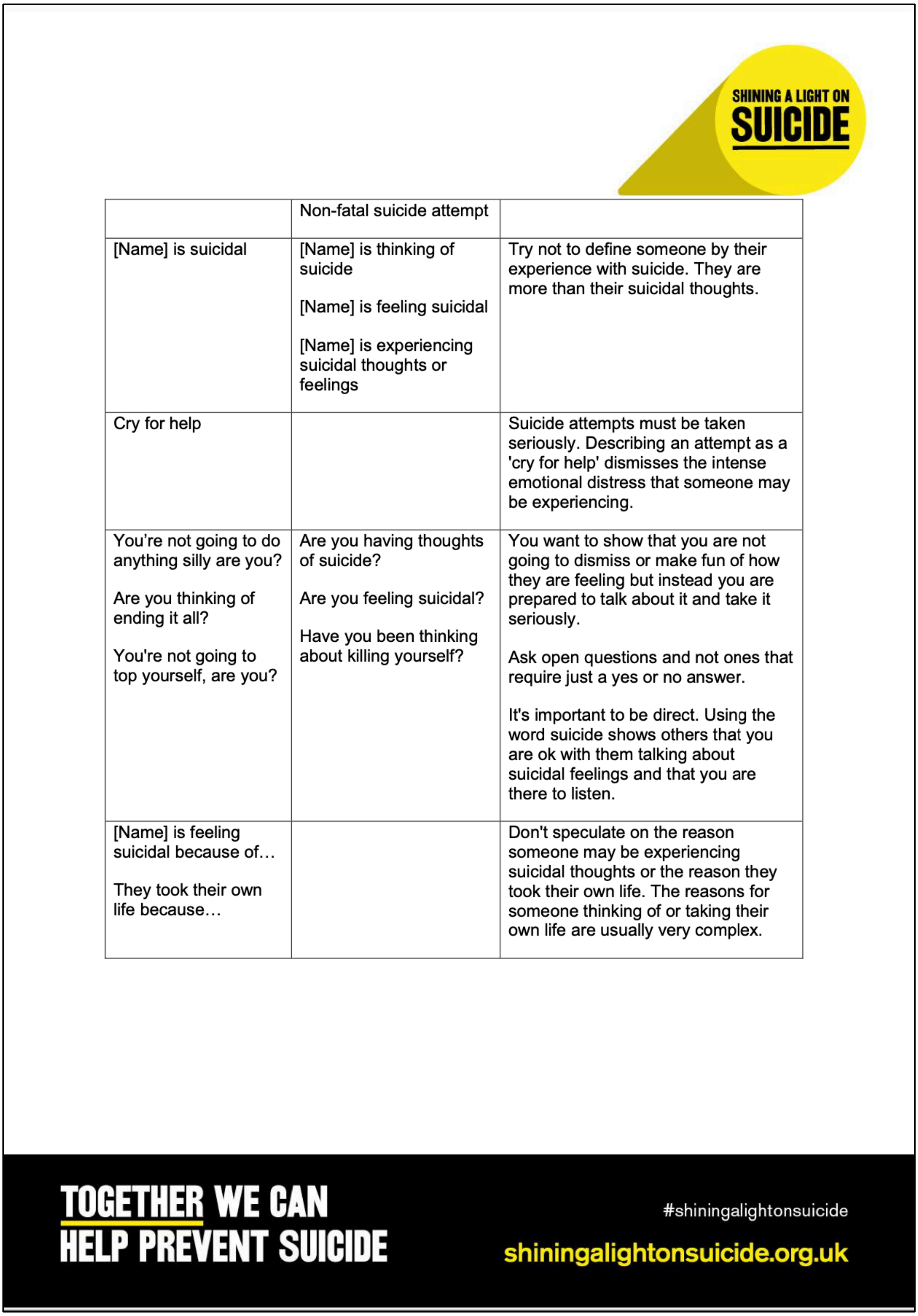
For more useful tips on how to talk about suicide, take part in Zero Suicide Alliance’s free 20-minute online training.

Avoid	Say	Why
Commit / committed suicide	Died by suicide Lost their life to suicide Took their own life	Using the word 'commit' implies suicide is a sin or crime, reinforcing the stigma that it’s a selfish act and personal choice. It has not been a crime in England since 1961. Using neutral phrasing like 'died by suicide' helps remove shame or blame.
Successful suicide Completed suicide	Died by suicide Fatal suicide attempt	Saying 'successful' or 'completed' is inappropriate because it frames a very tragic outcome as an achievement or something positive.
Failed suicide attempt Unsuccessful suicide attempt	Suicide attempt Survived a suicide attempt	Saying 'failed' or 'unsuccessful' is inappropriate because it implies that the opposite would be a positive outcome.

TOGETHER WE CAN
HELP PREVENT SUICIDE

#shiningalightonsuicide

shiningalightonsuicide.org.uk



SHINING A LIGHT ON SUICIDE

	Non-fatal suicide attempt	
[Name] is suicidal	[Name] is thinking of suicide [Name] is feeling suicidal [Name] is experiencing suicidal thoughts or feelings	Try not to define someone by their experience with suicide. They are more than their suicidal thoughts.
Cry for help		Suicide attempts must be taken seriously. Describing an attempt as a 'cry for help' dismisses the intense emotional distress that someone may be experiencing.
You're not going to do anything silly are you? Are you thinking of ending it all? You're not going to top yourself, are you?	Are you having thoughts of suicide? Are you feeling suicidal? Have you been thinking about killing yourself?	You want to show that you are not going to dismiss or make fun of how they are feeling but instead you are prepared to talk about it and take it seriously. Ask open questions and not ones that require just a yes or no answer. It's important to be direct. Using the word suicide shows others that you are ok with them talking about suicidal feelings and that you are there to listen.
[Name] is feeling suicidal because of… They took their own life because…		Don't speculate on the reason someone may be experiencing suicidal thoughts or the reason they took their own life. The reasons for someone thinking of or taking their own life are usually very complex.

TOGETHER WE CAN
HELP PREVENT SUICIDE

#shiningalightonsuicide

shiningalightonsuicide.org.uk

Bii: Samaritans Media Guidance

10 things to remember when reporting suicide

1 Avoid reporting methods of suicide in articles, such as describing someone as having died by hanging, particularly in headlines.

2 Include references to suicide being preventable and signpost sources of support, such as Samaritans' helpline. This can encourage people to seek help, which could save lives.

When life is difficult, Samaritans are here – day or night, 365 days a year. You can call them for free on 116 123, email them at jo@samaritans.org, or visit www.samaritans.org to find your nearest branch.

3 Avoid dramatic headlines and strong terms such as 'suicide epidemic'. Never suggest that someone died instantly or that their death was quick, easy, painless, inevitable or a solution to their problems.Steer clear of language that sensationalises or glorifies suicide.

4 Don't refer to a specific site or location as popular or known for suicides, for example, 'notorious site' or 'hot spot' and refrain from providing information, such as the height of a bridge or cliff.

5 Avoid dramatic, emotive or sensational pictures or video footage. Excessive imagery can glamourise a death and lead vulnerable individuals to over-identify with the deceased.

6 Avoid excessive amounts of coverage and overly prominent placement of stories, such as a front page splash or making it a lead story, and do not link to previous stories about suicide.

7 Treat social media with particular caution and avoid mentioning or linking to comments, or websites/forums that promote or glamourise suicide. Similarly, it is safer not to open comments sections on suicide stories and careful consideration should be given around the appropriateness of promoting stories through push notifications.

8 Including content from suicide notes or similar messages left by a person who has died should be avoided. They can increase the likelihood of people identifying with the deceased. It may also romanticise a suicide or cause distress to the bereaved family and friends.

9 Speculation about the 'trigger' or cause of a suicide can oversimplify the issue and should be avoided. Suicide is extremely complex and most of the time there is no single event or factor that leads someone to take their own life.

10 Young people are more susceptible to suicide contagion. When covering the death of a young person, do not give undue prominence to the story or repeat the use of photographs, including galleries. Don't use emotive, romanticised language or images – a sensitive, factual approach is much safer. Coverage that reflects the wider issues around suicide, including that it is preventable, can help reduce the risk of suicidal behaviour. Include clear and direct references to resources and support organisations.

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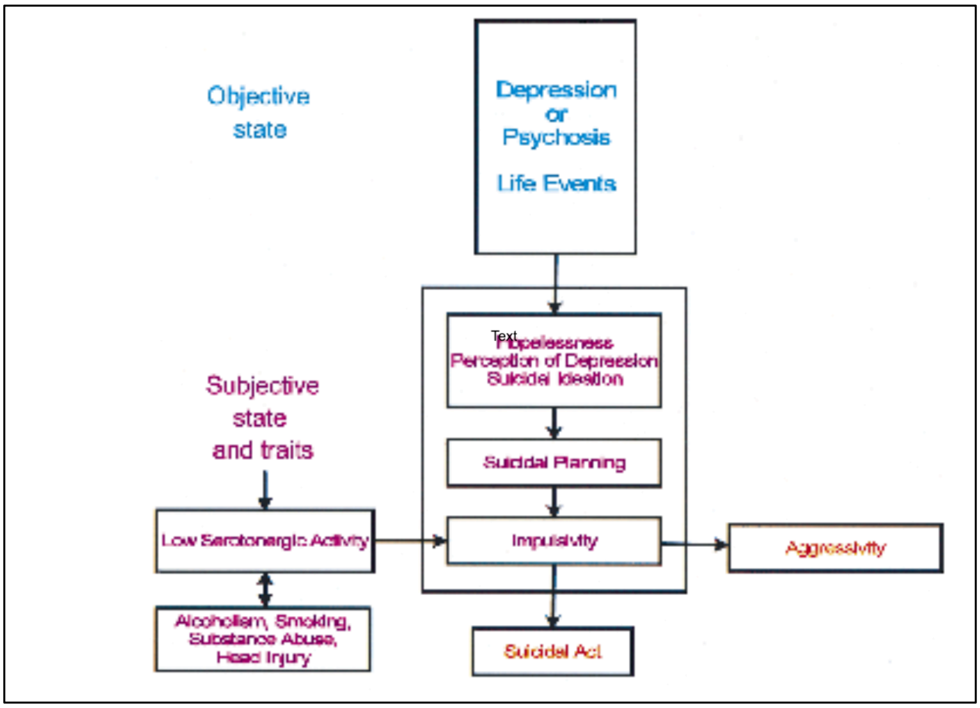
4

Media Guidelines for Reporting Suicide

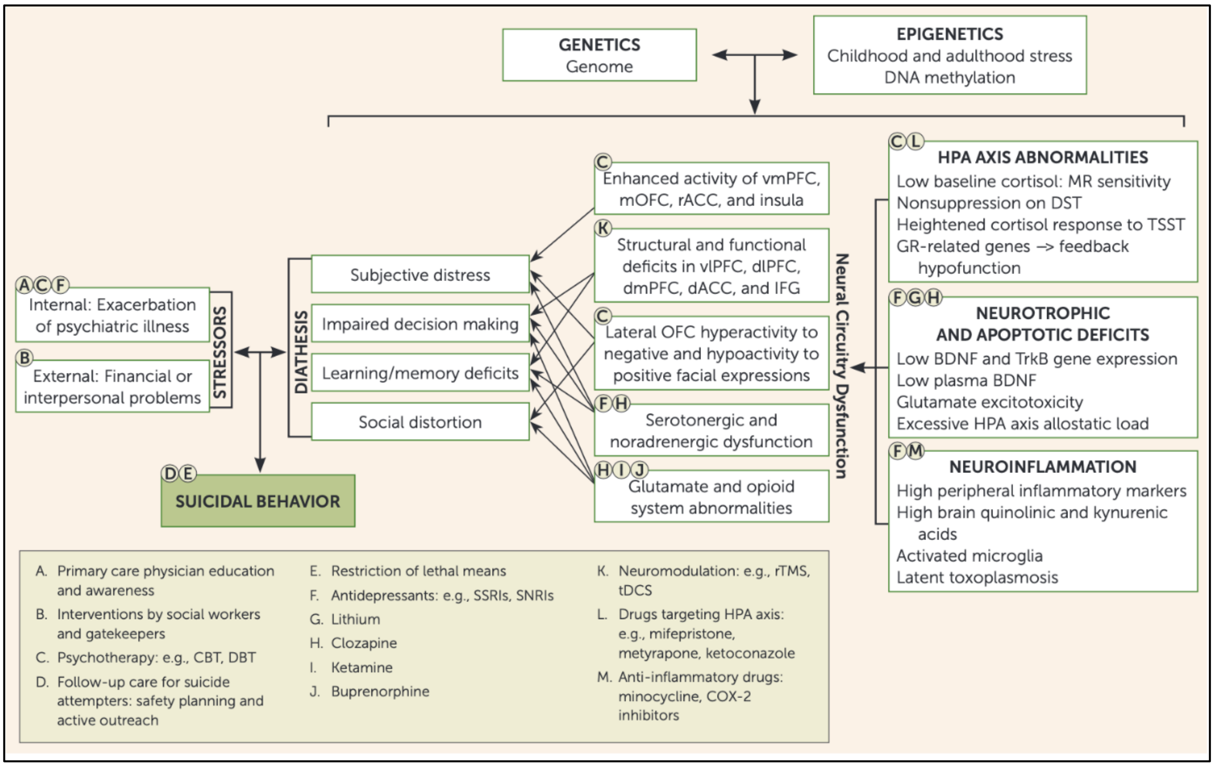
© Samaritans 2020

Appendix C: A Clinical Model of Suicidal Behaviour (Mann to al., 1999)

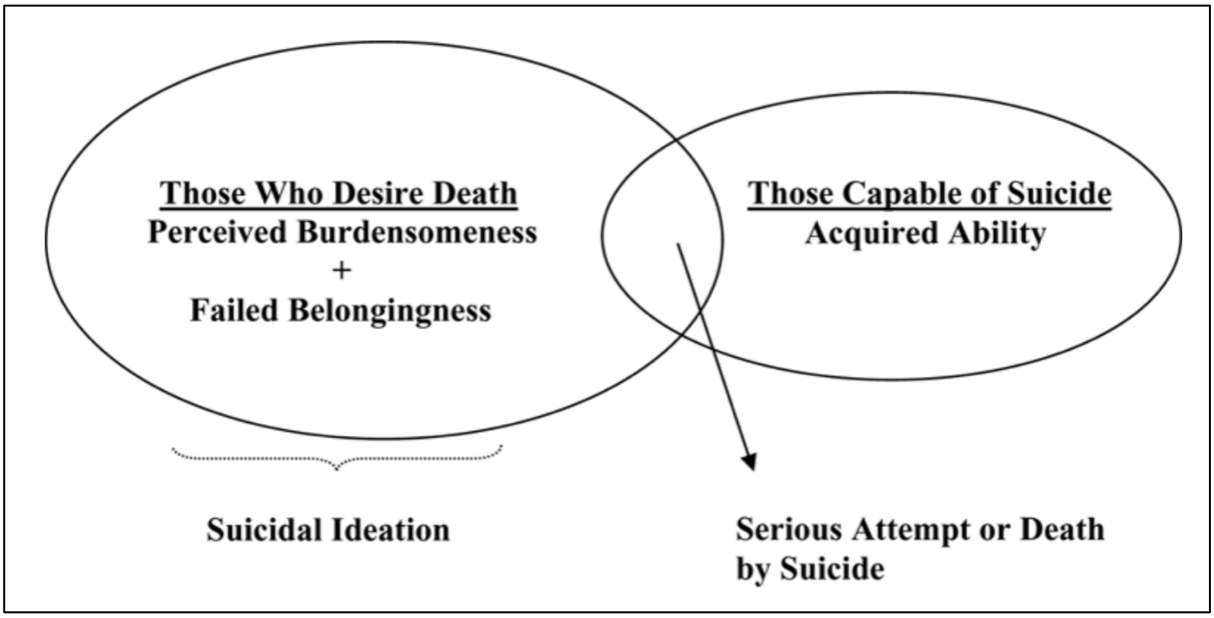
Ci) A Clinical Model of Suicidal Behaviour (Mann et al., 1999)



Cii) The Brain-Centric Model of Suicidal Behaviour (Mann & Rizk, 2020)

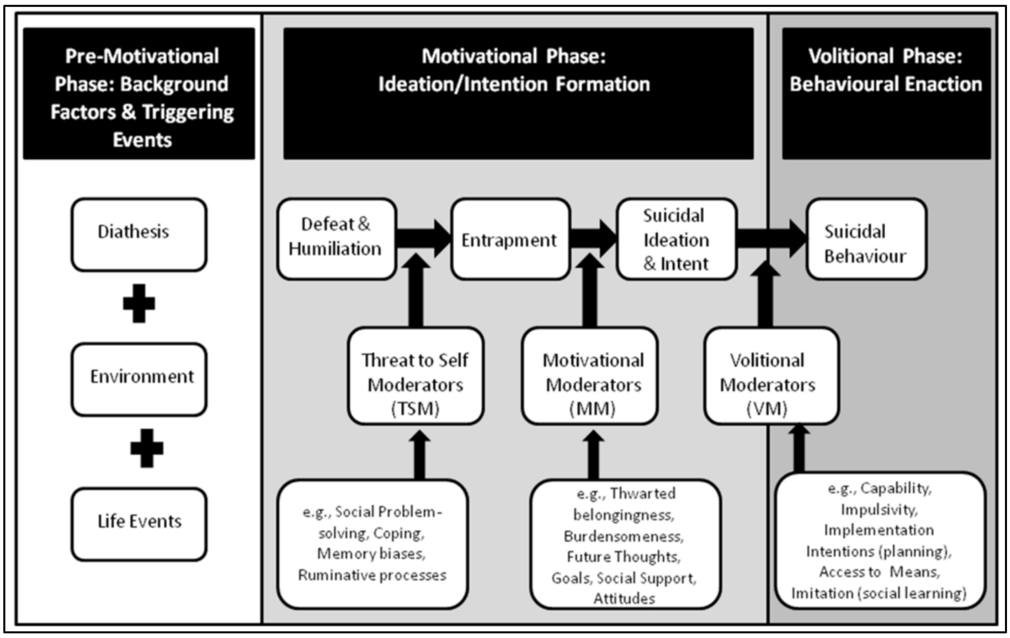


Appendix D: Interpersonal-Psychological Model of Suicidal Behaviour (Joiner, 2005)

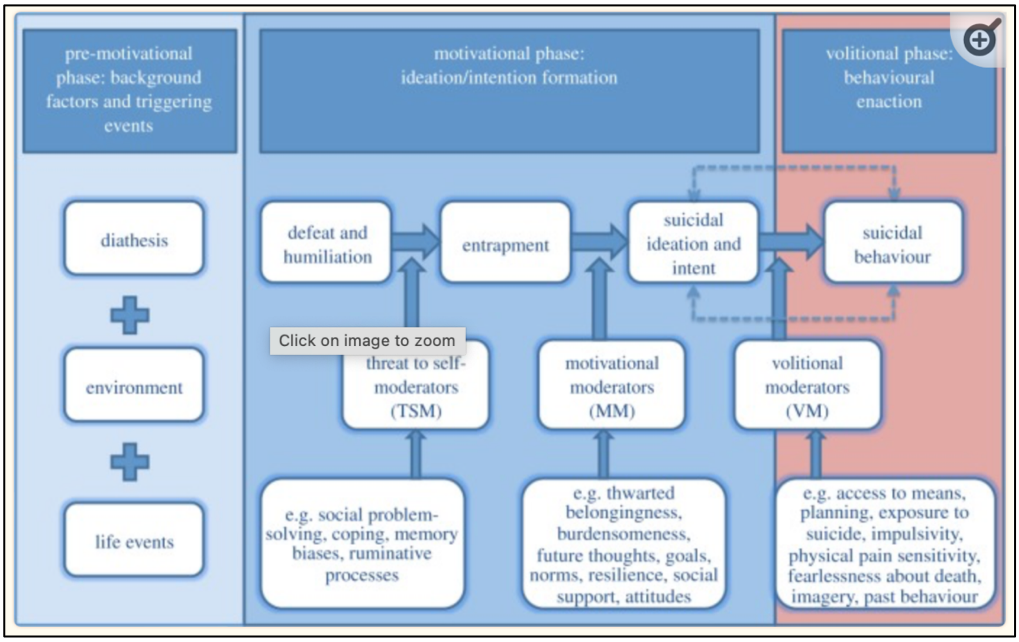


Appendix E: The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour (O'Connor, 2011)

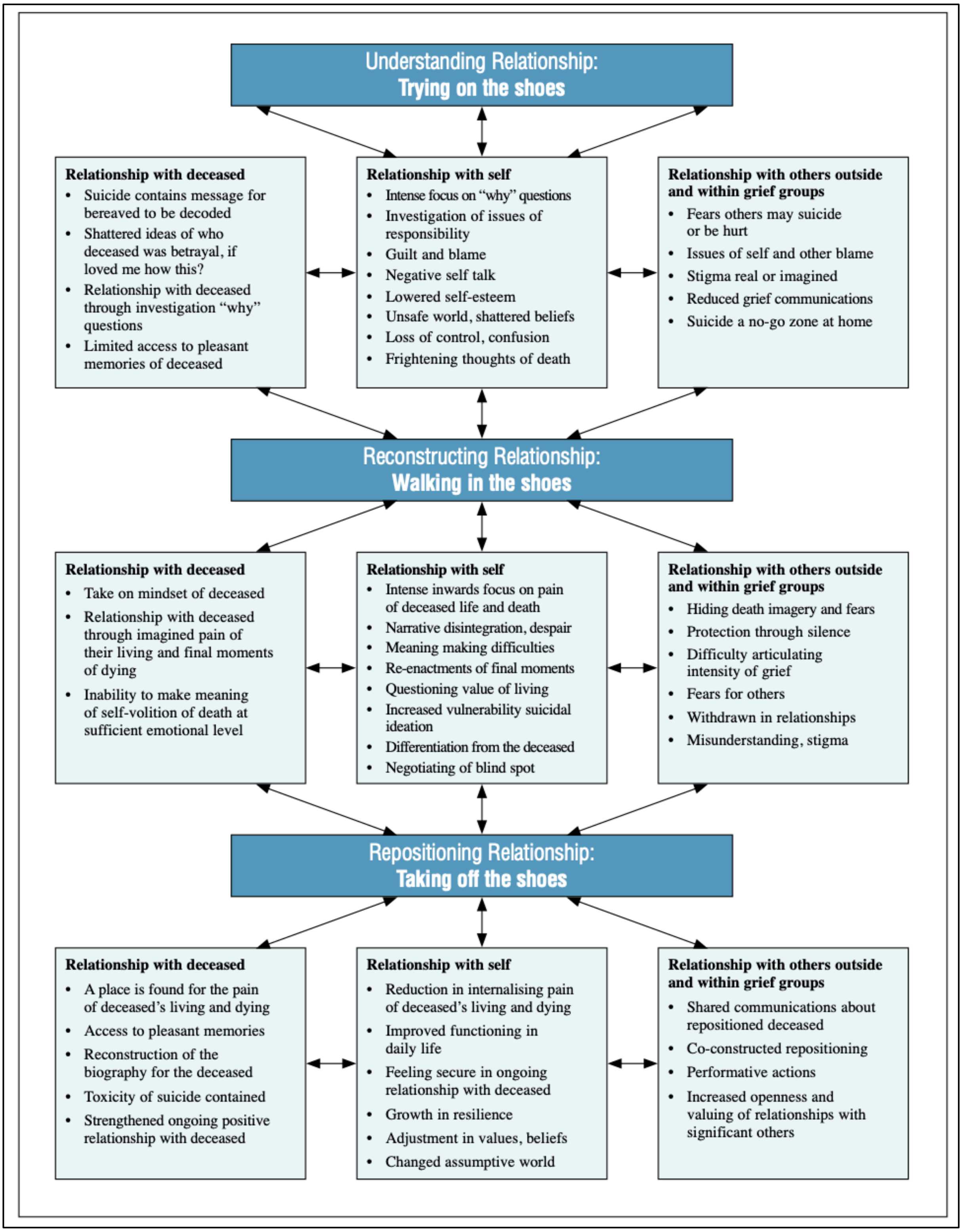
Ei) The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour (O'Connor, 2011)



Eii) The Integrated Motivational–Volitional (IMV) Model of Suicidal Behaviour (O'Connor & Kirtley, 2018)



Appendix F: Tripartite Model of Suicide Grief (Sands, 2009)



Understanding Relationship:
Trying on the shoes

Relationship with deceased
- Suicide contains message for bereaved to be decoded
- Shattered ideas of who deceased was betrayal, if loved me how this?
- Relationship with deceased through investigation "why" questions
- Limited access to pleasant memories of deceased

Relationship with self
- Intense focus on "why" questions
- Investigation of issues of responsibility
- Guilt and blame
- Negative self talk
- Lowered self-esteem
- Unsafe world, shattered beliefs
- Loss of control, confusion
- Frightening thoughts of death

Relationship with others outside and within grief groups
- Fears others may suicide or be hurt
- Issues of self and other blame
- Stigma real or imagined
- Reduced grief communications
- Suicide a no-go zone at home

Reconstructing Relationship:
Walking in the shoes

Relationship with deceased
- Take on mindset of deceased
- Relationship with deceased through imagined pain of their living and final moments of dying
- Inability to make meaning of self-volition of death at sufficient emotional level

Relationship with self
- Intense inwards focus on pain of deceased life and death
- Narrative disintegration, despair
- Meaning making difficulties
- Re-enactments of final moments
- Questioning value of living
- Increased vulnerability suicidal ideation
- Differentiation from the deceased
- Negotiating of blind spot

Relationship with others outside and within grief groups
- Hiding death imagery and fears
- Protection through silence
- Difficulty articulating intensity of grief
- Fears for others
- Withdrawn in relationships
- Misunderstanding, stigma

Repositioning Relationship:
Taking off the shoes

Relationship with deceased
- A place is found for the pain of deceased's living and dying
- Access to pleasant memories
- Reconstruction of the biography for the deceased
- Toxicity of suicide contained
- Strengthened ongoing positive relationship with deceased

Relationship with self
- Reduction in internalising pain of deceased's living and dying
- Improved functioning in daily life
- Feeling secure in ongoing relationship with deceased
- Growth in resilience
- Adjustment in values, beliefs
- Changed assumptive world

Relationship with others outside and within grief groups
- Shared communications about repositioned deceased
- Co-constructed repositioning
- Performative actions
- Increased openness and valuing of relationships with significant others

Appendix G: Sample of CASP for SLR Paper

CASP for (Asare-Doku et al., 2017)

CASP Criteria (incl. description)	**Quality Appraisal**	**Rating**
Section A: Are the Results Valid?		
Was there a clear statement of the aims of the research? ***Consider:*** *1) what was the goal of the research? 2) why it was thought important?, 3) its relevance.*	**Goal:** Outlined in aims/objectives - To understand the experiences of the families of attempt survivors and how they cope with the aftermath of the attempt. **Importance:** No research in this area in Ghana. **Relevance:** No research in this area in Ghana.	1
Is a qualitative methodology appropriate? ***Consider:*** *1) If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants, 2) Is qualitative research the right methodology for addressing the research goal?*	IPA is the right method, appropriate for sample size and for gaining a subjective experience. The author has made attempts to understand the subjective experiences of the participants after each quote / point made.	1
Is it Worth Continuing?		
Was the research design appropriate to address the aims of the research? ***Consider:*** *1) If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)*	Design was appropriate to address the aims of research, they have described why they chose to recruit from a specific setting.	1

Was the recruitment strategy appropriate to the aims of the research? ***Consider:*** *1) If the researcher has explained how the participants were selected, 2) If they explained why the participants, they selected were the most appropriate to provide access to the type of knowledge sought by the study, 3) If there are any discussions around recruitment (e.g., why some people chose not to take part)*	The research has explained how the participants were recruited, including where they were recruited from and what sampling methods were used. Given the context and the stigma around suicide in Ghana, the method of recruitment was appropriate. The paper includes a narrative on why some people chose to drop out of the study after they had been recruited.	1
Was the data collected in a way that addressed the research issue? ***Consider:*** *1) If the setting for the data collection was justified, 2) If it is clear how data were collected (e.g., focus group, semi-structured interview etc.), 3) If the researcher has justified the methods chosen, 4) If the researcher has made the methods explicit (e.g., for interview method, is there an indication of how interviews are conducted, or did they use a topic guide), 5) If methods were modified during the study. If so, has the researcher explained how and why, 6) If the form of data is clear (e.g., tape recordings, video material, notes etc.), 7) If the researcher has discussed saturation of data*	The setting for data collection was appropriate given the context around suicide in Ghana, this is explained and justified. It is clear that data was collected face-to-face, via semi-structured interviews. The topic guide has been attached as an Appendix. It does not look like methods were changes during the study. Data form (audio) and method of transcription is clear. The researcher has not discussed data saturation.	

Has the relationship between researcher and participants been adequately considered? ***Consider:** 1) If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location, 2) How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	This is not addressed in the study. There is no evidence that the researcher has reflected on their own role and potential biases etc. at any point in the study. There is no evidence that the researcher had to respond to any events and therefore consider how changes might impact research design.	0
Section B: What are the Results?		
Have ethical issues been taken into consideration? ***Consider:** 1) If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained, 2) If the researcher has discussed issues raised by the study (e.g., issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study), 3) If approval has been sought from the ethics committee*	There is not sufficient detail on how research was explained to participants. There is no mention of how issues raised in the study were addressed. The research obtained consent from Ethics Committee for the Humanities at the University of Ghana.	0
Was the data analysis sufficiently rigorous?	There is a description of how IPA was conducted. There is sufficient data presented to	0

***Consider:** 1) If there is an in-depth description of the analysis process, 2) If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data, 3) Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process, 4) If sufficient data are presented to support the findings, 5) To what extent contradictory data are taken into account, 6) Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	demonstrate themes derived from data analysis, supporting findings. Contradictory data is discussed openly, and thoughts are given as to why there are contradictions. No evidence that the researcher has critically examined their role in data analysis.	
Is there a clear statement of findings? ***Consider:** 1) If the findings are explicit, 2) If there is adequate discussion of the evidence both for and against the researcher's arguments, 3) If the researcher has discussed the credibility of their findings (e.g., triangulation, respondent validation, more than one analyst), 4) If the findings are discussed in relation to the original research question*	The findings are explicit. There is a discussion of evidence for the findings, not so much for against the findings. Credibility of findings is discussed when they describe how data analysis was completed. The findings are discussed in relation to the research questions.	1
Section C: Will the Results help Locally?		
How valuable is the research?	The authors discuss the importance of the research, adding to a very limited evidence base. They mention how suicide is still criminalised. Areas for new research are	1

Consider: *1) If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature If they identify new areas where research is necessary If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used)*	mentioned in terms of clinical implications. There is no discussion of how these results might be transferred to other populations.	
		Total Rating
		7/10

Appendix H: A Qualitative Summary of CASP Data

Consistent Areas of Strength. All 14 studies achieved a 'yes' for *Item 1* (Was there a clear statement of the aims of the research?) and *Item 9* (Is there a clear statement of findings?). This finding is fitting as it would be unlikely that an article which did not clearly outline its *aims* and *findings* would pass through the peer-review process, and this SLR excludes any article which has not been peer-reviewed. Equally, reporting on the *aims* and *findings* is an objective task often completed in a succinct manner to effectively inform the reader. The objectivity would have made it easier for the critical appraisers to notice, and therefore provide the 'yes' outcome.

Items 2-5 (Is 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?) were also identified as areas of strength across the 14 papers. *Item 2* achieved a 'yes' in nine of the 14 papers*, item 3* achieved a 'yes' in eight of the 14 papers, *item 4* achieved a 'yes' in 11 of the 14 papers, and *item 5* achieved a 'yes' in ten of the 14 papers. Collectively, these items speak to the methodological rigor involved in the respective articles. Table 10 shows that the articles which did not receive a 'yes' for these items, most commonly received a 'can't tell' which means that the rigor may actually be much stronger than this result suggests but the authors have just not made that explicitly clear.

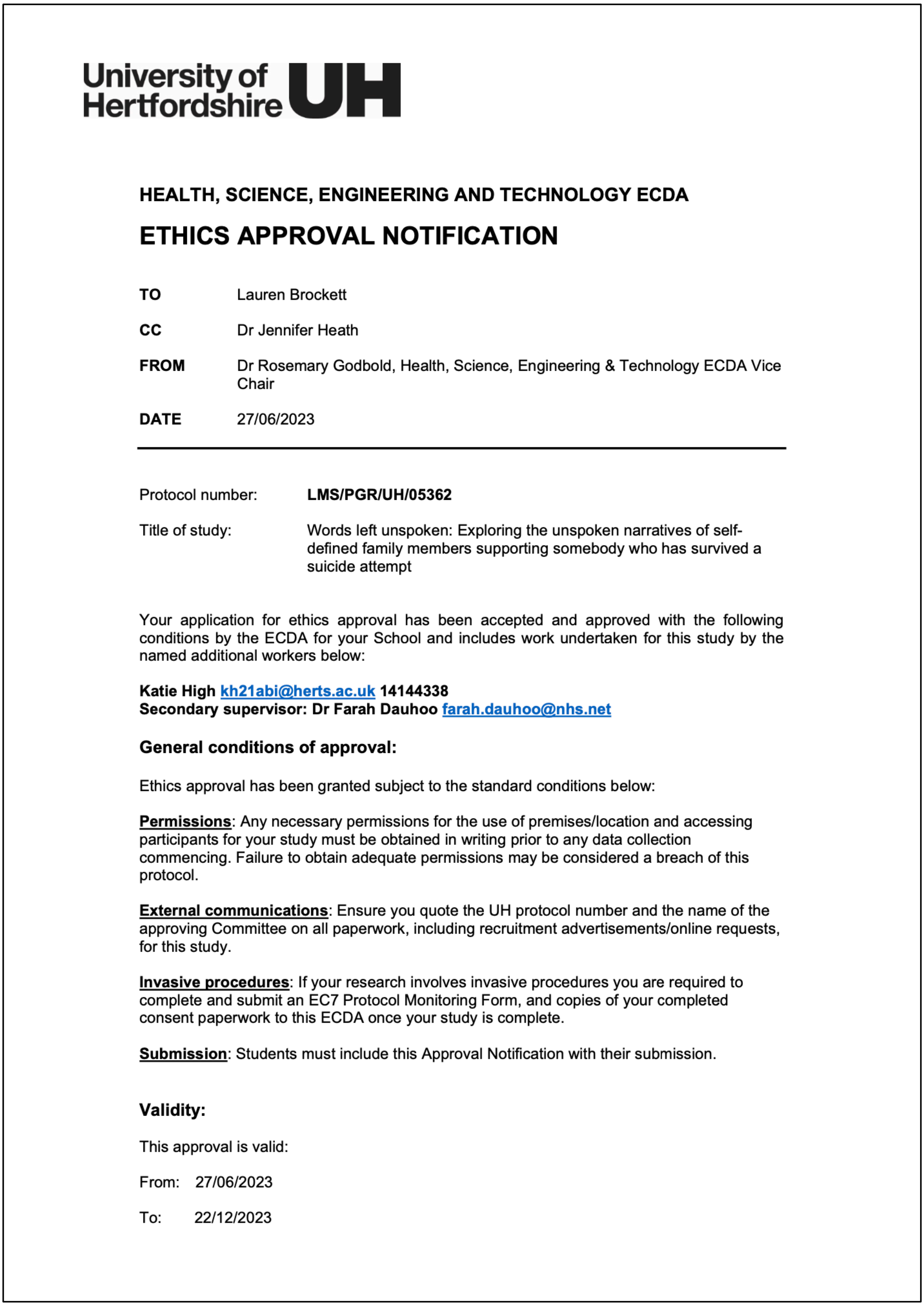
Consistent Areas of Challenge. *Item 6* (Has the relationship between researcher and participants been adequately considered?) and *Item 10* (How valuable is the research?) were the lowest scored questions across the dataset. Only one paper (Doyle et al., 2021) received a 'yes' for *Item 6.* In the article Doyle et al. consider researcher intersectionality and personal positioning in relation to that of their participants. The premise of the article is to compare qualitative responses from Black mothers and White mothers following the hospitalisation of their adolescents, bringing race to the forefront of thinking from the offset. Three articles (Asare-Doku et al., 2017; Doyle et al., 2021; Weissinger et al., 2023) received a ‘yes’ for *Item 10;* and three articles received a ‘no’ (Magne-Ingvar & Öjehagen, 1999b, 1999a; Ngwane & Van Der Wath, 2019). *Item 10* is subjective; the eight remaining papers received a ‘can’t tell’. This suggests that there is evidence that value had been thought about, but this evidence had not been made explicitly clear to the critical appraisers.

Discrepancies. There were discrepancies across the dataset as to how the articles addressed *Item 7* (Have ethical issues been taken into consideration?) and *Item 8* (Was the data analysis sufficiently rigorous?). Five articles received a ‘yes’ on both of these items, and five articles did not. This SLR allows for inclusion of international papers, but the CASP an English tool. Arguably, discrepancies are not a surprise as different countries will have different standards for publication which may not match with what the CASP is assessing. *Item 7* is interesting, as one would *assume* that ethical issues were taken into consideration or the ethics committee supporting the studies would not have endorsed them.

Appendix I: Tabulation of Thematic Synthesis

Author(s) and Date of Publication	**Main Themes and Subthemes**								
	Unmet Expectations		**Psychological Barriers to Help-Seeking**			**Connection is Key**			
	Hopes for Collaboration	"I was invisible"	"I blamed myself"	Shame and Stigma	Lacking Trust	"I felt alone"	Communication	Prayer	Peer Support
(Asare-Doku et al., 2017c)				✓	✓		✓	✓	
(Daly, 2005)	✓	✓	✓	✓	✓	✓	✓		✓
(S.-J. A. Dempsey et al., 2019)	✓	✓			✓		✓		✓
(Doyle et al., 2021)	✓	✓	✓	✓		✓	✓	✓	
(Dransart & Guerry, 2017)	✓	✓			✓	✓	✓		
(Gorman et al., 2023)	✓	✓	✓	✓		✓	✓		✓
(Marshall et al., 2022)	✓	✓		✓		✓	✓		✓
(McLaughlin et al., 2016c)	✓	✓	✓	✓		✓	✓		
(McLaughlin et al., 2014)	✓	✓	✓	✓		✓	✓		
(Ngwane & Van Der Wath, 2019)		✓	✓	✓	✓		✓		✓
(Nova et al., 2019)	✓		✓	✓		✓	✓	✓	
(Weissinger et al., 2023)		✓	✓	✓		✓	✓		✓
Total	**9/12**	**10/12**	**8/12**	**10/12**	**3/12**	**9/12**	**12/12**	**3/12**	**6/12**

Appendix J: Confirmation of Ethical Approval



University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Lauren Brockett

CC Dr Jennifer Heath

FROM Dr Rosemary Godbold, Health, Science, Engineering & Technology ECDA Vice Chair

DATE 27/06/2023

Protocol number: **LMS/PGR/UH/05362**

Title of study: Words left unspoken: Exploring the unspoken narratives of self-defined family members supporting somebody who has survived a suicide attempt

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:

Katie High kh21abi@herts.ac.uk 14144338
Secondary supervisor: Dr Farah Dauhoo 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: 27/06/2023

To: 22/12/2023

Appendix K: Psychological Distress Protocol

Ki: 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 helplines.

Kii: Risk Management Protocol - For Researchers

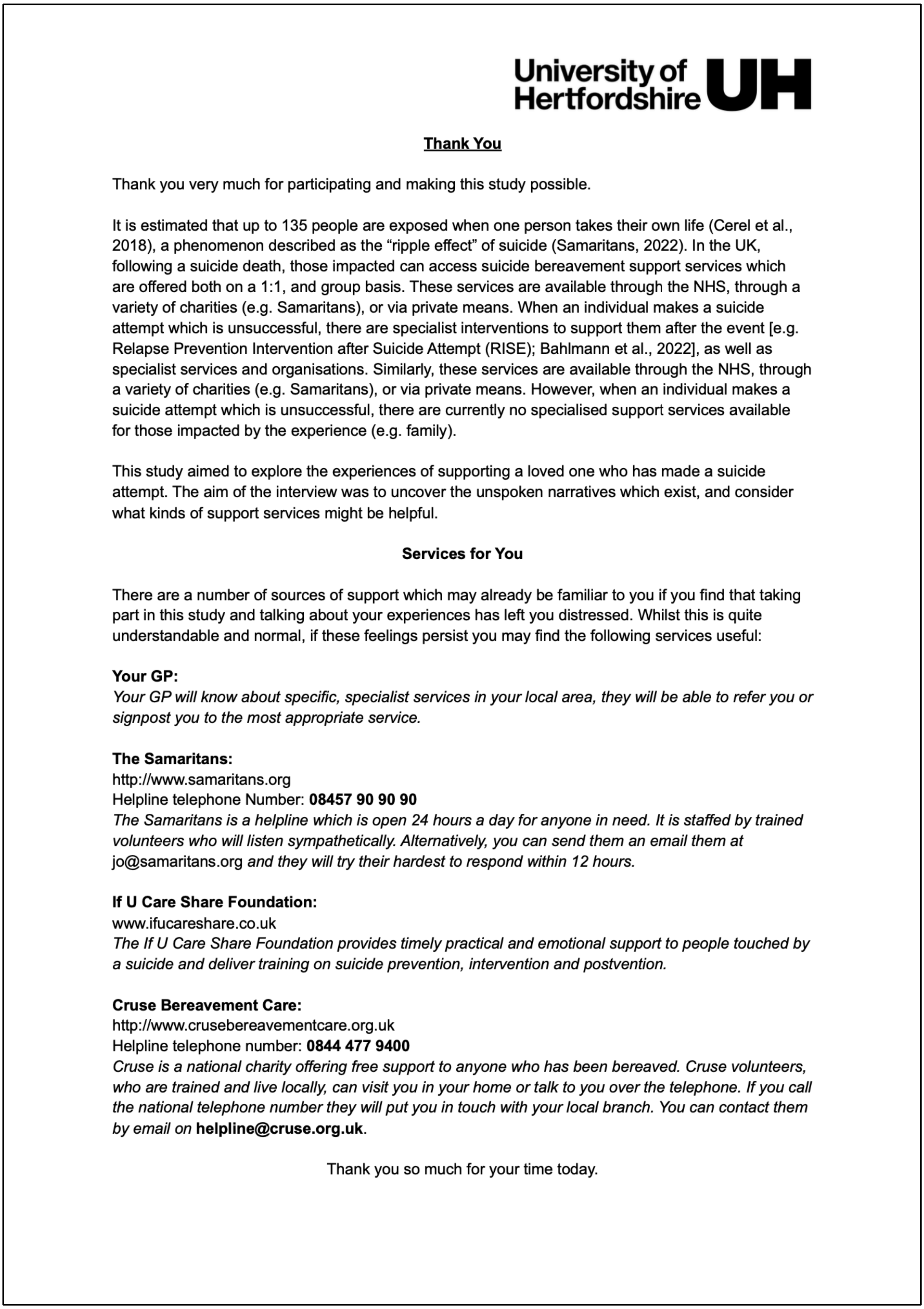
Prior to any interview taking place, research supervisors will be made aware of the time and location of the interview so that the researchers are able to contact them (telephone or email) should any concerns arise.

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: De-brief Sheet



University of Hertfordshire UH

Thank You

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

It is estimated that up to 135 people are exposed when one person takes their own life (Cerel et al., 2018), a phenomenon described as the “ripple effect” of suicide (Samaritans, 2022). In the UK, following a suicide death, those impacted can access suicide bereavement support services which are offered both on a 1:1, and group basis. These services are available through the NHS, through a variety of charities (e.g. Samaritans), or via private means. When an individual makes a suicide attempt which is unsuccessful, there are specialist interventions to support them after the event [e.g. Relapse Prevention Intervention after Suicide Attempt (RISE); Bahlmann et al., 2022], as well as specialist services and organisations. Similarly, these services are available through the NHS, through a variety of charities (e.g. Samaritans), or via private means. However, when an individual makes a suicide attempt which is unsuccessful, there are currently no specialised support services available for those impacted by the experience (e.g. family).

This study aimed to explore the experiences of supporting a loved one who has made a suicide attempt. The aim of the interview was to uncover the unspoken narratives which exist, and consider what kinds of support services might be helpful.

Services for You

There are a number of 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:

Your GP:
Your GP will know about specific, specialist services in your local area, they will be able to refer you or signpost you to the most appropriate service.

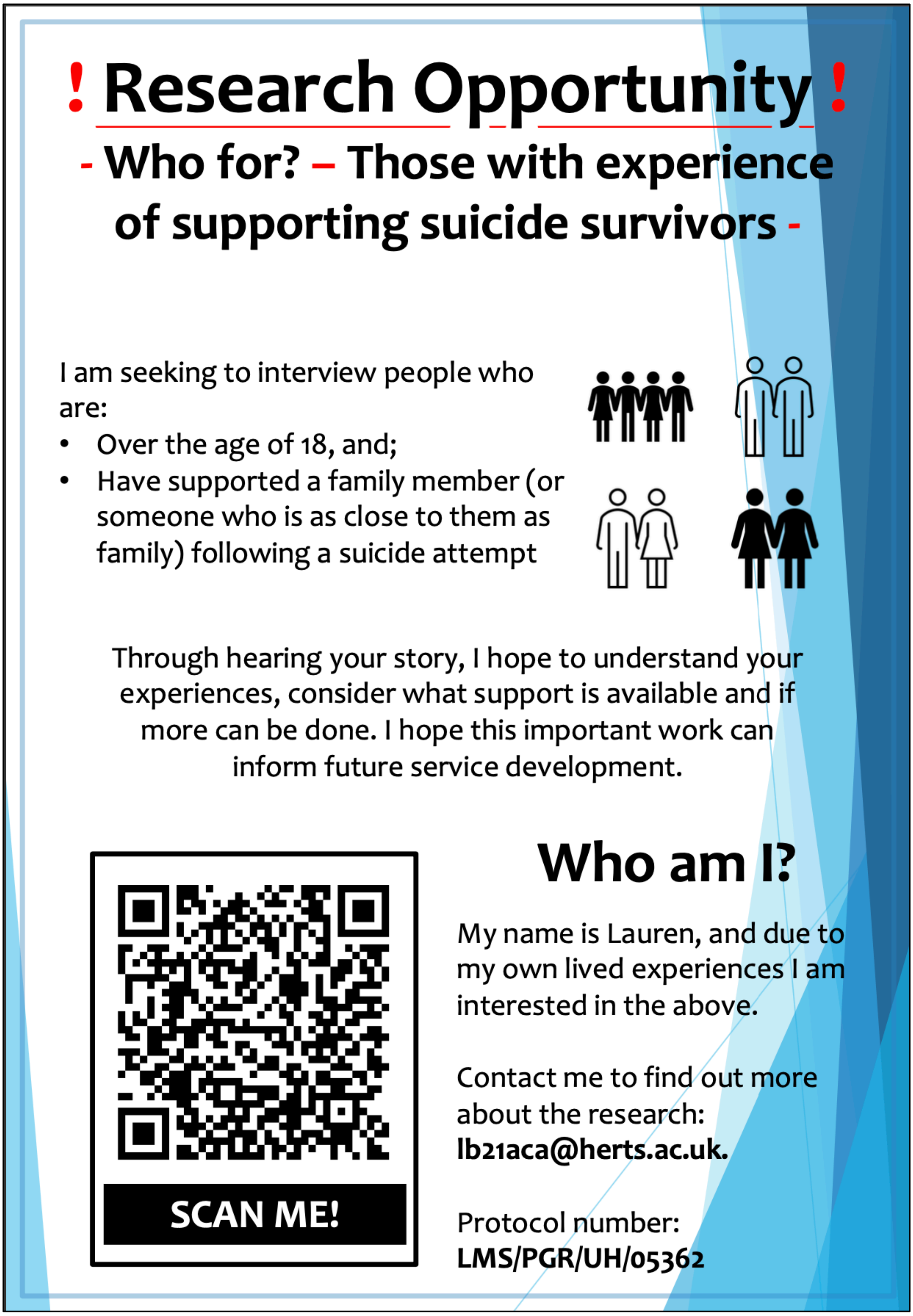
The Samaritans:
http://www.samaritans.org
Helpline telephone Number: **08457 90 90 90**
The Samaritans is a helpline which is open 24 hours a day for anyone in need. It is staffed by trained volunteers who will listen sympathetically. Alternatively, you can send them an email them at jo@samaritans.org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

If U Care Share Foundation:
www.ifucareshare.co.uk
The If U Care Share Foundation provides timely practical and emotional support to people touched by a suicide and deliver training on suicide prevention, intervention and postvention.

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**.

Thank you so much for your time today.

Appendix M: Advertisement Poster



! Research Opportunity !

- Who for? – Those with experience of supporting suicide survivors -

I am seeking to interview people who are:

- Over the age of 18, and;
- Have supported a family member (or someone who is as close to them as family) following a suicide attempt

Through hearing your story, I hope to understand your experiences, consider what support is available and if more can be done. I hope this important work can inform future service development.

SCAN ME!

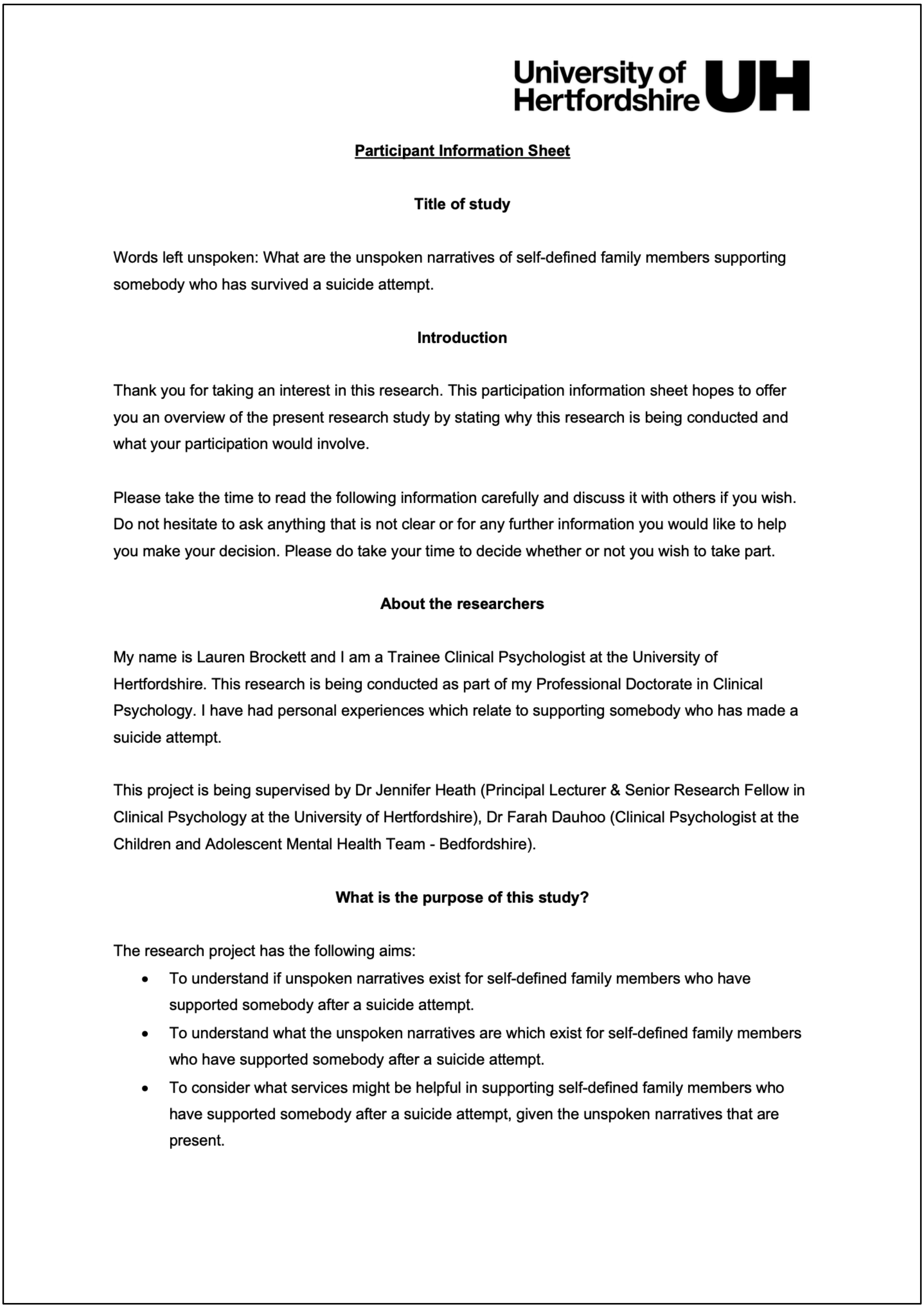
Who am I?

My name is Lauren, and due to my own lived experiences I am interested in the above.

Contact me to find out more about the research:
lb21aca@herts.ac.uk.

Protocol number:
LMS/PGR/UH/05362

Appendix N: Participant Information Form



University of Hertfordshire UH

Participant Information Sheet

Title of study

Words left unspoken: What are the unspoken narratives of self-defined family members supporting somebody who has survived a suicide attempt.

Introduction

Thank you for taking an interest in this research. This participation information sheet hopes to offer you an overview of the present 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 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.

About the researchers

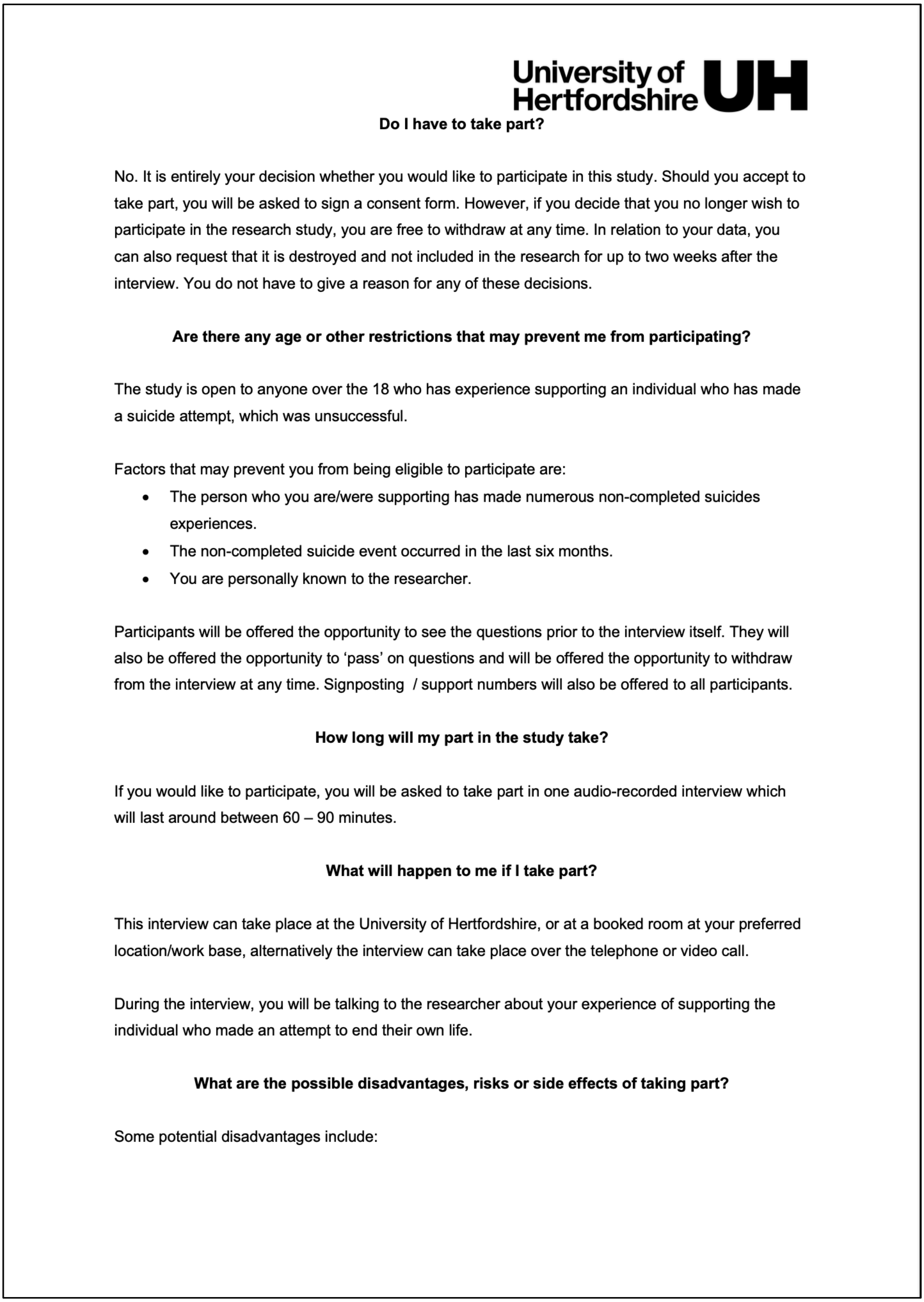
My name is Lauren Brockett and I am a Trainee Clinical Psychologist at the University of Hertfordshire. This research is being conducted as part of my Professional Doctorate in Clinical Psychology. I have had personal experiences which relate to supporting somebody who has made a suicide attempt.

This project is being supervised by Dr Jennifer Heath (Principal Lecturer & Senior Research Fellow in Clinical Psychology at the University of Hertfordshire), Dr Farah Dauhoo (Clinical Psychologist at the Children and Adolescent Mental Health Team - Bedfordshire).

What is the purpose of this study?

The research project has the following aims:

- To understand if unspoken narratives exist for self-defined family members who have supported somebody after a suicide attempt.
- To understand what the unspoken narratives are which exist for self-defined family members who have supported somebody after a suicide attempt.
- To consider what services might be helpful in supporting self-defined family members who have supported somebody after a suicide attempt, given the unspoken narratives that are present.



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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 you no longer wish to participate in the research study, you are free to withdraw at any time. In relation to your data, you can also request that it is destroyed and not included in the research for up to two weeks after the interview. You do not have to give a reason for any of these decisions.

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

The study is open to anyone over the 18 who has experience supporting an individual who has made a suicide attempt, which was unsuccessful.

Factors that may prevent you from being eligible to participate are:

- The person who you are/were supporting has made numerous non-completed suicides experiences.
- The non-completed suicide event occurred in the last six months.
- You are personally known to the researcher.

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 / support numbers will also be offered to all participants.

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.

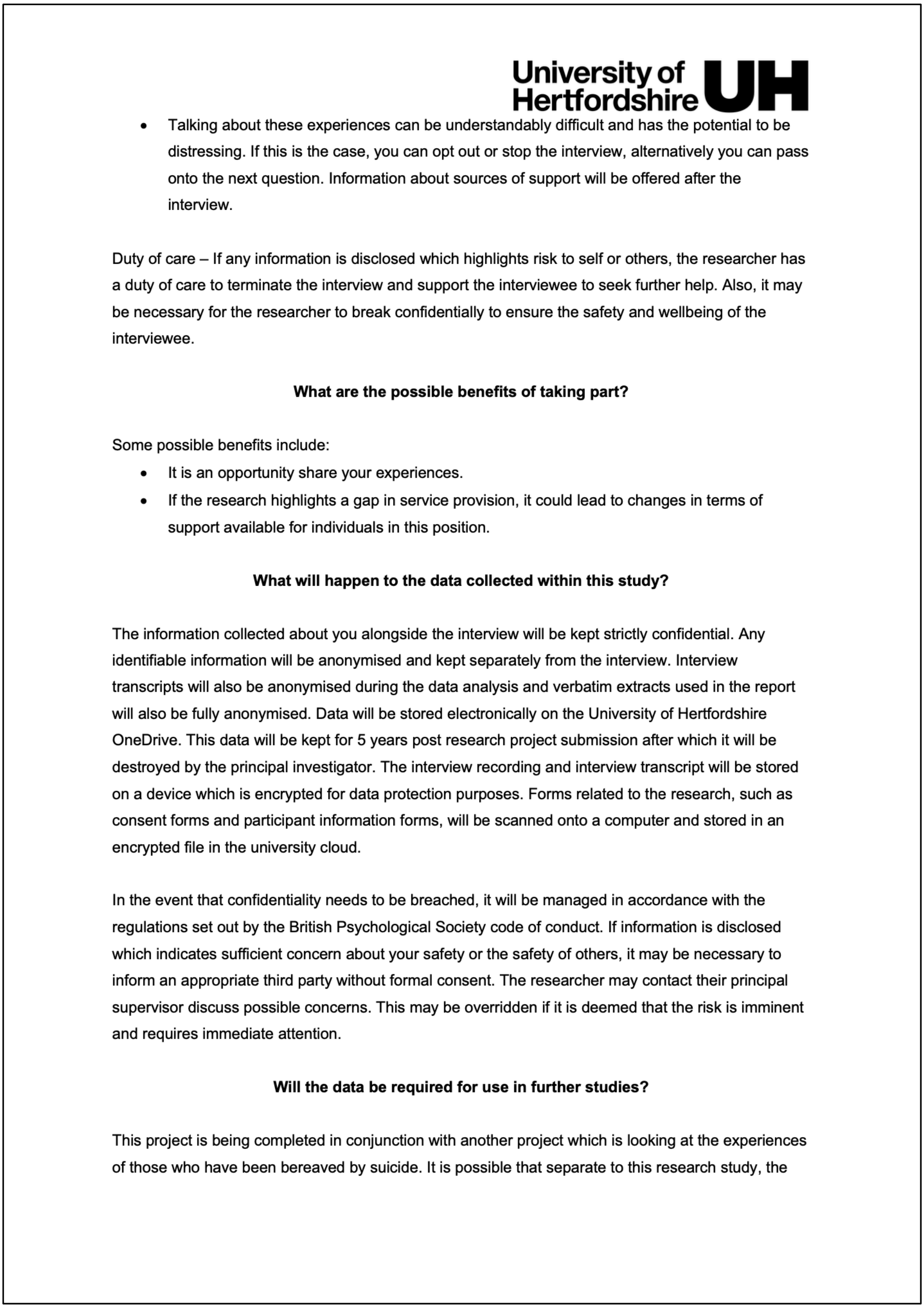
What will happen to me if I take part?

This interview can take place at the University of Hertfordshire, or at a booked room at your preferred location/work base, alternatively the interview can take place over the telephone or video call.

During the interview, you will be talking to the researcher about your experience of supporting the individual who made an attempt to end their own life.

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

Some potential disadvantages include:



University of Hertfordshire UH

- 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.

What are the possible benefits of taking part?

Some possible benefits include:

- It is an opportunity share your experiences.
- If the research highlights a gap in service provision, it could lead to changes in terms of support available for individuals in this position.

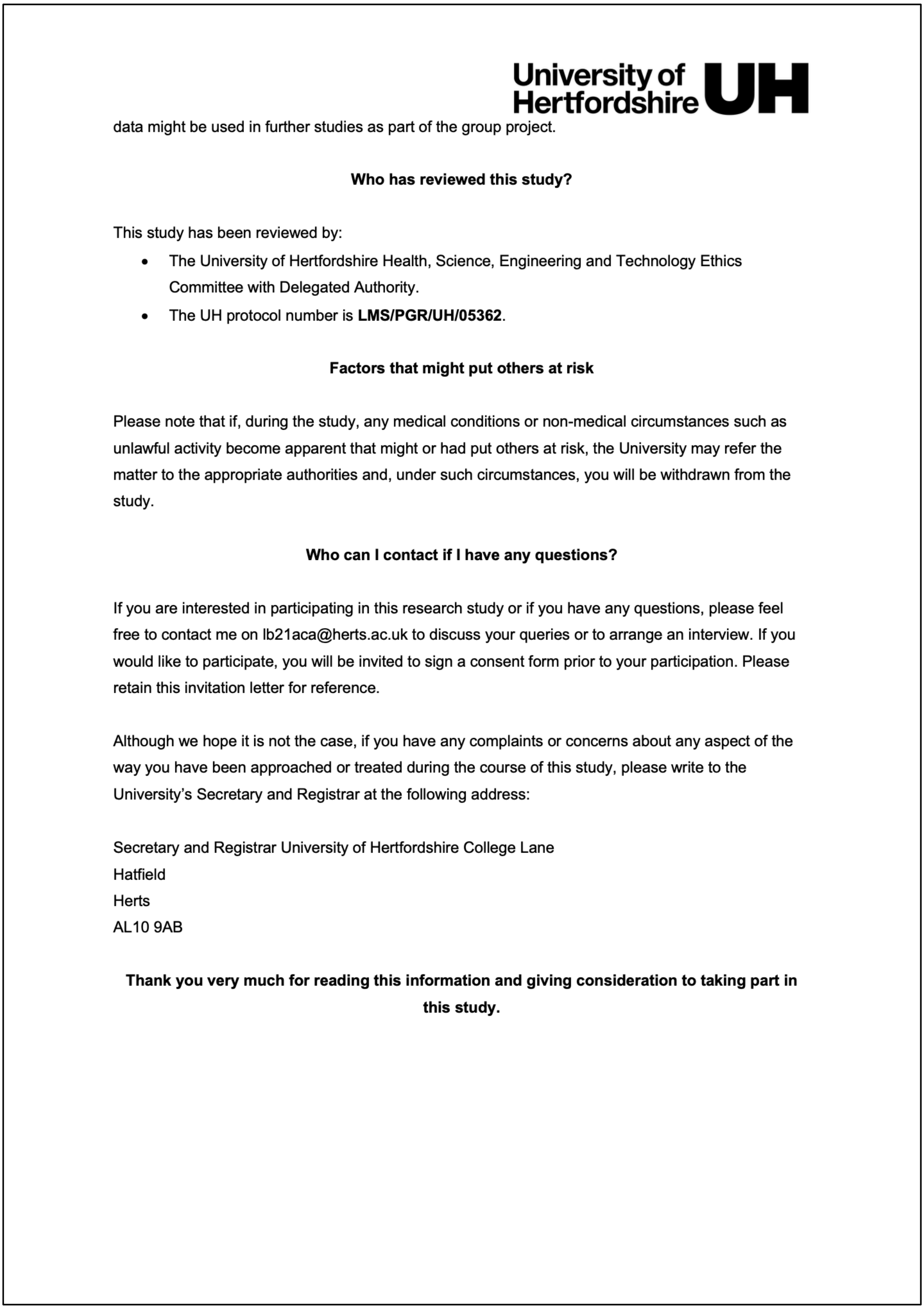
What will happen to the data collected within this study?

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. Interview transcripts will also be anonymised during the data analysis and verbatim extracts used in the report will also be fully anonymised. Data will be stored electronically on the University of Hertfordshire OneDrive. This data will be kept for 5 years post research project submission after which it will be destroyed by the principal investigator. The interview recording and interview transcript will be stored on a device which is encrypted for data protection purposes. Forms related to the research, such as consent forms and participant information forms, will be scanned onto a computer and stored in an encrypted file in the university cloud.

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.

Will the data be required for use in further studies?

This project is being completed in conjunction with another project which is looking at the experiences of those who have been bereaved by suicide. It is possible that separate to this research study, the



data might be used in further studies as part of the group project.

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.
- The UH protocol number is **LMS/PGR/UH/05362**.

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.

Who can I contact if I have any questions?

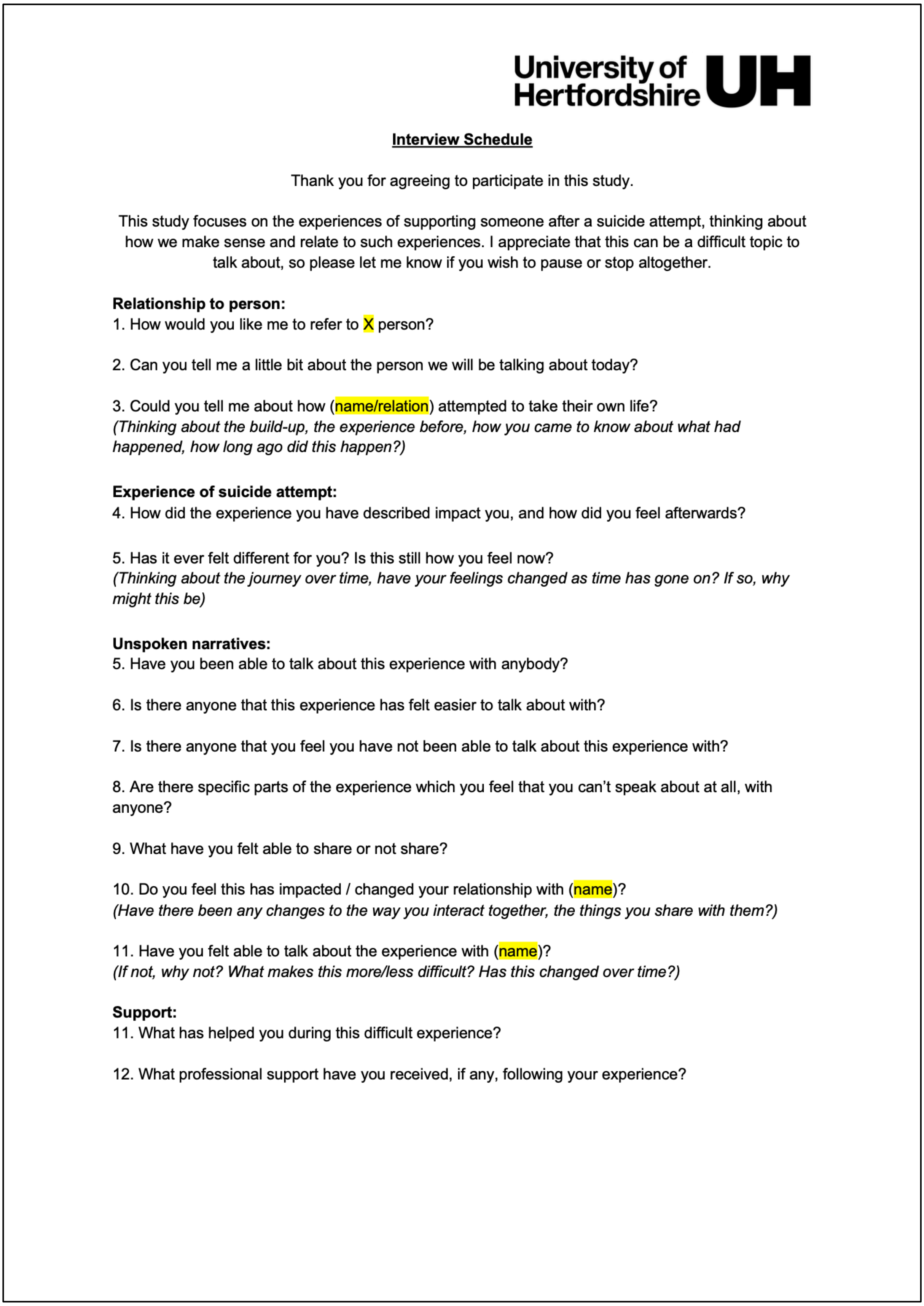
If you are interested in participating in this research study or if you have any questions, please feel free to contact me on lb21aca@herts.ac.uk to discuss your queries or to arrange an interview. If you would like to participate, you will be invited to sign a consent form prior to your participation. Please retain this invitation letter for reference.

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 O: Interview Schedule



University of Hertfordshire UH

Interview Schedule

Thank you for agreeing to participate in this study.

This study focuses on the experiences of supporting someone after a suicide attempt, thinking about 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.

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 today?

3. Could you tell me about how (name/relation) attempted to take their own life?
(Thinking about the build-up, the experience before, how you came to know about what had happened, how long ago did this happen?)

Experience of suicide attempt:
4. How did the experience you have described impact you, and how did you feel afterwards?

5. Has it ever felt different for you? Is this still how you feel now?
(Thinking about the journey over time, have your feelings changed as time has gone on? If so, why might this be)

Unspoken narratives:
5. Have you been able to talk about this experience with anybody?

6. Is there anyone that this experience has felt easier to talk about with?

7. Is there anyone that you feel you have not been able to talk about this experience with?

8. Are there specific parts of the experience which you feel that you can't speak about at all, with anyone?

9. What have you felt able to share or not share?

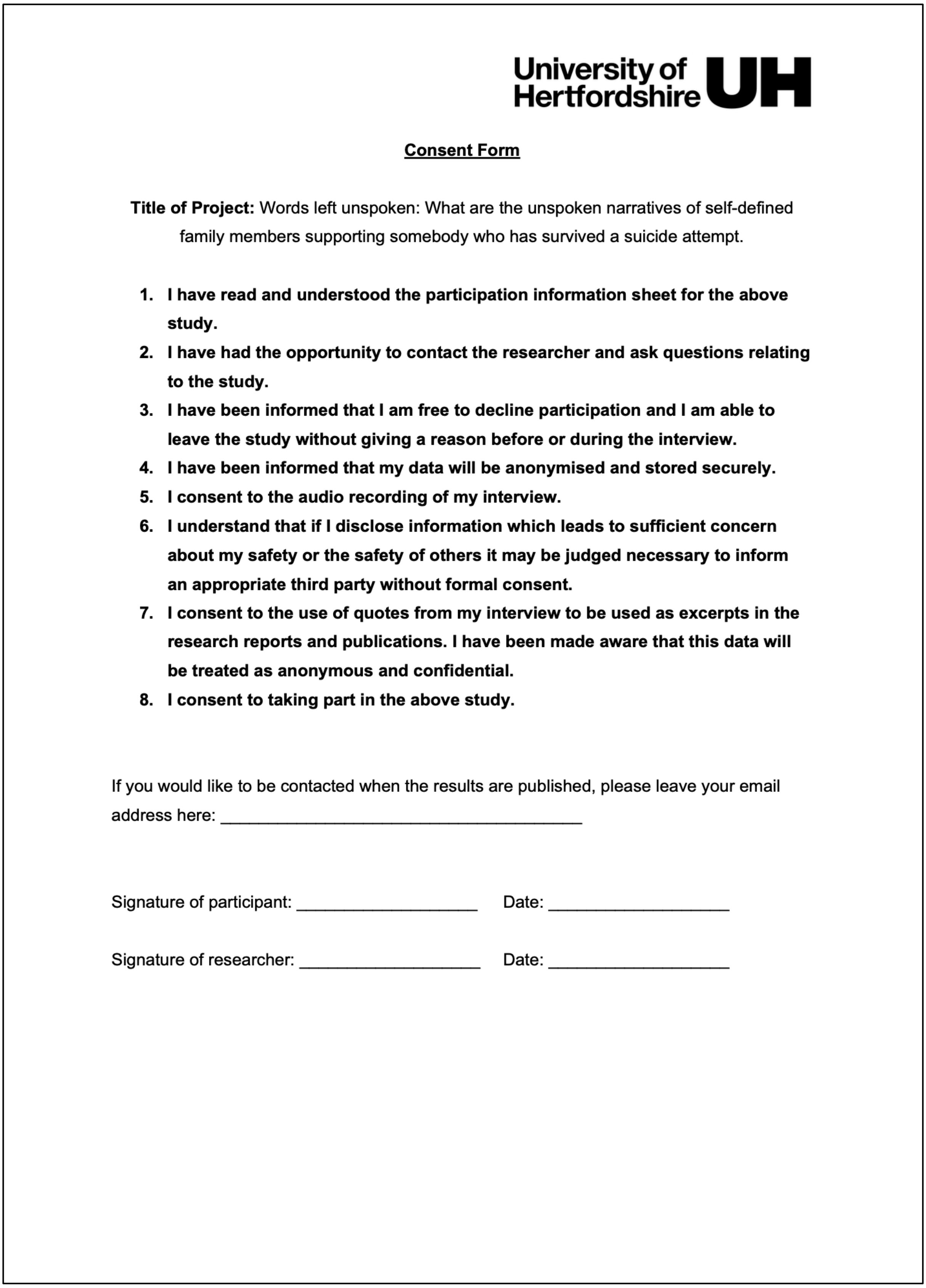
10. Do you feel this has impacted / changed your relationship with (name)?
(Have there been any changes to the way you interact together, the things you share with them?)

11. Have you felt able to talk about the experience with (name)?
(If not, why not? What makes this more/less difficult? Has this changed over time?)

Support:
11. What has helped you during this difficult experience?

12. What professional support have you received, if any, following your experience?

Appendix P: Consent Form



University of Hertfordshire UH

Consent Form

Title of Project: Words left unspoken: What are the unspoken narratives of self-defined family members supporting somebody who has survived a suicide attempt.

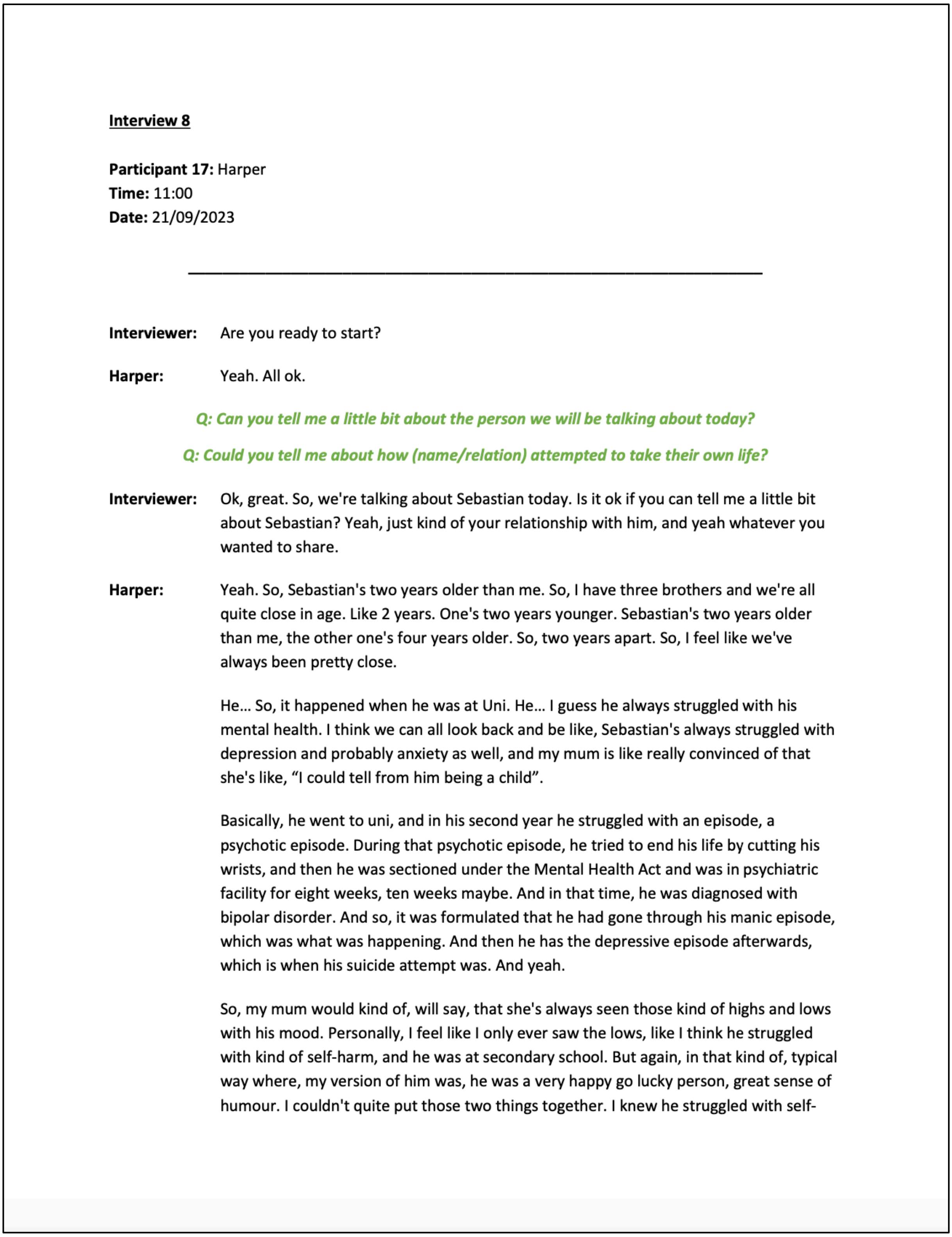
1. **I have read and understood the participation information sheet for the above study.**
2. **I have had the opportunity to contact the researcher and ask questions relating to the study.**
3. **I have been informed that I am free to decline participation and I am able to leave the study without giving 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.**

If you would like to be contacted when the results are published, please leave your email address here: ____

Signature of participant: ____________________ Date: ____________________

Signature of researcher: ____________________ Date: ____________________

Appendix Q: Transcript Sample



Interview 8

Participant 17: Harper
Time: 11:00
Date: 21/09/2023

Interviewer: Are you ready to start?

Harper: Yeah. All ok.

Q: Can you tell me a little bit about the person we will be talking about today?

Q: Could you tell me about how (name/relation) attempted to take their own life?

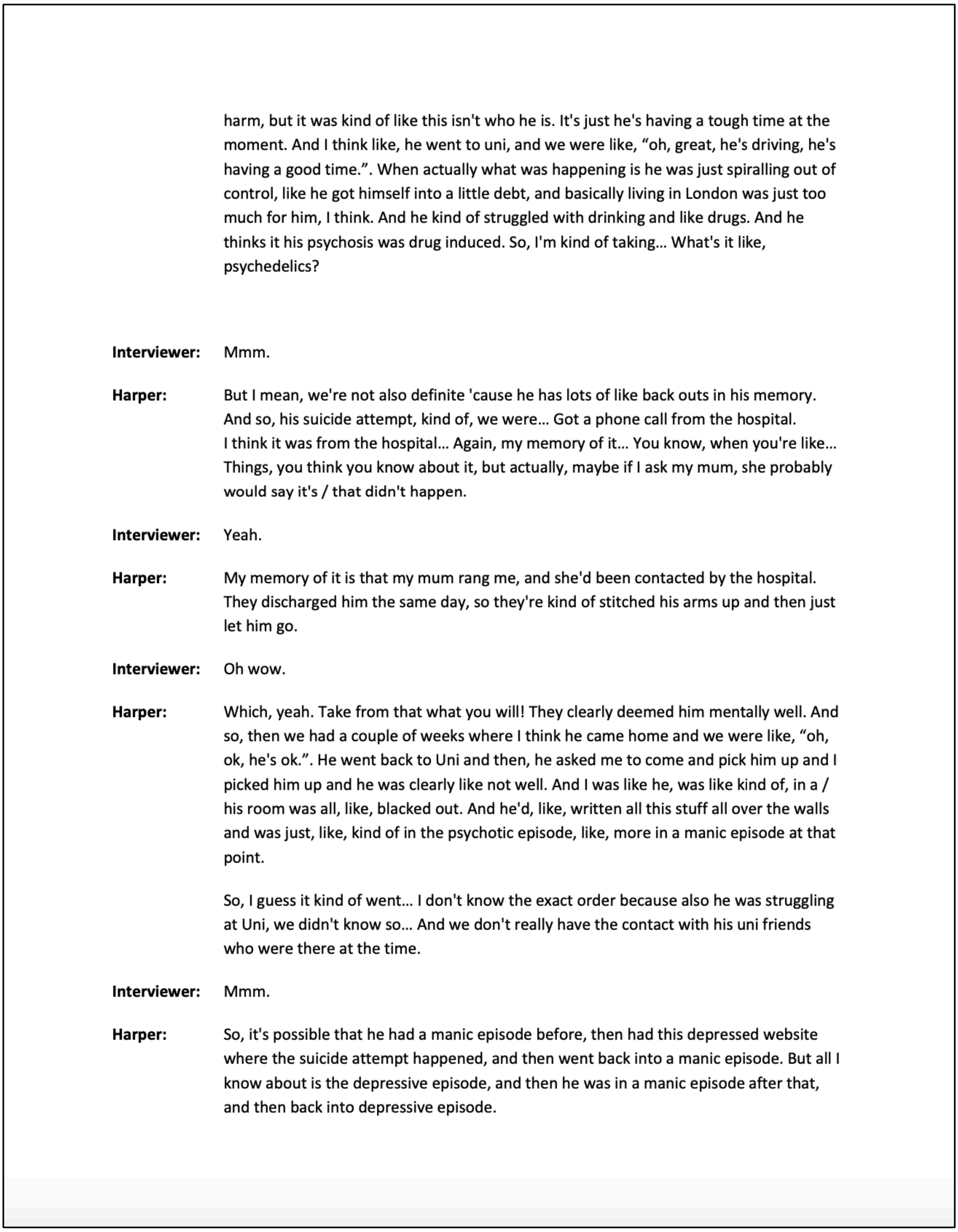
Interviewer: Ok, great. So, we're talking about Sebastian today. Is it ok if you can tell me a little bit about Sebastian? Yeah, just kind of your relationship with him, and yeah whatever you wanted to share.

Harper: Yeah. So, Sebastian's two years older than me. So, I have three brothers and we're all quite close in age. Like 2 years. One's two years younger. Sebastian's two years older than me, the other one's four years older. So, two years apart. So, I feel like we've always been pretty close.

He… So, it happened when he was at Uni. He… I guess he always struggled with his mental health. I think we can all look back and be like, Sebastian's always struggled with depression and probably anxiety as well, and my mum is like really convinced of that she's like, “I could tell from him being a child”.

Basically, he went to uni, and in his second year he struggled with an episode, a psychotic episode. During that psychotic episode, he tried to end his life by cutting his wrists, and then he was sectioned under the Mental Health Act and was in psychiatric facility for eight weeks, ten weeks maybe. And in that time, he was diagnosed with bipolar disorder. And so, it was formulated that he had gone through his manic episode, which was what was happening. And then he has the depressive episode afterwards, which is when his suicide attempt was. And yeah.

So, my mum would kind of, will say, that she's always seen those kind of highs and lows with his mood. Personally, I feel like I only ever saw the lows, like I think he struggled with kind of self-harm, and he was at secondary school. But again, in that kind of, typical way where, my version of him was, he was a very happy go lucky person, great sense of humour. I couldn't quite put those two things together. I knew he struggled with self-



harm, but it was kind of like this isn't who he is. It's just he's having a tough time at the moment. And I think like, he went to uni, and we were like, “oh, great, he's driving, he's having a good time.”. When actually what was happening is he was just spiralling out of control, like he got himself into a little debt, and basically living in London was just too much for him, I think. And he kind of struggled with drinking and like drugs. And he thinks it his psychosis was drug induced. So, I'm kind of taking… What's it like, psychedelics?

Interviewer: Mmm.

Harper: But I mean, we're not also definite 'cause he has lots of like back outs in his memory. And so, his suicide attempt, kind of, we were… Got a phone call from the hospital. I think it was from the hospital… Again, my memory of it… You know, when you're like… Things, you think you know about it, but actually, maybe if I ask my mum, she probably would say it's / that didn't happen.

Interviewer: Yeah.

Harper: My memory of it is that my mum rang me, and she'd been contacted by the hospital. They discharged him the same day, so they're kind of stitched his arms up and then just let him go.

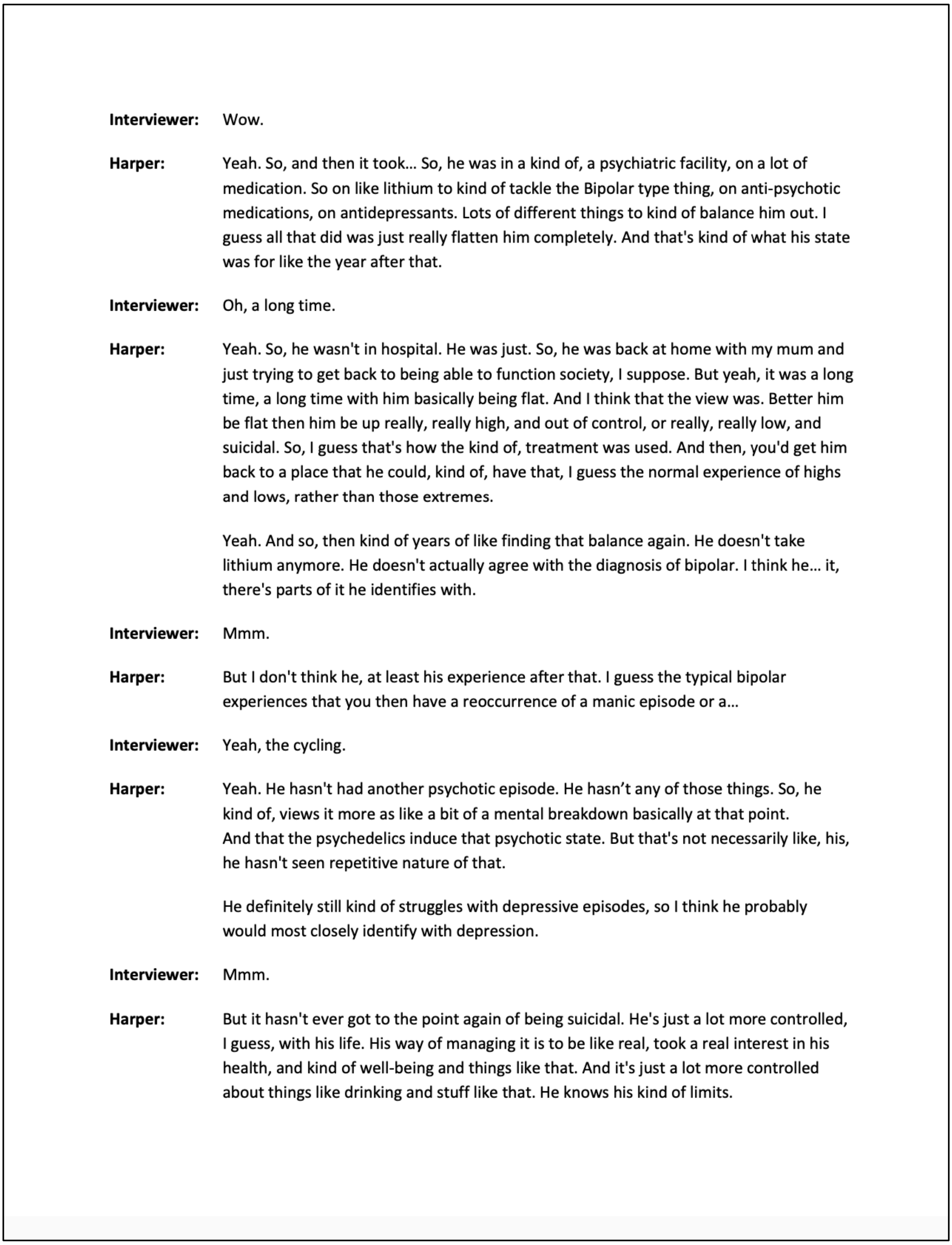
Interviewer: Oh wow.

Harper: Which, yeah. Take from that what you will! They clearly deemed him mentally well. And so, then we had a couple of weeks where I think he came home and we were like, “oh, ok, he's ok.”. He went back to Uni and then, he asked me to come and pick him up and I picked him up and he was clearly like not well. And I was like he, was like kind of, in a / his room was all, like, blacked out. And he'd, like, written all this stuff all over the walls and was just, like, kind of in the psychotic episode, like, more in a manic episode at that point.

So, I guess it kind of went… I don't know the exact order because also he was struggling at Uni, we didn't know so… And we don't really have the contact with his uni friends who were there at the time.

Interviewer: Mmm.

Harper: So, it's possible that he had a manic episode before, then had this depressed website where the suicide attempt happened, and then went back into a manic episode. But all I know about is the depressive episode, and then he was in a manic episode after that, and then back into depressive episode.



Interviewer: Wow.

Harper: Yeah. So, and then it took… So, he was in a kind of, a psychiatric facility, on a lot of medication. So on like lithium to kind of tackle the Bipolar type thing, on anti-psychotic medications, on antidepressants. Lots of different things to kind of balance him out. I guess all that did was just really flatten him completely. And that's kind of what his state was for like the year after that.

Interviewer: Oh, a long time.

Harper: Yeah. So, he wasn't in hospital. He was just. So, he was back at home with my mum and just trying to get back to being able to function society, I suppose. But yeah, it was a long time, a long time with him basically being flat. And I think that the view was. Better him be flat then him be up really, really high, and out of control, or really, really low, and suicidal. So, I guess that's how the kind of, treatment was used. And then, you'd get him back to a place that he could, kind of, have that, I guess the normal experience of highs and lows, rather than those extremes.

Yeah. And so, then kind of years of like finding that balance again. He doesn't take lithium anymore. He doesn't actually agree with the diagnosis of bipolar. I think he… it, there's parts of it he identifies with.

Interviewer: Mmm.

Harper: But I don't think he, at least his experience after that. I guess the typical bipolar experiences that you then have a reoccurrence of a manic episode or a…

Interviewer: Yeah, the cycling.

Harper: Yeah. He hasn't had another psychotic episode. He hasn't any of those things. So, he kind of, views it more as like a bit of a mental breakdown basically at that point.
And that the psychedelics induce that psychotic state. But that's not necessarily like, his, he hasn't seen repetitive nature of that.

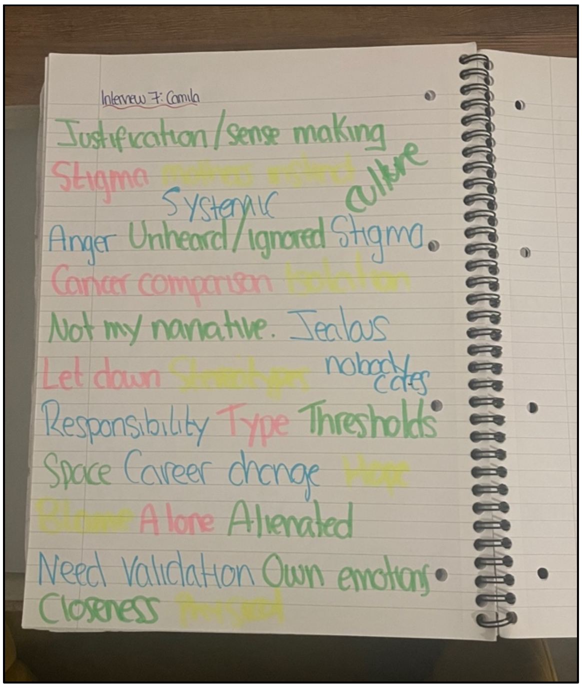
He definitely still kind of struggles with depressive episodes, so I think he probably would most closely identify with depression.

Interviewer: Mmm.

Harper: But it hasn't ever got to the point again of being suicidal. He's just a lot more controlled, I guess, with his life. His way of managing it is to be like real, took a real interest in his health, and kind of well-being and things like that. And it's just a lot more controlled about things like drinking and stuff like that. He knows his kind of limits.

Appendix R: Data Familiarisation Doodle

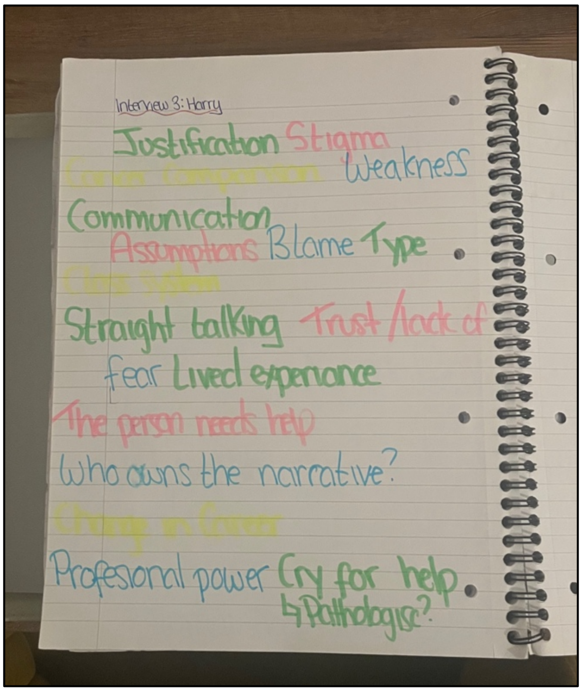
Data Familiarisation: Camila



Interview 7: Camila

Justification/sense making
Stigma mothers instinct culture
Systemic
Anger Unheard/ignored Stigma
Cancer comparison Isolation
Not my narrative. Jealous
Let down Stereotypes nobody cares
Responsibility Type Thresholds
Space Career change Hope
Blame Alone Alienated
Need Validation Own emotions
Closeness Physical

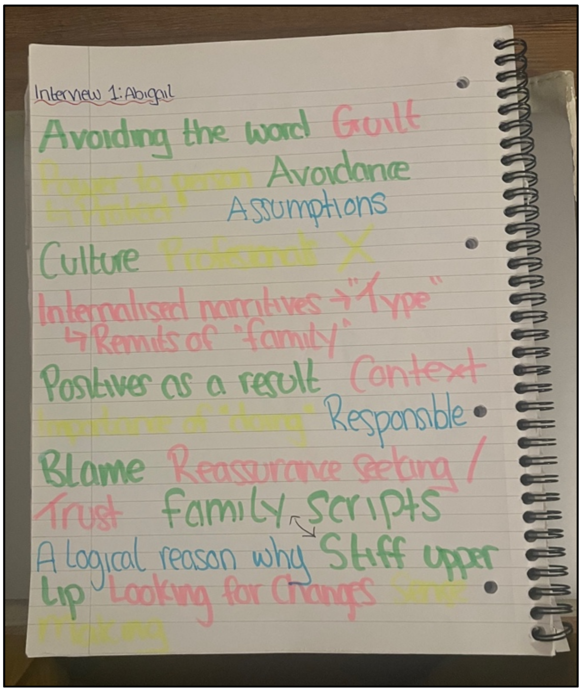
Data Familiarisation: Harry



Interview 3: Harry

Justification Stigma
Cancer Comparison Weakness
Communication
Assumptions Blame Type
Class System
Straight talking Trust/lack of
fear Lived experience
The person needs help
Who owns the narrative?
Change in Career
Profesional power Cry for help.
↳ Pathologise?

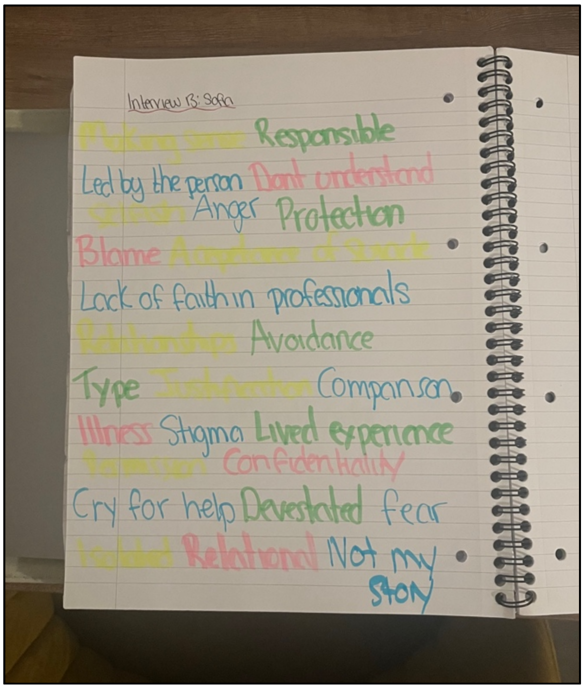
Data Familiarisation: Abigail



Interview 1: Abigail

Avoiding the word Guilt
Power to person Avoidance
↳ Isolated" Assumptions
Culture Professionals X
Internalised narritives → "Type"
↳ Remits of "family"
Positives as a result Context
Importance of "doing" Responsible
Blame Reassurance seeking /
Trust family scripts
A logical reason why Stiff upper
Lip Looking for Changes Sense
Making

Data Familiarisation: Sofia



Interview 13: Sofia

Making sense Responsible
Led by the person Dont understand
Selfish Anger Protection
Blame Acceptance of Suicide
Lack of faith in professionals
Relationships Avoidance
Type Justification Comparison
Illness Stigma Lived experience
[illegible] Confidentiality
Cry for help Devestated fear
Isolated Relational Not my
Story

Appendix S: Coded Transcript Sample

Transcript	Theme	Subtheme
Q: How did the experience you have described impact you, and how did you feel afterwards?		
Interviewer: What was it like supporting Maya over those two years? You what were the really difficult parts for you? And what…		
Camila: For me? Being alone.	Unequivocally Unspoken	Overwhelming Emotions
Interviewer: Feeling alone?		
Camila: Because my husband didn't understand. And Maya didn't want anybody to know. I… It was like a living on a roller coaster. One minute… And I remember at the same time, I had a friend who, especially when Maya was really ill, […]. And her little boy was only about 3, and being diagnosed with stage 4 cancer. And she was getting all this support.	The Conspiracy of Silence Making Comparisons	“It’s [their] story to tell”
Interviewer: Mmm.		
Camila: All her friends, you know, she could put something on Facebook, if she was having a bad day. And she'd get all this support, shouldn’t get people making meals for all of this thing. You know the doctors were there giving everything they can, throwing all the money, and everything else, which is fair enough. We didn't get any support. There was no support for us. I couldn't say if I was having a really bad day. I couldn't say if I was struggling, and I'd been told how many times today my daughter wanted to die. Or, you know, she's really in pain, and I don't know how to help her.	Making Comparisons Unequivocally Unspoken	Bearing Witness

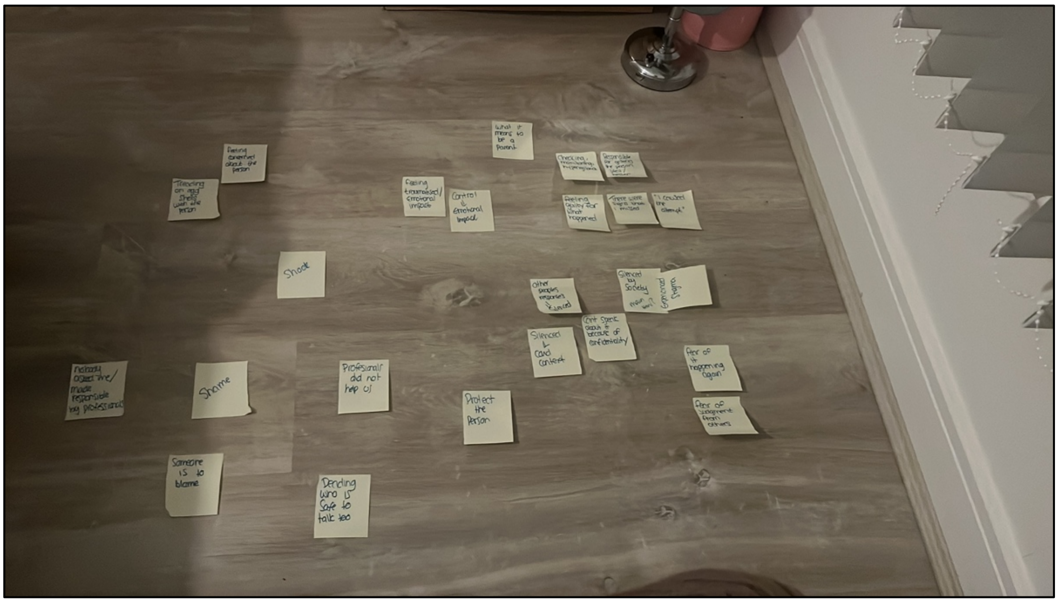
	I've got my husband. This is before she obviously did a major overdose. I've got a husband who thinks I'm pandering to her, and she just needs to snap out of it. I've got a son who I feel guilty that he's then not get the right attention. I feel pulled pilar to post. And no support at all.	Unequivocally Unspoken	Overwhelming Emotions
Interviewer:	Was there anybody that you did speak to? Or was it just…		
Camila:	Maya didn't want a lot of people knowing.	The Conspiracy of Silence	“It’s [their] story to tell”
Interviewer:	Okay.		
Camila:	But I spoke to, I'd speak to my mum. A little bit, but. She was finding it really difficult.		
Interviewer:	Yeah.		
Camila:	But no, this was the problem. There was nobody.		
Interviewer:	Yeah.		
Camila:	Nobody who could… My mum would oh my mum would… She's never been good. My mum doesn't validate.	The Conspiracy of Silence	Myriad of Protection
Interviewer:	Okay.		
Camila:	Never has done. She's awful. It's always “ohh, there’s other people worse off”, that sort of thing.		
Interviewer	Right okay. Quite dismissive?		
Camila:	And after I still tell her today, she's terrible at it. She just… When you want to just let things out, have a rant, have a rave. She will try and make an excuse for the other person you are having a rant and rave about.		
Interviewer:	Right.		

Camila:	Instead of saying, “that must be really difficult for you”, you know she just doesn't do empathy. She's… I love my mum to death, but she just can't validate, and do that empathy. She just can't do it. So, I wouldn't bother because I thought she's only going to make excuses for what I am needing to rant and rave about. She’s not listening to me .She's not validating how I'm feeling. And that was the same situation with Maya. And that's why I tried my best to validate her, because she didn't get it from the care. You know, she stopped talking to her friends because she would say to her friends originally how she was feeling, they would tell her to shut up. And I kept trying to explain to her, “they weren't doing it because they didn't care. It's very difficult as an adult to understand and hear what the things you're saying about how you feel… You don't want to be here. It's very, very difficult for 13-year-old, 14-year-old, to hear that, Maya.”. I said “it's not their fault and it's not. They don't care. They just can't process it, which is why they're saying do not talk about it.” But it made her just shut down and not talk to anybody.	The Conspiracy of Silence The Conspiracy of Silence	Myriad of Protection Myriad of Protection
Interviewer:	Yeah.		
Camila:	But for me, yeah, it was alone. I was jealous of my friend who had her son who had cancer. And that's terrible saying it. But I was jealous.	Making Comparisons	
Interviewer:	Yeah. Well, I think it makes complete sense.		

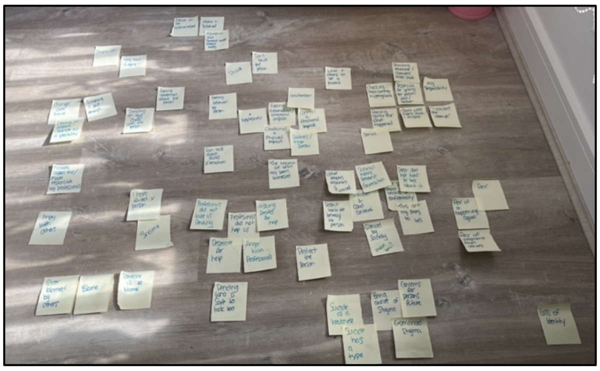
Camila:	Because at least her child was getting help. You know, she was getting support, and her child was getting help.	Making Comparisons	

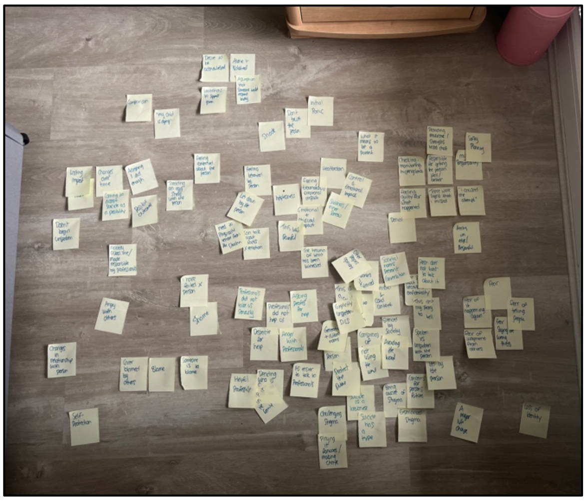
Appendix T: Thematic Map

Placing initial codes



Placing more codes





Grouping codes into initial patterns

Grouped codes become thematic map