

THE UNIVERSITY OF HULL

Making sense of it all: an interpretative phenomenological analysis
of bereaved survivors' coping experiences following intimate partner
suicide

being a Thesis submitted for the Degree of

Doctor of Philosophy

in the University of Hull

by

Samantha Angela Torres, BSc (Hons)

March 2018

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to both of my supervisors, Professor Julie Jomeen and Professor Debra K. Creedy. Their continuous encouragement, guidance and support throughout my PhD has been tremendous and beyond words.

In addition to my supervisors, I would like to offer my deepest thanks to the survivors who participated in the study. I am privileged that you have supported this research by sharing your experiences with me. Together we embarked on a journey to tell your story with the purpose of influencing change.

Finally, I would like to thank academics, consultors, peers, former colleagues, friends and my husband Geoff for assisting (no matter how big or small) in all areas of my PhD experience.

TABLE OF CONTENTS

List of tables	i
List of abbreviations	ii
Glossary of terms	vi
Abstract	vii
Chapter 1: Grief	1
1.1 Introduction.....	1
1.2 Grief and bereavement.....	1
1.3 Theoretical perspectives on grief.....	1
1.4 Phase and stage models	3
1.4.1 Bowlby's Attachment Theory	3
1.4.2 Kübler-Ross Model of Grief.....	3
1.4.3 Dual Process Model.....	4
1.5 Meaning-making.....	4
1.5.1 Meaning-Reconstruction Model	4
1.5.2 Disenfranchised Grief	5
1.5.3 Posttraumatic Growth Model.....	6
1.6 Continuing Bonds	7
1.7 Discussion	8
1.8 Summary	13
1.9 Conclusion.....	13
Chapter 2: Suicide	15
2.1 Introduction.....	15
2.2 Definition and prevalence of suicide.....	15
2.3 Suicide in the United Kingdom	16
2.3.1 Suicide rates	16
2.3.2 Mode of death.....	16
2.3.3 Characteristics of the suicidal act	17

2.4 Socio-economic factors	17
2.5 Culture and religion	18
2.6 Gender	19
2.7 Suicide survivors	19
2.7.1 Spousal survivors.....	20
2.7.1.1 Factors affecting spousal coping following suicide	21
2.7.1.2 Nature of the spousal relationship	23
2.8 Coping strategies during suicide bereavement.....	23
2.9 Suicide prevention	24
2.9.1 Postvention	25
2.10 Problem statement	25
2.11 Research aim	26
2.12 Significance	26
2.13 Conclusion.....	26
Chapter 3: Literature Review	28
3.1 Introduction.....	28
3.2 Method	28
3.3 Results	30
3.3.1 Themes.....	30
3.3.1.1 Events surrounding the suicide	30
3.3.1.2 Nature of the spousal relationship	37
3.3.1.3 Postvention	38
3.4 Discussion	41
3.4.1 Relations and relationships to the deceased	41
3.4.2 Appraisal of events	43
3.4.3 Factors contributing to survivor coping	44
3.4.4 Characteristics of the spousal relationship.....	47
3.4.5 Postvention	48

3.4.6 Methodological limitations.....	52
3.5 Conclusion.....	55
3.6 Summary	56
Chapter 4: Methodology	58
4.1 Introduction.....	58
4.2 Choice of research methodology.....	58
4.3 Researcher's position	59
4.4 Research methodology.....	62
4.4.1 Philosophical assumptions.....	62
4.4.2 Philosophical paradigms	63
4.4.3 Interpretivist/constructivist paradigm.....	65
4.4.4 Grounded Theory	65
4.4.5 Discourse Analysis.....	66
4.4.6 Phenomenology	67
4.4.7 Interpretative Phenomenological Analysis	69
4.4.8 Rationale for using Interpretative Phenomenological Analysis	71
4.5 Study aim	72
4.6 Study design.....	73
4.6.1 Sample.....	73
4.6.2 Sampling strategy	73
4.6.3 Sample Size.....	73
4.6.4 Sample selection	74
4.7 Recruitment.....	76
4.8 Ethical considerations.....	78
4.9 Data collection method.....	79
4.9.1 The Interview	80
4.9.2 Pilot study	83
4.10 Data analysis method.....	84

4.10.1 Transcription of interviews	84
4.10.2 Formatting and reading of transcripts	85
4.10.3 Initial noting.....	85
4.10.4 Developing emergent themes	85
4.10.5 Searching for connections across emergent themes	86
4.10.6 Moving to the next case	87
4.10.7 Looking for patterns across cases	87
4.11 Reflexivity	88
4.12 Assessing validity	91
4.13 Audit trail	92
4.14 Conclusion.....	93
Chapter 5: Results	94
5.1 Introduction.....	94
5.2 Presentation of the findings	94
5.3 Participants' characteristics	94
5.4 Summary of results	98
5.5 Super-ordinate themes	99
5.5.1 Manageability.....	100
5.5.1.1 Reactions to suicide-related grief	100
5.5.1.2 Supporting self	104
5.5.1.3 Helpful support offered by others	109
5.5.1.4 Unhelpful support offered by others	115
5.5.2 Attaching meaning	121
5.5.2.1 Rumination	121
5.5.2.2 Motivation to survive.....	125
5.5.2.3 Changing relationships.....	127
5.5.3 Relating to others.....	129
5.5.3.1 Need for a humanistic approach.....	130

5.5.3.2 Identifying with other survivors	132
5.5.3.3 Developing compassion for others	135
5.5.4 Changed perception of self	137
5.5.4.1 The changed self.....	137
5.5.4.2 New possibilities in life	140
5.5.5 Changed philosophy of life.....	142
5.5.5.1 Appreciation of Life.....	142
5.5.5.2 New priorities.....	144
5.5.5.3 Living in the 'here and now'	145
5.6 Summary	147
Chapter 6: Discussion	149
6.1 Introduction.....	149
6.2 Strengths of this study	149
6.3 Grief theories.....	150
6.3.1 Posttraumatic Growth theories.....	151
6.4 Manageability	153
6.4.1 Depression, anxiety and trauma responses.....	153
6.4.2 Overcoming suicidal ideation	154
6.4.3 Regulating emotions	155
6.4.4 Achieving mastery.....	157
6.4.5 Alcohol and drugs	158
6.4.6 Influence of personality traits on coping.....	158
6.4.7 Formal and informal interpersonal postvention	159
6.4.8 Nature and accessibility of postvention.....	160
6.4.9 Financial resources and postvention	161
6.4.10 Practical support	161
6.4.11 Postvention in the workplace	162
6.4.12 Unhelpful support.....	163

6.5 Meaning.....	164
6.5.1 Brooding rumination.....	165
6.5.2 Reflective rumination	166
6.5.3 Internal motivation to survive	168
6.5.4 External motivation to survive	168
6.5.5 Losing and gaining friends	169
6.5.6 Need for a humanistic approach	170
6.5.7 Identifying with other survivors.....	170
6.5.8 Developing compassion for others.....	171
6.6 Transformation	171
6.6.1 The changed self	172
6.6.2 New possibilities in life	172
6.6.3 Appreciation of life	173
6.6.4 New Priorities.....	174
6.6.5 Living in the ‘here and now’	174
6.7 Proposed new model of coping	175
6.7.1 Description of The Intimate Partner Suicide Bereavement Coping Model.....	175
6.7.1.1 Manageability	176
6.7.1.2 Meaning	176
6.7.1.3 Transformation	176
6.7.1.4 Model summary.....	177
6.8 Limitations of this study	178
6.9 Conclusion.....	179
Chapter 7: Conclusion and recommendations.....	181
7.1 Introduction.....	181
7.2 Conclusions and recommendations	181
7.2.1 The Intimate Partner Suicide Bereavement Coping Model potentially provides a framework for practice	181

7.2.2 Coping following intimate partner suicide is complex in nature, duration and outcome	182
7.2.3 Resilience is rarely considered in suicide literature and yet underpinned many of the coping strategies identified by participants.....	184
7.2.4 Support is essential.....	185
7.2.5 Survivors benefit from psychological interventions	187
7.2.6 The workplace plays an important role in support and recovery	188
7.2.7 Coping can be compromised as suicide is stigmatised.....	189
7.3 Concluding remarks	189
References.....	191
Appendices.....	220
Appendix A: Table 1: Summary of included studies	220
Appendix B: Reflexive notes.....	251
Appendix C: Recruitment advert.....	261
Appendix D: Participant information sheet	262
Appendix E: Participant consent form	265
Appendix F: Interview guide	267
Appendix G: Social demographic form	269
Appendix H: A case transcript example.....	270
Appendix I: A case example of clustering themes	294
Appendix J: Master table of themes	310

LIST OF TABLES

Table	Title	Page
Table 1	Summary of included studies	220
Table 2	Participants' characteristics	95
Table 3	Summary of results	99
Table 4	PTG related models and the super-ordinate themes	152

LIST OF ABBREVIATIONS

Abbreviation	Description
ACT	Acceptance and Commitment Therapy
AWS	Army Wives Survey
BDI	Beck Depression Inventory
BGP	Bereavement Group Postvention
BSI	Brief Symptom Inventory
CES-D	Center for Epidemiologic Studies Depression Scale
CQC	Care Quality Commission
DH	Department of Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPQ-RSS	Eysenck Personality Questionnaire
FAMILY APGAR	Family functioning: Adaptation, partnership, growth, affection and resolve
FES	Family Environment Scale
FUS	Family Unity Scale

GEI	Grief Experience Inventory
GP	General Practitioner
GEQ	Grief Experience Questionnaire
GHQ	General Health Questionnaire
GMC	General Medical Council
HSE	Health and Safety Executive
IAAF	International Adaptation in Army Families
ICD	International Classification of Diseases
IPA	Interpretative Phenomenological Analysis
IPSBCM	Intimate Partner Suicide Bereavement Coping Model
ITG	Inventory of Traumatic Grief
LEQ	Life Event Questionnaire
MBCT	Mindfulness-Based Cognitive Therapy
MBSR	Mindfulness-Based Stress Reduction
MHLTH	Self-Rated Mental Health
MHSR	Mental Health Self-Rating

MOS-SF36	Medical Outcomes Study-Short Form 36
MSPSS	Multidimensional Scale of Perceived Social Support
NHS	National Health Service
NIHME	National Institute for Mental Health in England
ONS	Office of National Statistics
PEO	People, Exposure and Outcome
PIL	Purpose in Life Scale
PMS	Pearlin Mastery Scale
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTG	Posttraumatic Growth
PTGI	Post-Traumatic Growth Inventory
PTSD	Post-Traumatic Stress Disorder
RAND-36	RAND 36-Item Health Survey
RDF	Researcher Development Framework
RSES	Rosenburg Self-Esteem Scale
SAS	Social Adjustment Scale

SCID-I	Structured Clinical Interview for DSM-IV Axis I: Major diagnoses
SCID-II	Semi-structured interview for making DSM-IV Axis II: Personality Disorder diagnoses
SDQ	Strengths and Difficulties Questionnaire
SGP	Social Group Postvention
SOS	Schwartz Outcome Scale
SRFI	Self-Report Family Inventory
TIG Past	Texas Inventory of Grief Past
TIG Present	Texas Inventory of Grief Present
UK	United Kingdom
USA	United States of America
VRS	Victim Rejection Scale
WHO	World Health Organization

GLOSSARY OF TERMS

Term	Definition
Intimate Partnership	An interpersonal relationship of closeness and connectedness with depth and intensity that might involve physical and/or emotional intimacy
Kinship	A relation between two or more persons that is based on common ancestry (descent) or marriage (affinity)
Partner	A general term referring to a union of two people
Postvention	An intervention provided for those bereaved by suicide
Spouse	A formal term for husband or wife
Suicide Survivor	A survivor of suicide is a family member or friend of a person who died by suicide

ABSTRACT

Suicide is a national and global concern. Men continue to die by suicide at higher rates compared to women. The burden of grief associated with loss of a partner to suicide may go unreported by survivors. This study aimed to explore the coping experiences of survivors following the suicide of their intimate partners. The research question was: How do bereaved survivors make sense of their coping experiences following intimate partner suicide?

Interpretative Phenomenological Analysis (IPA) enables inquiry into individuals' perceptions of their everyday lived experience particularly in the context of a past significant experience such as being bereaved by suicide. IPA as a methodology was also well situated within my epistemological position as an interpretative constructivist and the theoretical frameworks of phenomenology, hermeneutics and ideography that underpin its approach.

Eight women bereaved by intimate partner suicide took part in the study. Data were collected using semi-structured in-depth interviews. Participants were interviewed once as this data collection method provided rich first-hand accounts of each participant's lived experience.

Five super-ordinate themes were identified. (1) Manageability identified how participants reacted to their suicide related grief and support. (2) Attaching meaning involved rumination, ascribed purpose to survival, and changing relationships with others. (3) Relating to others highlighted participants' need for humanistic processes during interactions, identifying with other survivors, and develop compassion for others. (4) Changed perceptions of self became evident both as a person and in considering new possibilities in life. (5) A new philosophy of life reflected a changed sense of what is important, establishing new priorities, and living in the 'here and now'.

Coping was complex, differed amongst participants, and went beyond the parameters often specified in the bereavement literature. Complex elements associated with managing life, ascribed meaning, relationships with others and a changed 'self' were unique findings. While negative or harmful coping strategies were discussed, participants also highlighted their resilience and clearly articulated what was helpful and what hindered their coping. The findings

contributed to the development of the Intimate Partner Suicide Bereavement Coping Model (IPSBCM) to help shape supportive practices and models of care to support survivors at different stages of their suicide-related grief.

CHAPTER 1: GRIEF

1.1 Introduction

While previous research has focussed on the risk factors and perceived causes of suicide, this thesis explores factors that may influence the responses of people in the aftermath of suicide. In particular, this research is focused on the coping experiences of bereaved survivors following suicide of their intimate partner. This first chapter will outline the concept of grief and bereavement. Theoretical concepts on grief experienced through bereavement from traditional to more current theories will be presented and discussed. The chapter will then consider the grief theories and its relevance to the research study.

1.2 Grief and bereavement

Grief and bereavement is associated with a loss, separation and death. Clarification and distinction between terms are required. Bereavement is a period of time that follows a loss (Buglass, 2010). In bereavement, grief experiences and mourning occur (Shear, 2012). Grief is a normal process which includes psychological, physical, emotional and social responses (Greenstreet, 2004; Hall, 2011). Mourning is a display of grief through processes and behaviour regulated by social, religious or cultural norms (Davies, 2004; Boerner, Stroebe, Schut, and Wortman, 2015). An example of mourning is wearing black at a western funeral to mark respect to the deceased. Grief is what happens when we experience a loss. To better understand how individuals cope with their loss we need to understand grief.

1.3 Theoretical perspectives on grief

The concept of grief was first introduced by Sigmund Freud, a psychologist in the early twentieth century (Davies, 2004). Freud (1961) proposed that grief was normal and a natural response to loss. His theory was based on clinical experience with people with depressive symptoms. Grief resolution required detachment and severing emotional bonds to help the bereaved overcome their grief (Freud, 1961; Buglass, 2010; Smit, 2015). To achieve this, attached energy had to be altered for new attachments to be developed (Freud, 1961; Dunne, 2004). This theory did not consider grief experienced amongst the general

population and relied heavily on complete detachment to the deceased which is not commonly experienced amongst the bereaved (Dunne, 2004).

Freud's work was developed further by another psychologist Erich Lindemann. Lindemann (1944) coined the term 'anticipatory grief' after studying grief reactions of relatives of those who served in the armed forces. He proposed five features of anticipatory grief: guilt, anger, somatic distress, a fixation with the image of the dying person and loss of patterns of conduct (Lindemann, 1944).

Lindemann's theory suggested that grief is manifested by psychological (blame, guilt, anger) and somatic (chest pain, muscle tension, stomach problems) symptoms (Lindemann, 1944). Lindemann's theory is based on usual expected grief responses which was then developed to understand grief symptomology in the general population such as those bereaved following long-term illnesses for example. However, Lindemann did highlight that grief can be experienced both psychologically and physically. Lindemann's work was heavily rooted in the role of emotions in grief and described the five features of grief. Lindemann considered that grief can be normal but also abnormal. He argued that the nature and duration of grief was determined by how well an individual can relinquish their psychological dependence on the deceased, re-adjust to life, and build a new relationship with the deceased (Lindemann, 1944).

Freud introduced the concept of grief with Lindemann developing an understanding of grief. Both gave insight on how grief might be experienced by individuals following a loss. There are limitations to their theories. Both authors were psychologists with psychoanalytical views who conducted their work with specific populations. Their work also took place against the back drop of two world wars (Davies, 2004). Where the need to survive for individuals could delay grieving. This suggests that the context of grief should be considered. Context might have not been considered at the time as theoretical understandings on grief were underpinned by psychoanalytical views.

There has been significant development of grief theories since the earlier works of Freud and Lindemann. This chapter will not discuss all grief theories but will draw upon the dominant grief theories pertinent to death and explain how grief theory has evolved over time. This chapter will therefore start with phases and stage models of grief.

1.4 Phase and stage models

Since, the initial grief work of Freud and Lindemann, the development of grief theory has provided models to understand how grief is experienced. Models attempt to provide a 'framework' to help gain a further understanding of grief (Davies, 2004; Stroebe, Schut and Boerner, 2017). In this chapter section, the works of Bowlby's Attachment Theory, Kübler-Ross Model of Grief and the Dual Process Model will be discussed.

1.4.1 Bowlby's Attachment Theory

Bowlby, a psychodynamic psychologist further developed Freud's attachment theory but focused on relationships initially between infants and parents (1969). Unlike Freud, Bowlby suggested that attachments can be maintained rather than broken (Bowlby, 1969). Bowlby suggested that these attachments characterised by strong emotion are active and remain throughout adult life (Bowlby, 1973). He also identified that grief is a process that is experienced through phases (Boerner, et al., 2015). His grief model has four phases: shock and numbness, yearning and searching, disorganisation and despair, and reorganisation (Bowlby, 1980). Grief work through these phases minimised adverse mental and physical problems (Smit, 2015). Emotional distress was likely to occur when attachments were forcibly broken by such events as a death (Bowlby, 1969; Dune, 2004). This model reinforces that losing someone can be very distressing because of attachments made between people. It does suggest that understanding the nature of emotion and attachment to the deceased could provide insight into how the bereaved experience grief.

1.4.2 Kübler-Ross Model of Grief

Stage theory was introduced by Kübler-Ross when she developed The Kübler-Ross Model of Grief (1969). Her work became widely known as the 'five stages of grief', which was inspired by her work with terminally ill patients (Kübler-Ross, 1969). The five stages include denial, anger, bargaining, depression and acceptance to explain stages of grief as part of the dying process (Kübler-Ross, 1969). This model was focused on the dying person coming to terms with their anticipated death at the later stages of life. Her grief work was based on clinical observations rather than research evidence (Kübler-Ross, 1969). Kübler-Ross

suggested that the stages of grief were a linear experience, but recent work has revealed more complexity (Smit, 2015).

1.4.3 Dual Process Model

The Dual Process Model or Oscillation Theory was developed specifically to understand coping related to complicated grief following the death of a partner (Stroebe and Schut, 1999). Complicated grief is characterized by intensified grief symptoms that do not diminish within six months of the death and has associated clinically significant psychological and physical symptoms (Prigerson, Horowitz, Jacobs, Parkes, Aslan, Goodkin, et al., 2009). This model is underpinned by a 'loss' (grief work) and 'restoration' (distraction from grief and change) orientation to coping (Stroebe and Schut, 1999). This model acknowledges that coming to terms with the death and current life co-exist in a dual oscillation process (Stroebe and Schut 1999). Unlike phased and staged grief theories, the oscillation process accounts for moving between the two domains and is not linear. This suggests that grief is more complex and individual. Most grief theories reflect western cultural norms. The dual process considers individuality and can be more sensitive to cultural differences (Stroebe, et al., 2017). The model does allude to the influence of coping, suggesting that poor coping indicates abnormal grief especially if the person is experiencing mostly loss-orientation grief (Dunne, 2004). Meaning-making is expressed cognitively and likely to occur in the oscillation process although it is not a focus in the model (Stroebe and Schut, 2001).

1.5 Meaning-making

Theories discussed so far have highlighted psychological (emotional/psychodynamic) and physical responses that are experienced through a process regardless of whether it is phased, staged or oscillated. Stroebe and Schut (2001) highlighted previously that grief can be experienced cognitively by trying to make meaning of the death. Therefore, meaning-making models will now be discussed.

1.5.1 Meaning-Reconstruction Model

This model, also known as meaning-making, is a construct central to coping in grief and was developed by Neimeyer (2001). He theorized that individuals need

to find a way to understand what has happened which, re-defined over time, gives the person, the situation, and the death, some meaning. It recognises that individuals make meaning based on their core assumptions or beliefs (Neimeyer, Baldwin and Gillies, 2006). Searching for meaning happens at different levels: practical, relational and spiritual (Neimeyer and Sands, 2011).

Ability to find meaning is a marker of positive adaptation. The inability to find meaning is associated with core assumptions being conflicted which could lead to complicated grieving (Neimeyer, 2001). Unlike Freud's theory, meaning-reconstruction encourages the individual to modify their relationship with the deceased (Currier, Neimeyer and Berman, 2008) and this is achieved by sense-making and benefit-finding (Neimeyer, 2001). This model specifically focuses on making sense of the death but implies that successful coping can be only be achieved through satisfactory resolution, through finding meaning. Those bereaved sometimes cannot make sense of the death even many years later, but this does not suggest that they have not grieved. Meaning-making predominantly focuses on individuals' grieving. Disenfranchised grief attempts to explain the impact that society makes on the meaning of a death.

1.5.2 Disenfranchised Grief

Disenfranchised grief is a term describing grief that is not acknowledged by society (Doka, 1989). Disenfranchised grief encompasses psychological, physical and social factors related to grief, but the ability to grieve is determined by others. Disenfranchised grief is categorised by (1) a relationship which is not recognised (by family members or the legal system); (2) the loss is not acknowledged (considered socially insignificant such as an animal or a person who is socially dead through cognitive impairment but biologically alive); and (3) the griever is excluded (those determined to be incapable to grieve such as young children or considered to not have the right to grieve (Doka, 1989; 2008). This reinforces that meaning-making is influenced on varying levels by society and affects those individuals grieving within it.

According to Disenfranchised Grief theory, society's norms and rules determine if an individual has the right to grieve and if so, regulates how they grieve. These norms are influenced by family, culture, religion and social expectations (Doka,

2002). A bereaved individual can be conflicted and experience disenfranchised grief within different cultures, as society has different sub-groups with varying expectations and rules (Doka, 2008). For example, a bereaved individual who was married to someone from another cultural group might be able to grieve within their own cultural norms, but these might not be recognised or acknowledged by the deceased's family because cultural expressions differ (Doka, 2008). Doka also proposed that the death itself can be disenfranchising (Doka, 1998; 2002). The nature or circumstances of the death are judged by societal attitudes which places values on it (Doka, 2008). Deaths related to suicides, AIDS or caused by alcohol or drugs are highly stigmatised and can leave the bereaved disenfranchised and unsupported (Corr 1999; Doka, 2008). In some deaths related to suicide, there could be exclusion of religious rituals and as a consequence those bereaved could experience delayed grief (Beautrais, 2006a; Doka, 2008).

Disenfranchised grief does not propose a process of grieving but rather the context in which grief is experienced. These norms and expectations by society are complex and powerful. Society influences the grieving process and can determine how an individual grieves, if at all. This can leave the bereaved individual to feel excluded and invalidate their grief experiences.

Disenfranchised grief suggests that society can engender a negative grief experience for individuals by not recognising certain relationships, not acknowledging the death, and excluding an individual from grieving. By contrast, some grief theories have suggested that some positive experiences could occur as result of a traumatic death like suicide.

1.5.3 Posttraumatic Growth Model

The Posttraumatic Growth (PTG) model developed by Tedeschi and Calhoun (1995) identified that positive changes could occur as result of a trauma. Three major domains of growth include: perceived changes in self, relationships with others, and philosophy of life (Tedeschi and Calhoun, 1996). The PTG model has continued to evolve and now also includes personal strengths and new possibilities, and changed philosophy on life's priorities, appreciation and spirituality (Calhoun and Tedeschi, 2014).

Like the meaning-reconstruction model, the PTG model suggests that trauma affects and challenges core beliefs about the lifeworld. PTG is both a process and an outcome, where individuals make and find meaning about what's happened by engaging with complex cognitive, emotional, and social factors which can contribute to a greater sense of well-being and life satisfaction (Tedeschi and Calhoun, 1996). Meaning-making is done through cognitive processes to try and make sense of their disrupted lifeworld and is often experienced by different rumination styles (intrusive or deliberate) about their appraisal of events during grieving (Znoj, 2014). PTG can also provide purpose and meaning of an individual's changed lifeworld following a loss through processes such as valuing and appreciating life (Tedeschi and Blevins, 2016). Some individuals find benefits as a consequence of loss such as positive changed relationships or spiritual growth (Affleck and Tennen, 1996; Triplett, Tedeschi, Cann, Calhoun and Reeve, 2012). PTG describes a loss as being traumatic, such as a death by suicide, and suggests that some positivity and growth could occur as a result.

1.6 Continuing Bonds

Unlike meaning-making, the concept of continuing bonds suggests that not everyone wants to 'let go' and this is not necessarily an indication of abnormal grieving. Continuing bonds is considered a 'new' grief theory that challenges traditional perspectives held by Freud, such as the need to detach and sever emotional bonds (Davies, 2004).

Klass, Silverman and Nickman (1996) suggested that the bereaved maintain a link with the deceased by finding a new way to relate to them over time. Continued bonds will over time change but will never end. Klass and colleagues (1996) suggest that continuing bonds in this way is not only normal and healthy, but an important aspect of the grief experience. Continuing bonds are expected and natural, such as holding onto memories, and are often viewed as grief resolution (Klass, et al., 1996). Bonds are likely to be transformed rather than relinquished (Neimeyer, et al., 2006; Root and Exline, 2014). This is achieved by integrating them into future lives by the means of a continuing bond (Klass, et al., 1996).

Klass and colleagues (1996) allude to more positive continuing bonds but do not

provide an explanation on how these healthy bonds are achieved or maintained. Furthermore, they do not consider how those grieving experience and manage 'not so unhelpful' bonds such as excessive rumination about the deceased. Previously, Bowlby suggested that attachments can be maintained but focused more on how they are likely to be related to emotional distress (Bowlby, 1969). For example, the nature of continuing bonds could represent denial and contribute to unresolved grief (Root and Exline, 2014). Further work is required to understand continuing bonds in all its entirety to help to further understand the role of continuing bonds in coping with grief.

1.7 Discussion

Most grief theories attempt to provide an understanding of how the bereaved cope with their grief. The current research is focused on the coping experiences of bereaved survivors following suicide of their intimate partner. The theories in this chapter have provided different understandings of grief.

Some grief theories refer to symptoms (Lindemann, 1944), phases (Bowlby, 1969), stages, (Kübler-Ross, 1969), oscillation (Stroebe and Schut, 1999), meaning-making (Tedeschi and Calhoun, 1995; Neimeyer, 2001), continuing bonds (Klass, et al., 1996) which are often contextualised by society (Doka, 1989). There are limitations with these grief theories. The work of Freud (1961) and Lindemann (1944) set the landscape for grief theory and as a result their work is still regularly cited (Stroebe, et al., 2017). However, these theories did not explain how grief was experienced amongst the bereaved.

The emergence of a 'model' of grief could provide a better understanding of grief related to suicide bereavement. Grief models were developed to understand and try to explain individual differences, or in response to the emergence of different theoretical perspectives (Davies, 2004). Bowlby's (1969) phases of attachment gave some insight but related predominantly to parent-child attachment, so when Kübler-Ross' stage theory (1969) was introduced it provided a clearer understanding of grief. It also provided an expectation of grief, how it could be experienced, and added a timeframe (Stroebe, et al., 2017).

Stage models could account for similar grief reactions, but they do not account for differences. In most cases, differences were often viewed as abnormal grief

(such as complicated grief) when those bereaved did not meet the expectations of the stages of grief (Shear, 2012). Staged theory is particularly unhelpful despite its best intentions. It appeared to initially 'describe' grief but became 'prescriptive' (Stroebe, et al., 2017). This suggests that the bereaved can be pigeonholed and there is a limited understanding of individuality (Boerner, et al., 2015). Stage models are popular and still a dominant perspective but more amongst academics and those supporting the bereaved because of simplicity (Hall, 2014). The model can be worked through, but it does not help those who do not fit a particular pattern of grieving. Traditional grief theories can create sweeping generalisations (Rosenblatt, 2017) which denies an individual grief experience. This suggests that stage theory might not fully capture individual coping experiences of those bereaved by suicide and limit the likelihood of adequate support during a very difficult time.

Grief is complex and sometimes considered 'messy' which highlights the inadequacies of staged models used to understand grief. The oscillation process as seen in the Dual Process Model provides a more flexible understanding of grief by acknowledging that grief is complex, individual, and not experienced in a linear manner (Stroebe and Strut 1999). This approach may give more insight into the coping experiences of survivors bereaved by intimate partner suicide.

Individuality needs to be considered as there are divergences in grief. Those bereaved have different life experiences (Parkes, 1998), personalities (Smit, 2015) and gender-related coping styles (Martin and Doka, 2011). Grief models do not necessarily help us understand everyone's grief experience (Smit, 2015) but understanding differences could help to explain different grief coping styles (Carmichael, 2005).

Boerner and colleagues (2015) reinforce that interpersonal processes are imperative to understanding coping with loss. Meaning-making grief theories provide an additional dimension to understanding to grief. It builds on previous theories of staged symptoms (Lindemann, 1944; Bowlby, 1969; Kübler-Ross, 1969) by suggesting that cognition is part of coping with grief.

The Posttraumatic Growth (PTG) is one model that suggests positive changes could occur as result of a trauma (Tedeschi and Calhoun, 1995). The model reinforces the use of cognitive engagement and processing through a narrative

journey that challenges an individual's beliefs, experiences of different rumination styles and self-disclosure experienced in their social world (Calhoun and Tedeschi, 2014).

The bereaved need to make sense of what has happened as highlighted in the meaning-reconstruction model (Neimeyer, 2001). The model reinforces how a major loss can challenge an individual's assumptions and the need to find meaning. But finding meaning suggests positive adaptation (Neimeyer, 2001). It is possible that after a death like suicide, meaning might never be reached (Martin and Doka, 2011). An explanation for this is complicated grief. For some bereaved individuals, grief can be a struggle to adapt to their loss. Complicated grief is more likely if the death is violent (as in suicide) and more likely in close and romantic relationships (intimate partnerships) (Shear, 2012).

Complicated grief for such individuals is prolonged and intensified causing significant impairment (Prigerson, Frank, Kasl, Reynolds, Anderson, Zubenko, et al., 1995). Complicated grief is also known as prolonged grief disorder (Prigerson, et al., 2009) or traumatic grief (American Psychiatric Association, 2013).

There are several possible contributing factors why a bereaved individual might develop complicated grief. Disenfranchised Grief provides an explanation of complicated grief. Family, culture, religion and social expectations are formed by society and how they view and see the world. Being restrained from openly grieving a suicide for example, contributes to complicated grief and intensifies emotional reactions (Doka, 1989).

Post-Traumatic Stress Disorder (PTSD) has been an indicator of complicated grief with sufferers reporting flashbacks, distressing recollection of events and nightmares (Young, Iglewicz, Glorioso, Lanouette, Seay, Ilapakurti, et al., 2012). Complicated grief is associated with poor quality of life that has implications for the family as well as social and work life (Crunk, Burke and Robinson, 2017). This type of grief is associated with life-threatening consequences such as suicidal ideation and behaviour (Latham and Prigerson, 2004; Prigerson, et al., 2009) therefore warranting the need for treatment (Currier, et al., 2008).

As previously mentioned, continuing bonds theory reinforces that bonds will never end with the deceased, are normal and healthy grief related responses,

and an indicator of resolution (Klass, et al., 1996). Complicated grief could provide an additional explanation if the continued bonds are abnormal or unhealthy. Complicated grief could develop if attachments and bonds are problematic post death especially if the bereaved have not been able to reach a satisfactory conclusion about the death (such as the causes of suicide) (Neimeyer, et al., 2006; Jordan and McIntosh, 2011). The state and quality of attachment in relationships provides an understanding of how bereaved individuals cope with their grief. This reinforces the nature of the relationship with the deceased (Parkes, 1998). Broken attachments violate safety and security (Bowlby, 1969; Jordan and McIntosh, 2011) and intense emotions are present in all attachment relationships (Dunne, 2004) whilst attachment styles could predict complicated grief (Crunk, et al., 2017). This suggests an interplay between attachment to the deceased, the nature of the continuing bonds, and meaning-making of the death.

Theoretical perspectives and models help the understanding of grief but are often based on the theorist's academic discipline (Davies, 2004). Traditional perspectives and models were based on psychology and deeply rooted in a positivistic research paradigm (Davies, 2004). This is evident with psychology perspectives, albeit with different viewpoints over time (Lindemann, 1944; Freud, 1961; Bowlby, 1969; Tedeschi and Calhoun, 1995; Stroebe and Schut, 1999; Neimeyer, 2001), a psychiatrist (Kübler-Ross, 1969).

The emergence of trying to understand more about grief was underpinned by a shift in paradigms with newer models being rooted in a non-positivistic research approach (Davies, 2004). Understanding grief from psycho-social perspectives emerged (Doka, 1989; Klass, et al., 1996). This included psychologists conducting research in the context of the social world within which individuals live, such as the meaning-reconstruction model (Neimeyer, 2001) and the PTG model (Tedeschi and Calhoun, 1995).

Context is important because grief is not the same for everyone (Rosenblatt, 2017). New models were needed to account for differences as well as factors such as context (Davies, 2004). Most models reflect grief being experienced in certain populations: clinical populations of people with depressive symptoms (Freud, 1961), grief reactions of relatives of those who served in the armed forces

(Lindemann, 1944), original work on attachment between mother and child (Bowlby, 1969) and terminally ill patients (Kübler-Ross, 1969). These models have limitations as it is not possible to generalise grief experiences to the general or other specific populations such as those bereaved by suicide. They also did not consider the wider context such as the impact of world wars on an individual's bereavement in their lifeworld or cultural differences for example.

Some of these traditional theories were based on clinical observations (Stroebe, et al., 2017). Furthermore, some grief theories were based on anticipatory grief (Costello, 1999), while Kübler-Ross (1969) focused specifically on anticipation of death by those who were terminally ill.

In most suicides, these deaths are traumatic, unexpected (Smit, 2015) and the nature, or circumstances, surrounding the death can influence an individual's response to grief (Parkes, 1998; Clements, DeRanieri, Vigil and Benasutti, 2004; Hall, 2011). If the death was violent or unexpected, as in suicides, it can have significant impact on how an individual grieves (Martin and Doka, 2011; Neimeyer and Sands, 2011). There is a struggle for meaning, as core beliefs about their lifeworld, especially the one they shared with the deceased is challenged (Jordan and McIntosh, 2011; Neimeyer and Sands, 2011). This reinforces that those bereaved following suicide are more likely to experience complicated grief.

This research study is focused on coping experiences of bereaved survivors following suicide of their intimate partner. Traditional grief theory can give some insight into grief symptoms and how they might be experienced but are unlikely to give a full and deeper understanding of suicide bereavement and coping. Most traditional grief theories are not aimed at specific types of bereavement (Boerner, et al., 2015). Oscillation Theory is the closest that could explain coping related to complicated grief following the death of a partner (Stroebe and Schut, 1999) though it is not specifically aimed to understand suicide bereavement. The concept of meaning-making provides an additional element to understanding suicide related grief, which factors in the role of cognition and how this affects the grieving individual and their social world. The notion of disenfranchised grief may give a greater understanding of context and how society regulates those bereaved. Newer grief theories such as continuing bonds may provide a different theoretical perspective.

1.8 Summary

The grief theories presented and discussed can provide some insight into how individuals bereaved by suicide cope with the loss of an intimate partner. Theoretical explanations of grief experiences during bereavement, suggest differences, similarities and some overlaps. Critique of the theories reinforced that grief is personal, unique and complex. Grief can be complicated and influenced by the nature and circumstances of the death and whether it was anticipated, sudden or unexpected. Additional factors such as culture and social norms contribute to the grieving process and need to be considered in bereavement. No substantive theory provided a comprehensive understanding of coping in bereavement following intimate partner suicide. In later chapters of this thesis, such as the review of the literature and discussion, grief theories will be used to support the central thesis and contextualise the findings of this research study.

Understanding suicide related grief will help identify the needs of the bereaved, how they cope and enable supportive interventions to improve better health related outcomes.

1.9 Conclusion

This first chapter provided different theoretical concepts and models of grief experienced through bereavement. The theories were presented and discussed temporally in relation to how they evolved over time and provide an understanding of how the bereaved might cope in their grief following a loss. The chapter then considered how existing grief theories might help provide some insight into suicide bereavement and relevance to the current research study.

The remainder of this thesis consists of six chapters. This study is focused on the coping experiences of bereaved survivors following suicide of their intimate partner. *Chapter Two* will discuss factors associated with suicide bereavement. This chapter provides definitions of suicide, postvention, survivor and spouse, and outline some of the factors that may influence the responses of people in the aftermath of suicide. The chapter outlines social factors associated to suicide bereavement and how spouses in particular, might face additional challenges such as the nature of the relationship with the deceased, and events surrounding

the death, that impact on their grief.

The literature review is presented in *Chapter Three* and outlines a structured review of coping experiences of spouses following suicide of their partner. The findings are organised according to emerging themes: events surrounding the suicide, nature of the relationship to the suicide victim, and postvention. The review identified a dearth of qualitative studies on spousal coping and limited understanding of how spouses come to terms with the loss of their partner, and factors that assist coping.

In *Chapter Four*, the researcher's position, research methodology, philosophical assumptions and paradigms are discussed. An Interpretative Phenomenological Analysis (IPA) approach was chosen as the research methodology for this study. This reflexive approach aims to provide a transparent commitment to ethical principles and research rigour.

Chapter Five presents the findings of this study. Five super-ordinate themes and fifteen themes were identified. The findings are presented and illustrated by transcript extracts and the researcher's interpretation within a 'case within theme' approach.

The major findings from this study are discussed in *Chapter Six*. The discussion presents the strengths and limitations of the study and compares the findings to coping theories and models of bereavement. This leads to an exploration of the literature, super-ordinate themes and emergent themes from the study. The discussion concludes with a proposed new model of coping.

The final chapter (*Chapter Seven*) in this thesis presents seven major conclusions which include a (1) proposed model of coping following intimate partner suicide bereavement, (2) the notion that coping following intimate partner suicide is complex in nature, duration and outcome, (3) resilience is rarely considered in suicide literature, (4) support is essential, (5) survivors may benefit from psychological interventions, (6) the workplace plays an important role in support and recovery, and (7) coping can be compromised as suicide is still stigmatised. The conclusions are discussed with recommendations for future practice and research. This chapter concludes with some brief remarks.

CHAPTER 2: SUICIDE

2.1 Introduction

This chapter begins with a definition of suicide, and current prevalence rates of suicide in the United Kingdom (UK). Factors contributing to suicide are then discussed as well as the central concepts of suicide survivor and spouse introduced. The range of factors affecting coping are then addressed briefly. The problem statement aim of the research and significance are outlined.

2.2 Definition and prevalence of suicide

Suicide is currently defined as ‘the act of deliberately killing oneself’ (World Health Organization (WHO), 2017a). The definition of suicide has evolved over time with legal, cultural and religious systems influencing how a society views and manages death by suicide (De Leo, Burgis, Bertolote, Kerkhof and Bille-Brahe, 2006). Worldwide more than 800,000 people die every year from suicide which on average represents a death occurring every 40 seconds (WHO, 2017c).

Classifications of suicide such as those presented in the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) inform the recording of these deaths. In 2011, the ICD changed the coding of verdicts of intentional self-harm from ‘accidents’ to ‘suicidal related deaths’. The changed codes could have contributed to an increase in reported suicide rates. Narrative verdicts, where previously the deaths might have been coded as accidents because of a lack of information about intent, are now more frequent (Office for National Statistics (ONS), 2013). More recently, in 2016, the suicide definition was further revised to include deaths from intentional self-harm in children aged between 10 and 14 years which was not previously reported (ONS, 2016). These changes have had an impact on suicide statistics, and in part, explains the significant increase in reported suicide rates.

According to some researchers, variation of definitions of suicide also occurs across countries despite the use of revised and complementary diagnostic manuals (Judd, Jackson, Komiti, Bell and Fraser, 2012; De Leo, Milner, Fleischmann, Bertolote, Collings, Amadeo, et al., 2013). Inconsistent definitions lead to both over and under reporting of suicide rates and cross-country variations

(De Leo, et al., 2006). In some cases, over reporting was based on guessing or making assumptions due to inconsistent criteria (De Leo, et al., 2006). Under reporting often reflects cultural and religious stigmatising views on suicide which might preclude the deceased from being buried with full religious rites or the spouse being able to claim from their partner's life insurance (Beautrais, 2006a).

2.3 Suicide in the United Kingdom

2.3.1 Suicide rates

The latest suicide rates of the United Kingdom (UK) reflect England, Wales and Scotland and Northern Ireland (ONS, 2017b). In 2016 in the UK, a total of 5,965 suicides of people over ten years of age were reported, comprising of 75% males and 25% females (ONS, 2017b).

In England, there was a total of 4,575 suicides of people over ten years of age in 2016 with the majority being males (3,464) and females (1,111) (ONS, 2017a). In England, the suicide rate has fallen from 10.1 in 2015 to 9.5 per 100,000 people in 2016 (ONS, 2017a).

In recent years suicide rates in English males have seen a steady decline from a peak in 1988 at 20.8 per 100,000 to its lowest point in 2007 at 13.9 per 100,000 males (ONS, 2017a). Suicide amongst English females saw a significant improvement during the 1980s and the rate has been falling with the rate in 2016 rate of 4.5 per 100,000 females (ONS, 2017a). The highest regional age-standardized suicide rate was recorded in the the South West of England at 11.2 deaths per 100,000 of population (ONS, 2017a).

In 2016, the highest suicide rate occurred for males between the ages of 45 to 59 years at 21.7 deaths per 100,000 of population and for females between the ages of 50 to 54 years at 8.0 deaths per 100,000 of population (ONS, 2017a). Males and females in these age groups were more likely to have been spouses.

2.3.2 Mode of death

In the UK, methods of suicide commonly reported are hanging, suffocation or strangulation (58.7% of males compared to 42.8% for females) with a larger proportion of females poisoning themselves (36.2%) than males (18.3%) (ONS,

2017b).

Suicide by hanging has increased particularly in females possibly due limited availability of other methods such as drug overdosing (ONS, 2017b). Hanging is often chosen for two main reasons - the nature of the death (quickest and painless) and accessibility (easiest and straightforward) (Biddle, Donovan, Owen-Smith, Potokar, Longson, Hawton, et al, 2010).

2.3.3 Characteristics of the suicidal act

The characteristics or means of a suicide varies (De Leo, et al., 2013). Common forms of suicide methods are hanging, jumping (off a building or into the path of a train) or poisoning (Young, et al., 2012). It is known that men are more likely to use lethal methods in conjunction with drug and/or alcohol at the time but may not have a history of previous suicide attempts, a mental health diagnosis or long-term drug and alcohol abuse (Coleman, Kaplan and Casey, 2011). The preference for lethal methods reinforces why men are more likely to complete suicide on their first attempt. Women generally have a history of previous suicide attempts before a completed suicide, or may never successfully die by suicide (Chang, Stuckler, Yip and Gunell, 2013).

Drug related poisoning is a common method used by women, and represents over a third of suicides (Beautrais, 2006a; 2006b; Department of Health (DH), 2012b). The means of suicide are influenced by social acceptance and availability. In some cases, a new 'means' can spark of a trend when previous suicide attempts have failed. In recent times, social media is often seen to aid those wanting to die by suicide. This is evident with websites providing encouragement and assistance (Gregory, 2013). In Hong Kong, the use of charcoal burning as a method of suicide has been reported with copycats adopting this method (Beautrais, 2006a; Yip and Liu, 2006).

2.4 Socio-economic factors

Socio-economic factors such as global recessions create personal stress associated with unemployment, homes being repossessed, and bankruptcies, all of which can contribute to suicide (Chang, et al., 2013).

Widespread political and economic changes can contribute to uncertainty and

personal hardship. Jukkala and Mäkinen (2011) reported that although Russia has one of the highest suicide rates in the world, this rate increased by fifty percent in the early 1990s with the fall of communism. Similarly, the economic recession in Asia in 2004 accounted for a high percentage of suicides amongst men (Beautrais, 2006a). Europe also observed a significant rise in suicides following the last economic recession in 2008 (De Vogli, Marmot and Stuckler, 2013).

Worldwide, men are generally expected to provide for their families (Khan, 2002; Hawton and Haw, 2013). Men are often the highest income earner or sole earner for many households (Chang, et al., 2013), which might offer one explanation for the higher incidence of male suicide. Unemployment is recognised as a risk factor to suicide, but financial burden can also be associated with having a low paid job and being in debt (De Leo, et al., 2013).

2.5 Culture and religion

Suicide is often stigmatised by societies because suicide is still considered a taboo in society (Cvinar (2005). This taboo is largely because the act of suicide continues to be a criminal offence in many countries (Hjelmeland, Osafo, Akotia and Knizek, 2014) although it has not been a crime in England and Wales since 1961 (Suicide Act, 1961). Suicide is also considered an 'unforgiveable sin' according to some religions and cultures. Historically some cultures viewed suicide as being a crime ranked just beneath that of murder in terms of seriousness (Alvarez, 1974).

Cultural and religious beliefs and traditions contribute to social views of suicide and the cultural context determines society's understanding of suicidal death. In Western developed countries, the view of suicide focuses on the individual carrying out the act, whereas in Eastern countries there is an emphasis on others being influential in the suicide (De Leo, 2002). In some cultures, suicide has been viewed as an expectation at certain times. In the past, suicides in Eastern countries were viewed as honourable and a social and religious expectation. This can be seen in Japan with hari-kari, a ritual suicide, or the practice of suttee in India. Suttee is a voluntary death carried out by a Hindu female widow to fulfil her role as a wife to her late husband (Beautrais, 2006b).

There are lower rates of suicide in countries where the population is represented by a dominant religion (De Leo, 2002). Most countries in southern Europe follow the Roman Catholic faith which states that dying by suicide is a mortal sin (Colucci and Martin 2008; Hoffer, Shelton, Behnke and Erdberg, 2010). Religious beliefs and institutional support processes can be protective against suicide (Coleman, et al., 2011). However, it is not clear whether fewer suicides actually occur in religiously dominant societies or that suicides are underreported because of stigma and religious views.

2.6 Gender

Both men and women attempt suicide worldwide, but men are more successful in completing suicide (Judd, et al., 2012). Men account for most suicides worldwide and suicide is one of leading causes of death in men (Coleman, et al., 2011; Owens and Lambert, 2012). The one exception where women die by suicide more than men is in China (De Leo, 2002; Yip and Liu, 2006; Coleman, et al., 2011). Therefore, overall, it is more likely that women will grieve their spouses' suicides than men.

Traditional gender roles have their roots in society. Men strive to be powerful and successful, and failure can contribute to despair (Coleman, et al., 2011). According to Owens and Lambert (2012) declaring failure is a threat to being a man and suicide can be a way of escaping this failure. Women are less likely to die by suicide. Even in the face of crisis, they usually have better coping skills and larger informal and formal support networks than men (De Leo, 2002). Men tend not to seek help or support during a life crisis and if they do, it is often as a last resort (Chang, et al., 2013). This may be because for men, accessing and utilising support would be at odds with traditional male behaviour of being self-reliant and emotionally strong.

2.7 Suicide survivors

A family member left behind following a completed suicide is known as a 'suicide survivor' (Shneidman, 1965; Wertheimer, 2014; Ali, 2015). People who die by suicide are often grieved by their partner, family and friends (Begley and Quayle, 2007). Suicide survivors have different bereavement experiences following suicide (Jaques, 2000; Cerel, Jordan and Duberstein, 2008; Public Health

England (PHE), 2016a; 2016b). In the same family, members can have different grief responses (Wertheimer, 2014). Factors affecting family grief include the family life cycle, and the role of the deceased in the family prior to the suicide (Jaques, 2000). The research in this thesis is focused on the coping experiences of bereaved survivors following suicide of their intimate partner. This research therefore considers the specific role of spousal survivors, influencing factors, and the nature of the spousal coping.

2.7.1 Spousal survivors

The term 'couple' is often used to describe an intimate partnership. Individuals in a couple relationship are often referred to as 'spouse'. A committed relationship may occur between a man and woman as well as consenting partners of the same sex. Couples may be married under common law, in a de facto relationship, or consider themselves as being in a committed relationship. The living arrangements of couples may vary across the lifespan to include just two adults, two adults with children of one or both spouses, and/or extended family members. Some couples may not live together on a permanent basis but consider themselves to be in an intimate partnership. These representations of intimate partnerships have changed over time and reflect self-appraisal of 'family' and of 'being together' (Clarke, 2010). The spousal relationship has a structure, function and emotional connection between individual adults that differs from other relationships (Weigel, 2008).

Assumptions are often made about what constitutes a 'relationship' which leads to assumptions on the nature of those relationships. Kinship is a term often used to define relations. Kinship is often viewed as a relationship between two or more persons that is based on common ancestry (descent) or marriage (affinity). Kinship is a cultural construct that is displayed in marriages, families, lineage and legislated in laws (Leonetti, 2008). There are also family-like relationships that include non-blood relatives such as godparents or close family friends (Cooper, 2012). Kinship is not necessarily an accurate reflection of contemporary relationships as there have been changes in the family structure outside of blood ties or marriage such as cohabitation, births outside of a marriage, step families and partners (Manning and Brown, 2011). The definition of kinship based on blood ties or marriage does not provide insight into the quality of a relationship.

It is unlikely that grief can be fully understood following the death of a loved one in the context of kinship alone. A relationship is based on attachment responses and expectations (Leonetti, 2008) and an emotional connectedness (Levin, 1999) which is based on love and caring for each other (Bogenschneider, 2014). Emotional connectedness (Girardin and Widmer, 2015) is developed longer-term through activities that are shared and create dependence on each other (Leonetti, 2008).

An intimate couple partnership may share several characteristics that are evident in other relationships but often has a special psychological connection. Bowlby's (1969) attachment theory for infants and mothers was further developed by Zeifman and Hazan (2000) who devised a four-stage attachment theory for adults. Stages of attachment for adults are attraction and flirting, falling in love, loving, and living life as usual. Bowlby identified three behavioural systems to include attachment, caregiving, and sex (Bowlby, 1969). These systems were also recognised in the theory of romantic love that bonds adults together in partnerships (Shaver, Collins and Clark, 1996). As such, people commonly use terms such as 'we are as one' to describe the closeness and connectedness of an intimate partnership between adults. The relationship reflects depth and intensity.

Often partners are left to manage the aftermath of a self-inflicted death (Cerel, et al., 2008). In the aftermath of a suicide it is normally the surviving spouse who takes a lead role in supporting and organising the family (in whatever form that may be (Wertheimer, 2014). As well as grieving the loss of their spouse, the surviving spouse often has to provide emotional support for others (especially children), assume greater household and financial responsibilities, and navigate enforced role changes (Cerel, et al., 2008). Of particular interest to the current thesis is the coping of a bereaved survivor following their intimate partner's suicide. Given that men are more likely to die by suicide successfully; it is usually women who are the surviving spouse.

2.7.1.1 Factors affecting spousal coping following suicide

There is relatively little known about the impact of suicide on spouses (HM Government, 2011; DH, 2012a; 2016). Recent government reports indicate that the bereaved following suicide are at higher risk of emotional and mental health

problems and are at risk of suicide themselves (HM Government, 2011; DH, 2012a; 2016; PHE, 2016b). Following the loss of a partner, spouses are at high risk of suicidal ideation linked with emotional loneliness and depression (Stroebe, Stroebe and Abakoumkin, 2005). Some factors influencing coping may include the quality of the couple relationship, events surrounding the suicide, as well as social, economic and psychological factors (Lindqvist, Johansson and Karlsson, 2008).

Factors previously discussed in this chapter such as characteristics of the suicidal act, socio-economic factors, gender and culture and religion may affect coping of spouses. Furthermore, factors associated with grieving need to be considered. These could include the spouse ruminating whether the deceased was genuine in their intention; or acted impulsively due to alcohol effects; or the effects of guilt for a failure to observe signs of distress from their spouse before the suicide (Hawton and Haw, 2013).

Economic recessions (De Leo, et al., 2013) or difficulties (Hawton and Haw, 2013) impact families and affect individual coping. This suggests that financial difficulties may adversely affect coping of survivors because of this additional burden and stress (Lindqvist, et al., 2008). Loss of the primary income or a significant income earner due to suicide may contribute to considerable stress in survivors and make positive coping less likely. The long-term effects of loss of income or invalidated life insurance policies can impact greatly on the family (Beautrais, 2006a; Wertheimer, 2014).

In more recent times, changing family structures have led to women contributing more to household finances (Hawton and Haw, 2013). However, women may assume other unwanted roles and responsibilities from their spouse as a consequence of the suicide, which affect their ability to cope. Regardless of gender and financial status, spouses left to cope are likely to experience stigma because the act of suicide has ethical, legal and religious implications that may affect coping including their perceived right or ability to grieve (Cvinar, 2005; Doka, 2008; Wertheimer, 2014)

While many surviving spouses may suffer adverse consequences for an extended period of time, other spouses may process their grief and attain a good quality of life following their loss. However, we know relatively little about the

grieving of male and female suicide survivors.

2.7.1.2 Nature of the spousal relationship

There are several explanations to suggest why spousal suicide is more impactful than other forms of spousal death such as natural illness, motor vehicle accidents and other forms of misadventure. Some authors suggest that the degree of intimacy rather than kinship is likely to account for impact and how the individual grieves and copes following suicide (Mitchell, Crane and Kim, 2008). It could also be that spouses often blame themselves for events that occurred before the death (Ali, 2015) or for being a 'failure' in the relationship and not adequately supporting their spouse (Cerel, et al., 2008). This suggests that the quality of the relationship with the deceased around the time of the death may contribute to the grieving process.

2.8 Coping strategies during suicide bereavement

Any death is impactful for those left to grieve. As discussed in the previous chapter, bereavement is associated with varying levels of grief (Wertheimer, 2014). As part of the grieving process the bereaved will use different strategies in an attempt to cope. Grief generally comprises acute, integrated and complicated reactions (Pompili, Lester, De Pisa, Del Casale, Tatarelli and Girardi, 2008; Young, et al., 2012). Complicated grief is prolonged grief which affects all areas of functioning (Young, et al., 2012). Grief reactions have psychological, social and physical components with psychological grief being associated with fear, guilt, sadness, or even relief. Socially, grief can impact relationships or ability to nurture. Physically, health can deteriorate as sleep and eating patterns become irregular and other health problems develop (Rando, 1988; Gall, Henneberry and Eyre, 2014).

Suicide survivors are at higher risk of developing complicated grief including depression, PTSD and suicidal ideation and behaviours (Young, et al., 2012). These responses may be in response to the nature and suddenness of the death (Clements, et al., 2004). An anticipated death can allow the bereaved to prepare for their loss. Suicide survivors however, are likely to be informed about the suicide after the event and quickly need to come to terms with the shock of this news.

Survivors commonly have responsibilities immediately following the suicide. Often the spouse will have to take a lead in dealing with the police investigation and coroner's court, followed by funeral arrangements (Biddle, 2003; Wertheimer, 2014). These processes can be an invasion of privacy, and a potentially traumatic experience if the person found the body, is required to give evidence, and is scrutinised by the media (Wertheimer, 2014).

The acceptance of the inquest verdict can be difficult for the bereaved spouse who might be feeling rejected by the deceased partner or blaming themselves in some way (Wertheimer, 2014). This can be amplified by gossip and judgement towards the bereaved spouse about their role in the suicide (Ali, 2015). For suicide survivors, the grieving process is often described as a 'lonely and long journey' (Clements, et al., 2004). Family disruption and conflicts have been reported to occur more often in suicide survivors than those bereaved by natural causes (Jordan, 2001). Coping involves appraising the event (primary) and appraising what can be done about the event (secondary) (Lazarus, 1966). Coping behaviours can be both helpful and unhelpful with short and long-term effects. It is therefore important to understand the impact of suicide on survivors and the postvention strategies they employ to help them cope.

2.9 Suicide prevention

Suicide is the leading cause of death amongst males aged between 15 and 49 years (DH, 2016) particularly amongst middle aged men aged between 45 to 59 years (ONS, 2017a). At least 25% of those who died by suicide were in contact with a healthcare professional in a primary care setting within at least a month or a week before their death (DH, 2016).

Suicide prevention is a national priority (DH, 2012b; HM Government, 2012; DH, 2016; PHE, 2016a; 2016b; HM Government, 2017). The UK government has developed policies and strategies for health services and guidelines for professionals to reduce suicide rates with a focus on prevention (HM Government, 2011; DH, 2012b; 2016). One main preventative focus is to target at-risk groups. For example, it is widely known that users of mental health services or people in the prison system are at high risk of suicide and resources have been directed to these areas (HM Government, 2011; DH, 2012b; DH,

2016). There has been a decline in suicides amongst inpatients in mental health hospitals which may be due to the safety precautions in place. (DH, 2016). However, a significant proportion of those who die by suicide have never been in contact with mental health services in any capacity or the criminal justice system (HM Government, 2011). This suggests a higher incidence of suicides in communities, with an associated burden of suicide-related grief, that may go unreported. In particular, middle aged men are at high risk of suicide. Suicide prevention strategies therefore need to include this group and support those close to them. Therefore, a better understanding of the impact of suicide on grieving of those in a close relationship to the suicide victim is required.

2.9.1 Postvention

Postvention is an important prioritised national strategy to support those affected by suicide because of their risk for suicidal ideation and suicide themselves (HM Government, 2012; 2017; DH, 2016; PHE, 2016a; 2016b). Postvention is a term that describes supportive activities whether it be information, resources or services used by people bereaved by suicide to aid their recovery and reduce the risk of suicide (PHE, 2016b). Different professionals beyond healthcare services are involved in providing postvention immediately and ongoing, with the General Practitioner (GP) providing a pivotal role (Foggin, McDonnell, Cordingley, Kapur, Shaw and Chew-Graham, 2016; Nic an Fhaili, Flynn and Dowling, 2016).

The UK Government is clear that postvention is an essential part of public health as suicide costs £1.67m with 70% related to the emotional impact of those bereaved by suicide (PHE, 2016b). Postvention recognises that suicide affects a wide range of people, their needs are significantly unmet and differ from person to person, and wider social issues contribute to this type of bereavement (PHE, 2016b). Postvention activities are needed both nationally and locally with a reliance on learning from others, strong partnerships and evaluation of postvention because at this time suicide bereavement support is emerging and developing (PHE, 2016a; 2016b).

2.10 Problem statement

Suicide continues to be a worldwide problem with significant personal, social and economic costs. There are increasing rates of adult males who die by suicide.

Relatively little is known about how bereaved spouses cope following suicide and what factors help or hinder their recovery. As a result of on-going concern about suicide rates, the UK government has recognised the need to ensure that those bereaved or affected by suicide are identified, can access services, and obtain information as well as support. To better support surviving spouses, an understanding of their grieving processes is required.

2.11 Research aim

This research study aims to investigate the coping experiences of bereaved survivors following intimate partner suicide.

2.12 Significance

Bereavement following suicide continues to have high personal, social, economic and health costs (DH, 2012b; HM Government, 2012; DH, 2016; PHE, 2016a; 2016b; HM Government, 2017). Survivors have been found to have impaired mental health in the twelve months after suicide and be at risk of suicide themselves (Young, et al., 2012). They are often neglected in the health care system or their needs are not recognised (Dyregrov, 2002; DH, 2016).

Understanding bereaved spouses' experiences following their partner's suicide and coping patterns will better inform the provision of health care; the development of intervention programs; the health education of consumers, and training of health professionals in this area. Assisting bereaved spouses to cope following suicide will contribute to better mental health outcomes and reduced morbidity. Life stresses are unique and impact people differently. Investigating coping experiences of spouses following suicide can also assist in minimizing the adoption of negative or harmful strategies and enhance our understanding of what is helpful during this life crisis.

2.13 Conclusion

This chapter of the thesis provided a definition of suicide, postvention, survivor and spouse, and outlined some of the factors that may influence the responses of people in the aftermath of suicide. To understand how a spouse copes following suicide, the death needs to be contextualised according to the spousal

relationship, events surrounding the death and how society in which the couple live views suicide. Social factors such as socio-economic status, culture, religion and gender can impact on coping as well as psychological variables such as mental health, self-efficacy, stress levels, and usual coping strategies. The next chapter presents a structured review of the literature related to coping experiences of spouses following suicide of their partner.

CHAPTER 3: LITERATURE REVIEW

3.1 Introduction

This chapter presents a structured review of the literature related to those bereaved by suicide who are often referred to as 'suicide survivors' in the literature. The review will have a focus on the coping experiences of spouses. The methodology of the review using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher, Liberati, Tetzlaff, Altman and The PRISMA Group, 2009) framework is outlined, including the search terms, results of the search and number of sources included and excluded in the review. Results of the review are presented and discussed according to the major themes. The major themes include events surrounding the suicide, nature of the relationship to the suicide victim and postvention.

A previous literature review of bereavement following a suicide was conducted by Henley (1984). The review summarised findings of studies published from 1964 to 1983 on the impact of suicide to relations with one section focussing on spousal suicide. Henley (1984) included a range of literature containing theories of suicide and suicide coping, with the majority of sources from books as well as an unpublished report. Therefore, this present review of the literature has a date range of 1983 to 2017 to include the years 1983 to 1984, as some papers might have been in press when the Henley review was published. This consideration was also to ensure that all possible available literature could be reviewed. The present review builds on previous work in the field.

3.2 Method

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework guided the review to ensure a consistent and comprehensive search process of the literature was followed (Moher, et al., 2009). Using the people, exposure and outcome (PEO) framework (Salmond, 2011) the review question was: What are the coping experiences of spouses following the loss of their partner to suicide? The search included English language papers published from 1983 until 2017; on contributing factors; involved original research; used qualitative/quantitative/mixed methods /literature reviews

(meta-analyses) and books; and presented data from primary research studies. The search excluded unpublished theses/ narratives/ hypothetical and fictional cases, practice/ theoretical and policy literature and terms such as business partners/physician-assisted suicide/euthanasia/suicide-pact/ homicide-suicide/ murder-suicides/ double suicides/ para suicide.

Three electronic databases: CINAHL Complete with Full Text, Medline and PsycINFO between date ranges of 1983 to 2017 were searched. The search strategy was as follows: Search terms: suicid* OR "self-inflicted death*" OR "post-suicide*" OR "killing oneself" OR "taking one's own life" OR "completed suicide*" AND cope* OR coping OR experience* OR effect* OR impact* OR postvention* OR bereave* AND husband* OR wife OR wives OR partner* OR spouse* OR girlfriend* OR boyfriend* OR widow* OR kinship*. Each database was searched individually and then combined to re-run the search terms. The total number of sources were 2103. Duplicates of 605 sources were removed.

The remaining 1498 sources were screened according to the search terms in the title or abstract, with 1441 sources being excluded. The 57 sources included 52 papers and 5 books. A general observation of excluded articles identified that the term 'partner' was often in regard to 'intimate partner violence' or words that had a suffix of '-cide'. The 5 books were checked for any documented research data but were excluded as they provided generic bereavement advice with a focus on theoretical explanations and interventions. The 52 papers were assessed according to the exclusion criteria and 33 papers were excluded. Exclusion examples include: an editorial interpretation and discussion of a research study; a loss of a spouse was part of the widower's history and not the focus of the study; and a study of participants that were not personally affected.

Hand searching for authors publishing on this topic in reference lists of both the excluded and included papers was undertaken. A further 3 papers were retrieved and a total of 22 papers were included in the review.

A framework was used to assess the validity and reliability of the studies (Aveyard, 2010). Papers that used quantitative research designs, the framework guided questions to consider in the critique: the quality of the journal, the research question and why the study was conducted, what method was selected, sample size, the appropriateness of the sample, data collection methods, data analysis

techniques and conclusions (Aveyard, 2010). Papers that used qualitative research designs, the framework guided questions to consider in the critique: relevant qualifications/experience of the author/s, the quality of the journal, the research question and appropriate method of addressing the question, suitability of qualitative method selected, sample size, the appropriateness of the sample, data collection methods, data analysis techniques and conclusions (Aveyard, 2010).

3.3 Results

The 22 studies were published from 1984 to 2017 with 4 conducted in the 1980's, 9 in the 1990's and 9 from 2000 until the present. Seventeen studies were conducted in the United States of America (USA). Most studies used quantitative methods with the majority using a comparative design. Four studies used a qualitative method with 1 study using a mixed method design. A summary table of included studies is provided (Table 1 in Appendix A).

3.3.1 Themes

The reporting of results is organised according to emerging themes related to the research question. The themes are as follows: events surrounding the suicide, nature of the relationship to the suicide victim and postvention.

3.3.1.1 Events surrounding the suicide

Perceptions of events surrounding the suicide of a partner may affect spousal coping. Eleven of the 22 studies compared coping following suicide as the cause of death to other forms of death. Demi (1984) compared the social adjustment of widows (n=40) following the sudden death of their spouse by suicide, natural, or accidental causes. All participants completed the Social Adjustment Scale (SAS) and the study-specific Family Unity Scale (FUS). Participants reported good levels of social adjustment and leisure with no significant differences between groups. However, spouses of partners who died by suicide experienced more guilt and resentment compared to spouses of other causes of death.

Pennebaker and O'Heeron (1984) compared the health and coping strategies of bereaved spouses of suicide (n =20) and accidental motor vehicle deaths (n =19) at twelve months. All participants completed a 5-item coping questionnaire.

Contrary to expectations, suicide survivors were more likely to talk with friends (mean = 2.52) compared with accident survivors (Pennebaker and O'Heeron, 1984). More discussions were associated with less rumination about the death and fewer reported health problems. Although the number of health problems increased in the year following the death (from a mean of 0.83 to 2.53 problems), those who talked about the death to counsellors had a mean of 1.58 illness events. Pennebaker and O'Heeron (1984) concluded that talking with friends and professionals was protective for suicide survivors.

Farberow, Gallagher, Gilewski and Thompson (1987) compared the early impact of bereavement of elderly survivors (n =358) following a suicide or natural death of a spouse to a non-bereaved group. Measures included the Texas Inventory of Grief Past (TIG Past) and Texas Inventory of Grief Present (TIG Present); Beck Depression Inventory (BDI); the severity index subscale from the Brief Symptom Inventory (BSI) and Mental Health Self-Rating (MHSR). Both survivor groups scored significantly poorer than the non-bereaved group on all measures. Grief reactions were not significantly different, however, suicide survivors (both women and men) reported significantly more anxiety than natural death survivors.

McNiel, Hatcher and Reubin (1988) compared the well-being of bereaved widows (n=26) of suicide and accidental death victims. Standardised measures included the Family Environment Scale (FES); Life Event Questionnaire (LEQ); General Health Questionnaire (GHQ) and Family Functioning: Adaptation, Partnership, Growth, Affection and Resolve (Family APGAR). Suicide survivors reported no more family dysfunction, life stress, or psychiatric symptomology than accident survivors. Suicide survivors did report a mild elevation on family cohesion compared with accidental death survivors but were not significantly different. However, during the structured interview suicide survivors described more guilt and self-blame.

Barrett and Scott (1990) compared the bereavement of spouses (n =57) following suicide, natural, or accidental death on quality of grief resolution at 24-48 months post death. Measures included the Grief Experience Questionnaire (GEQ) and Purpose in Life Scale (PIL). Suicide survivors consistently experienced more grief reactions and higher levels of rejection than other survivor groups but were not significantly different.

Van Dongen (1990) explored the perceived lived experience of adult survivors (n=35) 3 to 9 months after the suicide death of a family member. Participants experiences were captured in the following themes: perception of the death, emotional turmoil, cognitive dissonance, physical disturbances, altered socialization, survival strategies and life experiences over time.

Perception of the death: most participants described their relationship to the deceased as positive (n=33) with the other two being conflicted or estranged. Some acknowledged that the victim was a risk of suicide (n=25) but not suicidal before the death. Participants (n=7) anticipated the likelihood of a suicide in victims who were chronically suicidal.

Following the death, participants described symptoms of acute grief (emotional turmoil): anger (n=31) guilt (n=21), depressive symptoms (n=20) (altered sleep and eating patterns, irritability, overwhelming sadness and emptiness). For some, responses became more severe 3 to 5 months post suicide and 5 participants developed suicidal ideation. Less depressive symptoms were reported by those who expected the suicide or had an explanation for the death. Those who perceived the victims as chronically suicidal also felt some relief.

Participants who did not expect the suicide experienced significant cognitive dissonance. This was evident in the need to read or speak to people to get information that would give answers to why the suicide happened. Participants reported going over the events leading up to the suicide and analysing the victim's childhood. In turn, this affected the ability to concentrate and make decisions. Constant thinking about the suicide to obtain an answer was extended to flashbacks, dreams and picturing the event.

All participants described changes in their physical health (physical disturbances) which led to visiting health professionals (n=19) with the suicide only being discussed (n=7) at the consultations. Common symptoms included poor or disrupted sleep (often with thoughts about the suicide), insomnia, nightmares, lack of energy and marked exacerbation of pre-existing conditions.

Participants expressed a change in social interactions with family and others (altered socialization). Experiences varied as participants were conscious of what others thought about them, the victim, and the suicide, and how to behave in front of others with controlling display of emotions. Communication amongst family

members was intense very early on as they attempted to make sense of the suicide but held back on sharing emotions to avoid burdening family members. Feeling unsafe to express their feelings was mentioned. Family members shared concerns about adjustment following the suicide particularly for child survivors. Overall there was a sense of strong support (n=24) regardless of whether the suicide was unexpected or not. Some participants (n=9) felt rejected and avoided by others.

Coping was evident in emotional, cognitive, physical and social experiences (survival strategies). The motivation of participants response was underpinned by trying to make sense of the suicide and efforts to conserve energy and reduce pain. Coping was displayed through active involvement in religious activity, keeping busy, having routines, distracting thoughts and trying to be positive and talking to others especially other survivors. Some participants at least once attended survivor related groups (n=13) or engaged in one to one or marital counselling (n=11). Unanimously participants felt that health care should be offered after a suicide and have a caring approach, be knowledgeable about the impact of suicide on survivors and be able to discuss it. Not many participants were contacted by health care professionals (n=6) to offer support after the suicide.

Overall participants reported slow improvement over time in how they felt and functioned (life experiences over time). Overwhelming feelings particularly unexpectedly and at times of remembrance of the victim such as anniversaries was described. Participants explained how the feelings reduced over time but never completely went away leaving a feeling of never recovering from the suicide. There was some indication that after 6 months post suicide participants were making sense of the suicide and trying to move on.

Gilewski, Farberow, Gallagher and Thompson (1991) studied the effects of depression on bereavement in the elderly (n= 393) following spousal suicide or natural death compared to non-bereaved controls at 2, 6, 12, and 30 months. Those with high initial levels of depressive symptoms manifested more symptoms of psychopathology over time compared to those not initially depressed. Compared to the natural death group, suicide survivors reported more moderate-severe levels of depressive symptoms initially and at 30 months post-suicide (Gilewski, et al., 1991). Depressed, elderly suicide survivors were at higher risk.

Suicide survivors generally reported more phobic anxiety symptoms and manifested considerably more hostility and paranoid ideation at 30 months relative to other groups (Gilewski, et al., 1991).

In another publication from this longitudinal research program, Farberow, Gallagher-Thompson, Gilewski (1992a) compared grief changes and mental health in older spouses (n=230). Researchers analysed data from the TIG Present, BDI, a subscale of the BSI and MHSR. Mean scores on standardised measures of grief, depression and stress decreased at each time point indicating improvement over time. Women, however, reported higher anxiety, tension and apprehension than men, particularly in the first six months. Suicide survivors experienced the highest levels of grief for the first 12 months but differences were not evident at 30 months.

Farberow, Gallagher-Thompson, Gilewski and Thompson (1992b) examined the changing role of social support in the bereavement of surviving spouses following suicide or natural death (n=472). All participants completed measures at 2, 6, 12 and 30 months as part of a longitudinal study reported previously. Compared to men, women received more practical support, had more people in their current network and felt more positive about this support. Men in both the natural death and suicide survivors' groups reported receiving more emotional support than women. Suicide survivors received significantly less emotional support than natural death survivors, but both groups reported reduced social support at 6 months. By the end of the second year there were no differences between male and female suicide survivors in emotional support received.

Cleiren, Grad, Zavasnik and Diekstra (1996) examined patterns of reactions to loss of spouses (n=85) bereaved by suicide or fatal traffic accidents in Slovenia and The Netherlands. Data were collected in the homes of the bereaved at 2 months post bereavement in Slovenia and 3 to 4 months in The Netherlands. Slovenian participants reported more depressive symptoms (according to the BDI) compared to Dutch participants but symptom patterns were almost identical. Slovenian participants reported significantly more sadness, pessimism, loss of appetite, indecisiveness, and disinterest in others. In regards to day to day functioning Dutch participants reported more avoidance by others and increased alcohol consumption compared to the Slovenian group. Dutch suicide survivors

felt abandoned by society and perceived they were blamed for the death (Cleiren, et al., 1996). Bereaved spouses from both countries reported more similarities than differences in their psychosocial well-being.

De Groot, De Keijser and Neeleman (2006) compared spouses and first-degree relatives of suicide (n=159) and natural death (n=70). Measures included the Eysenck Personality Questionnaire (EPQ-RSS), Pearlin Mastery Scale (PMS), Rosenberg Self-Esteem Scale (RSES), RAND 36-Item Health Survey (RAND-36), Center for Epidemiologic Studies Depression Scale (CES-D), Suicidality was assessed on a 5-point Likert Scale with higher scores indicating stronger suicidality and the Inventory of Traumatic Grief (ITG). Participants were asked two open ended questions regarding methods or cause of death and if they felt unmet need for professional help to help them cope following the death.

Suicide survivors reported higher levels of neuroticism, depression, complicated grief and loneliness with lower levels of functioning (general health concerns) and a need for professional help. Significantly more suicide survivors attempt suicide (6.5%) compared to the general adult population of The Netherlands (2.9%). Both groups did not differ in regard to self-esteem and mastery. Spouses and parents across both groups scored high levels of depression and complicated grief. Across groups female gender depression scores were higher but not complicated grief.

A. Smith, Joseph and Das Nair (2011) explored the lived experience of personal growth in 6 adults bereaved by suicide using a semi structured interview schedule. Participants reported posttraumatic growth representing 'change for the better' following the suicide.

Participants reported a change in their life view. This included a greater awareness and appreciation of life and their role within it and a sense of what it means to be alive. Valuing life and considering their own mortality led to making the most of life as it is unpredictable. However, enjoyment was also a form of coping as it provided distraction from underlying pain.

Participants described a greater awareness of the past 'self' in their relationships with the suicide victims and in other areas of their lives and who they are now. Self-management (to reduce or avoid emotions) was evident through controlling

psychological capabilities which encompassed awareness, perceived capability and balance. Participants consciously avoided certain events or places at anniversaries or used distraction with activities (including during the research interview).

Participants also described a changed relationship towards others with a sense of noticing emotions, being cautious about making assumptions and upsetting others and being more supportive towards them.

Social context (themes: gaze of others, public guise and solace of other survivors) highlighted where growth took place. Participants explained that 'others' ascribed a 'role' for them which differed from their true self (gaze of others). This contributed greatly to careful consideration of disclosing emotions with a fear of people forming a different view of them and was underpinned by feelings of vulnerability and being judged. Consequently, the gaze of others contributed to behaviour modification of pretence to selective control of emotions (public guise) as means to protect the 'self' and others. Participants found they could display their true self with other survivors (solace of other survivors) as they felt safe and understood through shared experience. However, the notion of personal growth and positivity as a consequence to suicide was still refrained upon in discussing with other survivors and people but shared with researcher during the interviews.

Aronson, Kyler, Morgan and Perkins (2017) compared family functioning before and after a suicide of three groups that included marine spousal suicide survivors (n=17), other marine survivors of accidental deaths (n=19) and death by combat (n=34). Measures included the Self-Report Family Inventory (SRFI), Schwartz Outcome Scale (SOS), Army Wives Survey (AWS), Multidimensional Scale of Perceived Social Support (MSPSS), the stigmatization and shame subscales from the Grief Experience Questionnaire (GEQ), International Adaptation in Army Families (IAAF), Strengths and Difficulties Questionnaire (SDQ), Inventory of Complicated Grief-Revised (ICGR) and Post-Traumatic Growth Inventory (PTGI). Open-ended questions asked about support. Suicide survivors reported lower levels of family cohesiveness, more family conflict, poorer psychological health (pre-mortem risk and resilience) compared to combat survivors.

Suicide survivors reported lower family cohesiveness, more family conflict, poorer psychological health compared to those who died in combat. Participants

reported higher levels of stigma and shame and support from friends. Qualitatively, suicide survivors commented that support was mixed with others being uncomfortable talking about death. Participants' social support from significant others and family members did not differ across groups and family support was simple but meaningful. Current spouse and family functioning did not differ with groups concerned about the impact of the death on their children. Suicide survivors did differ from other groups with increased appreciation of life and seeing new possibilities (posttraumatic growth).

3.3.1.2 Nature of the spousal relationship

Four studies investigated effects of the spousal relationship on coping. Constantino, Sutton and Rohay (1997) examined the relationship between domestic violence and rejection levels of surviving female widows (n=49) toward the suicide victim (spouse) as part of a postvention study discussed later (Constantino and Bricker, 1996). Participants provided details of verbal, physical or sexual abuse experienced before the suicide and completed the Victim Rejection Scale. Relatively high proportions of female suicide survivors experienced verbal (65.3%), physical (42.9%) and sexual (32.7%) abuse. The study demonstrated that survivors who experienced verbal abuse reported less happiness and decreased satisfaction in the pre-suicide relationship with their spouse.

Mitchell, Sakraida, Kim, Bullian and Chiappetta (2009) compared depression, anxiety and quality of life of 27 closely-related (children, spouses and parents) and 33 distantly-related suicide survivors. All participants completed the BDI, BSI and Medical Outcomes Study-Short Form 36 (MOS-SF36). Close relations were more likely to report depression and anxiety compared to distant relations but not physical health. After controlling for age and gender effects, spouses had the highest levels of depression, and similar high levels of anxiety with children (Mitchell, et al., 2009).

Schneider, Grebner, Schnabel and Georgi (2011) explored how emotional reactions of those bereaved by suicide (n=167) varied according to gender, relationship to the deceased, consequences of the death, and professional support received. The structured interview (developed originally by Henriksson, Aro, Marttunen, Heikkinen, Isometsä, Kuoppasalmi, et al., 1993) consisted of

seven sections including Structured Clinical Interview for DSM-IV Axis I: Major diagnoses and Semi-structured interview for DSM-IV Axis II: Personality Disorder diagnoses. Schneider, et al. (2011) found that 89% of all suicide survivors experienced strong, frequent emotions such as depressed mood and guilt that disturbed their everyday life and minimised any positive consequences of the suicide. Being female, a parent, or spouse was associated with less energy, with spouses at highest risk. As a kinship group, 'spouses' and 'parents' were more affected by a loss than adult children. Most participants (61%) reported that family and friends provided sufficient support. Those who received insufficient professional support reported more sorrow, lack of energy and abandonment (Schneider, et al., 2011).

3.3.1.3 Postvention

Seven studies investigated postvention related experiences with four studies reported on outcomes for spouses attending a group intervention. In another publication based on Van Dongen's previously reported qualitative study, Van Dongen (1991) reported on the pivotal role of the GP in providing initial and follow up care to survivors of suicide. In this publication, many participants reported that they expected the GP to initiate the discussion but did not because they appeared to be uncertain about how to. Participants explained that the GP appeared to be hurried and uninterested in their emotional problems. Three case studies of survivors related to the victim (mother, sibling and spouse) were provided. The mother, interviewed at 6 months post suicide, had no prior warning of her son's suicide. She received a physical examination due to her stress response to the suicide and found the GP was non-judgemental, a good listener, sensitive, and recommended grief counselling for both the participant and her husband.

The sibling interviewed at 5 months post suicide described clues of his brother's suicide that were retrospectively identified. The suicide victim had a history of alcohol abuse, and depression associated with a relationship breakdown. The sibling became depressed which interfered with his home and work life. His anger towards his brother coloured social occasions and he became verbally abusive towards his wife. The participant saw his GP with physical complaints but was disappointed as the doctor did not offer any opportunity to discuss the suicide despite knowing about the death.

The spouse who was interviewed at 4 months post suicide explained that her husband was chronically suicidal with a history of alcoholism and severe depression. The spouse never visited her GP or sought any counselling and was able to quickly resume her home and work responsibilities. Her coping was attributed to a sense of relief that was experienced following the suicide, feeling her husband was finally at peace, and that she did all she could. She would have seen the GP if needed.

Constantino and Bricker (1996) examined coping of participants using a randomised, two group comparison design; Constantino, Sekula and Rubinstein (2001) published findings from the 3-year follow-up study; and Constantino, Sekula, Lebish and Buehner (2002) examined depression in female survivors of abuse and female survivors of suicide in the cohort.

The intervention consisted of two nurse-led programs known as Bereavement Group Postvention (BGP) and Social Group Postvention (SGP). Both 8-week programs aimed to mediate grief reactions through group interactions and activities. The BGP was underpinned by the Yalom (1985) model of 12 curative factors of group psychotherapy. The SGP was based on socialization, recreation and leisure principles (Iso-Ahola 1980; Neulinger 1981). Outcome measures were depression (BDI), psychological distress (BSI), grief resolution (Grief Experience Inventory) and social adjustment (SAS).

Participants in both groups reported less depression, despair, rumination, and depersonalization after group attendance (Constantino and Bricker, 1996). There were no significant differences between groups for social isolation, loss of control, somatization, or death anxiety. SGP participants showed better social adjustment but were less adjusted in their parental roles. BGP participants reported significantly less anger/hostility and guilt compared to the SGP group.

In a 3-year follow-up of the 60 participants, 47 were contacted (Constantino, et al., 2001). Data from both groups were combined. All participants reported improved psychological adjustment and reduced phobic anxiety and paranoid ideation.

A secondary analysis of original cohort data compared BDI scores and behavioural manifestations of depression between female abuse survivors (n =

39) and female suicide survivors (n=39) (Constantino, et al., 2002). Both groups were found to be moderately to severely depressed. Suicide survivors experienced higher levels of sadness whereas abuse survivors experienced higher levels of irritability and social withdrawal.

Provini and Everett (2000) recruited next-of-kin adults mourning suicide and explored their perceptions of functioning, need for help, reasons for help-seeking behaviour, not desiring help and barriers to receiving desired help. Participants (n=144) provided information spontaneously during telephone conversations with staff as part of a larger project aimed at helping children following suicide bereavement.

Half the participants (53% n=76) volunteered information about their concerns. Participants reported an average of two concerns (M = 2.19, SD = .52). Concerns related to family relationships (difficulty in maintaining family routines), stress-related, psychiatric symptoms (depression and anxiety) bereavement-related (economic difficulties). Participants (57% n=81) reported one or more specific needs such as formal services (n=30), bereavement help (n=16), and coping assistance (n=14).

Thirty-four participants received assistance including: formal (professional therapy) (n=16), informal (emotional support and help from family and friends) (n=14), or both types of assistance (n=4). Eighteen participants desired assistance with few wanting informal or both types. A small number of participants (n=10) receiving support desired more help, whereas some had not received help (n=48) or felt they could cope without it. Barriers to receiving desired help included family disagreement over help (n = 15), language difficulties (n = 12), and practical issues (n = 9) (lack of time, transport or money). Participants in families with children aged 19 years of age or less reported more concerns than families without. Families with children reported an average of two or more non-specific concerns compared to those without children (p=.005).

McKinnon and Chonody (2014) explored formal supports used by those bereaved by suicide of different kinship. All participants (n=15) were interviewed by a semi structured framework with one participant responding by email. Participants reported two major themes: a mixture of immediate and ongoing formal supports. Nine participants reported that immediate support provided by first responders

were negative with the exception of the police who were kind and caring. Participants expressed frustration with the coroner's office related to lack of communication about processes (n=6) and time delays for the autopsy (n=7).

Ongoing support was both unhelpful and helpful to survivors. Physical and mental health were barriers to searching and engaging with ongoing support (n=9). Rural participants experienced additional barriers such as travel and distance.

Some participants (n=8) felt that ongoing peer support groups would not help them in their grief (listening to other survivors' stories and difficulty expressing their own) with some feeling groups were unproductive and some disengaged. Some positive experiences of groups included normalisation, mutual understanding, validation and hope through their shared experience with other survivors.

Ongoing support from other professionals was challenging due to lack of a humanistic approach, and lack of continuity of care which deterred survivors from seeking other support. GPs were perceived as attentive and caring in their approach and referred survivors to other supports.

3.4 Discussion

This section discusses the findings of the review in relation to pertinent literature, highlights implications for healthcare research and practice, provides a critique of methodologies, and presents limitations and conclusions of the review.

3.4.1 Relations and relationships to the deceased

Most of the studies were not focused on spouses specifically bereaved by suicide. Bereavement group interventions made comparisons amongst widows (Demi, 1984; Pennebaker and O'Heeron, 1984; Farberow, et al., 1987; McNiel, et al., 1988; Barrett and Scott, 1990; Gilewski, et al., 1991; Farberow, et al., 1992a; Farberow, et al., 1992b; Cleiren, et al., 1996; De Groot, et al., 2006; Aronson, et al., 2017). Female only comparisons occurred with abuse survivors (Constantino, et al., 2002). A handful of studies reported findings amongst different relations bereaved by suicide: spousal (Constantino and Bricker, 1996; Constantino, et al., 1997; Constantino, et al., 2001), family members (Van Dongen, 1990; 1991), next-of-kin (Provini and Everett, 2000); close and distant relations (Mitchell, et al.,

2009); different gender and relationship to the deceased including friends (Schneider, et al., 2011; A. Smith, et al., 2011); and kinship (Mc Kinnon and Chonody, 2014). Most studies did not report the relationship of kinship in the findings (Van Dongen, 1990; 1991; Provini and Everett, 2000; De Groot, et al., 2006; A. Smith, et al., 2011) or the quality and emotional attachment of participants to the deceased (Van Dongen, 1990; 1991; Provini and Everett, 2000; De Groot, et al., 2006; Schneider, et al., 2011; A. Smith, et al., 2011; Mc Kinnon and Chonody, 2014; Aronson, et al., 2017).

Assumptions were often made about what constituted kinship (descent or affinity) or close and distant relations (Mitchell, et al., 2009). Survivors who experienced more pain whilst trying to understand the suicide considered themselves to be close to the victim (Van Dongen, 1990). The concept of pain and closeness can be explained by understanding the relationship of those bereaved by suicide to the deceased and the quality and emotional attachment within it (Cerel, et al., 2008; Weigel, 2008). Emotional attachment is significant as it provides an understanding of the impact of the death and the coping styles that might be used by different survivors. Theories based on the notion of attachment can provide some insight into how different survivors cope following suicide (Bowlby, 1969; Shaver, et al., 1996; Zeifman and Hazan 2000). However, relationship components and dynamics are unique due to different expectations and outcomes of individuals concerned (Weigel, 2008).

Van Dongen (1991) reported explicitly on kinship and the unique experiences of three different categories of survivor (brother, spouse and mother). Nearly all survivors described being emotionally close to the deceased (Van Dongen, 1990). There was marked differences in coping such as displays of anger (brother) feelings of relief (spouse) and anger towards the deceased (mother). These findings should be considered with caution. The nature of the relationship the survivors and the deceased in these three case studies was not clear. Furthermore, there was no explanation as to why the behaviours differed amongst survivors.

It is likely that spouses, partners or parents are more affected by suicide because of their close relationship with the deceased (Weigel, 2008; PHE, 2016a) which is underpinned by emotional attachments that are abruptly ended because of

sudden death (Bowlby, 1969; 1973). Survivors are likely to have continued bonds with the deceased as part of their grieving process which can be both helpful and unhelpful in coping. Helpful continued bonds such as holding onto good memories or sharing funny stories about the deceased is an indicator of a transformed attachment to the deceased that suggests the survivor is adapting to their loss (Klass, et al., 1996). Klass and colleagues, add further that unhelpful continued bonds behaviours such as ruminating or focusing most of the time on the death are often considered as maladaptive and survivors are likely to be 'stuck' in their grief which can be a sign of avoiding the loss. What is important is the nature of the bonds and how the survivor transferred them into their new life (Root and Exline, 2014; Bell, Bailey and Kennedy, 2015a).

Closeness and distance should be considered within the attachment based on the quality and emotional connectedness of the relationship rather than kinship to better understand how a survivor copes. It could be possible that a close friend (A. Smith, et al., 2011) or in-law (Provini and Everett, 2000; De Groot, et al., 2006) might need more support to cope better after losing someone by suicide because their relationship was based on a deeper emotional attachment (PHE, 2016a).

3.4.2 Appraisal of events

Suicide bereavement was often compared to a sudden death by natural or accidental causes including motor vehicle accidents (Demi, 1984; Farberow, et al., 1987; Barrett and Scott, 1990; Gilewski, et al., 1991; Farberow, et al., 1992a; Cleiren, et al., 1996; De Groot, et al., 2006; Aronson, et al., 2017).

Suicide bereavement can be more devastating than other types of bereavement because it is often sudden and unexpected or violent in nature (Wertheimer, 2014). Appraisal of the suicide contributed negatively on grieving and coping of the surviving spouse with less depression amongst those who expected the suicide or received an acceptable explanation for the death (Van Dongen, 1990; De Groot, et al., 2006; Smit, 2015). Survivors are known to ruminate which can be traumatic (if for example, the person found the deceased) (Begley and Quayle, 2007; Gall, et al., 2014) and emotionally exhausting (Van Dongen, 1990; Calhoun and Tedeschi 2014). Attempts by survivors to make sense of the suicide from their own perspective, despite factual evidence, such as a coroner's ruling, can

reinforce suicide-related blame (Peters, Murphy and Jackson, 2013; Wertheimer, 2014).

Suicide survivors of the included studies were more likely to report guilt (Van Dongen, 1990) and resentment around their partner's death compared to other spouses. Survivors' guilt may indicate a sense of responsibility for the suicide (Li, Stroebe, Chan and Chow, 2014). Alternatively, the death may be perceived as a form of rejection (Wertheimer, 2014) and survivors may berate themselves for not being the 'ideal' partner (Young, et al., 2012). The notions of guilt and self-blame have important implications for assessment and interventions by healthcare professionals. A comprehensive understanding of survivors' appraisal of the suicide needs to be established including the extent of rumination and experience of possible post-traumatic symptoms such as flashbacks (Van Dongen, 1990). Rumination is often present in grief as survivors attempt to make sense of what has happened and why (Neimeyer, 2001). Rumination can be harmful to survivors particularly if they have associated guilt about the suicide. Cognitive therapy could be used to challenge unrealistic beliefs and reframe appraisal of the suicide event. Furthermore, engaging the survivor in postvention activities such as group therapy could normalise thoughts and feelings and foster a shared sense of experience with other survivors (Wertheimer, 2014).

3.4.3 Factors contributing to survivor coping

The review identified that social isolation was a key factor in survivor coping. Not only did survivors feel abandoned by society, they also withdrew from society. Commonly, suicide survivors reported avoiding others because of feelings of stigma, shame and responsibility (Demi, 1984; Barrett and Scott, 1990; Van Dongen, 1990; Cleiren, et al., 1996; Wertheimer, 2014; Aronson, et al., 2017). Suicide is still stigmatised and public awareness education is required (HM Government, 2012; Foggin, et al., 2016; PHE, 2016a; 2016b; Pitman, Osbourne, Rantell and King, 2016; HM Government, 2017).

Stigma can contribute to social isolation following suicide (Wertheimer, 2014; Frey, Hans and Cerel, 2016). Survivors reported changed relationships with others as they distance themselves because of the associated shame (Pennebaker and O'Heeron, 1984) or to avoid burdening others (Van Dongen,

1990). Disenfranchised Grief could explain social isolation if survivors perceive they have been excluded by society. Society determines grieving 'rules' based on attitudes and beliefs (Doka, 1989). Suicide is disenfranchised because of the circumstances surrounding the death (Doka, 2002) and those left to grieve are excluded as their grieving rights are not recognised or acknowledged (Doka, 2008). Fear was also another factor affecting coping as survivors worried about others changing their view of them (Aronson, et al., 2017). Survivors also felt that others avoided them which led to rejection (Van Dongen, 1990).

Regardless, survivors changed their behaviour to protect themselves and others (Aronson, et al., 2017). Indeed, some healthcare professionals may be challenged during their initial assessment with survivors because of their own attitudes towards suicide (Ali, 2015). Healthcare professionals have a key role in raising public awareness through health promotion activities and supporting survivors in their communities as part of their recovery process (National Institute for Mental Health in England (NIMHE), 2005; HM Government, 2012; Nic an Fhaili, et al., 2016; Peters, Cunningham, Murphy and Jackson, 2016; Foggin, et al., 2016; PHE, 2016a; 2016b; HM Government, 2017).

The cultural beliefs of a particular community can contribute to survivor coping and vary from mutual social isolation to acceptance of loss (Cleiren, et al., 1996). Cultural beliefs could help to explain participants' difficulty in accepting the suicide, feeling abandoned by society, feeling blamed for the death, or blaming themselves for not doing more to anticipate or prevent the death (Wertheimer, 2014). While culture can hinder or be protective of coping following suicide, few studies attempted to understand the significance of cultural differences on survivor coping. Several studies in this review included only Caucasian (Demi, 1984; Pennebaker and O'Heeron, 1984; Van Dongen, 1990; 1991; Gilewski, et al., 1991; Mitchell, et al., 2009) or predominantly Caucasian (Farberow, et al., 1987; McNiel, et al., 1988; Aronson, et al., 2017). Participants which does not reflect the reality of healthcare practice in many countries. Aronson and colleagues' study focused on a marine community which provided some insight though limited into the collective culture within armed forces such as ascribing different values to death. Combat deaths are considered heroic and selfless (Aronson, et al., 2017) which contrasts with suicide deaths because of stigmatised views (Praeger and Bernhardt, 1985; Begley and Quayle, 2007;

Foggin, et al., 2016). Healthcare professionals work with diverse cultural and ethnic groups. Therefore, assessment of needs should consider cultural differences and care offered in culturally sensitive ways. Further research with culturally and linguistically diverse groups is required in order to fully understand cultural differences and their influence on coping following suicide.

Psychosocial risk factors for suicide were present well before the actual death in some studies (Cleiren, et al., 1996). Complicated grief reactions experienced by suicide survivors were influenced by problems in the relationship, disturbed family background, and poor psychosocial functioning. Poor psychological wellbeing prior to the suicide was found to predict complicated grief (Prigerson, et al., 2009). Elderly survivors who were moderately to severely depressed at the time of their spouse's death experienced difficulty adjusting (Farberow, et al., 1987; Gilewski, et al., 1991; Farberow, et al., 1992b). Furthermore, high levels of depressive symptoms immediately following the suicide clearly impacted on the longer-term psychological health of individuals. Elderly suicide spouses were likely to have additional physical and social difficulties (Farberow, et al., 1987; Gilewski, et al., 1991; Farberow, et al., 1992b) and the interplay of these challenges can increase the risk of complicated grief and social isolation (De Leo, 2002). A full physical assessment as part of a holistic approach to care needs to be considered by healthcare professionals, particularly for clients at high risk, such the elderly, those with previous mental health difficulties, and those from culturally and linguistically diverse communities (DH, 2012a; PHE, 2016a). An understanding of physical and psychological changes following the suicide will enable healthcare professionals to prioritise access to services, facilitate support networks, and case manage the potentially complex needs of survivors.

Complicated grief responses were still evident after a significant bereavement period (up to 3 years), but experiences of managing these symptoms were rarely discussed in the included papers. In particular, some survivors were likely to experience high levels of hostility for around 2 years compared to non-depressed adults (Gilewski, et al., 1991). Spousal suicide survivors were also more likely to experience higher levels of anxiety. Farberow, et al. (1987) suggested that anxiety is a dominant grief reaction amongst the elderly and evident in the early stages of grieving regardless of mode death. However, the accuracy of this conclusion is questionable as their participants were recently bereaved and likely

to have been experiencing acute grief reactions when recruited (De Groot, et al., 2006). A more accurate indicator of distress may be to assess anxiety over time and compare levels at different stages of bereavement. Similarly, healthcare professionals, as part of their continuity of care to survivors, should assess anxiety levels at different time points, and help survivors identify triggers, as well as strategies for enhanced coping.

Posttraumatic Growth (PTG) was evident in two studies (A. Smith, et al., 2011) with limited evidence (Aronson, et al., 2017). Posttraumatic Growth is identifiable with positive changes that could occur as result of a loss (Tedeschi and Calhoun, 1995). Three major domains of growth include: perceived changes in self, relationships with others, and philosophy of life (Tedeschi and Calhoun, 1996). Both studies reported some examples of PTG: greater awareness, appreciation of life and changed relationship towards others (A. Smith, et al., 2011) with a purpose (Begley and Quayle, 2007) and new possibilities in life (Aronson, et al., 2017) with self-reflection and moving forward (Gall, et al., 2014). The notion of PTG needs to be understood more to help understand the complexities of coping whether it is helpful or unhelpful for survivors. PTG is not always evident and survivors refrain from talking about any growth and positivity such as enjoyment resultant from a suicide because of feeling guilty (A. Smith, et al., 2011).

3.4.4 Characteristics of the spousal relationship

Five studies focused on characteristics of the spousal relationship (Demi, 1984; Constantino, et al., 1997; Constantino, et al., 2002; Mitchell, et al., 2009; Schneider, et al., 2011). Problematic relationships with evidence of spousal separation prior to the suicide was recognised (Demi, 1984) with some survivors reporting lower family cohesiveness and more family conflict (Aronson, et al., 2017). While being separated from the suicide victim before the event may give some emotional distance for the survivor and facilitate grieving and closure, it could also compound feelings of self-blame and responsibility for what happened. Understanding the spousal relationship is required as part of comprehensive health care. Pre-suicide abuse was reported by female suicide survivors particularly verbal abuse compared to other populations (Constantino, et al., 1997). Abuse within the intimate relationship adversely affected quality of life, contributed to depression, and was associated with complicated grieving

following the death of the spouse to suicide. Although serious violence is more likely to be perpetrated by men against women, low-level abuse occurs in a high proportion of relationships (Petch, Halford, Creedy and Gamble, 2012) and same sex relationships. Both genders are potential victims of abuse and routine enquiry needs to occur. Exploring the quality of the spousal relationship is an important healthcare activity, as survivors may deny, minimise, or blame themselves for the abuse. Through the development of a trusting relationship, healthcare professionals can encourage frank disclosure, offer education and insight around abuse behaviour, enable survivors to develop new ways of relating to others in an intimate relationship, and promote healing and coping.

The critique of studies provided some insight into characteristics of the spousal relationship (Mitchell, et al., 2009; Schneider, et al., 2011), although this aspect was somewhat limited or neglected. Understanding the spousal relationship from the perspective of the survivor could be potentially illuminating. The quality of the relationship, evidence of abuse, and attachment to the suicide victim, needs to be established by healthcare professionals in order to assist coping.

3.4.5 Postvention

Seven studies reported postvention related experiences (Van Dongen, 1991, Constantino and Bricker, 1996; Constantino, et al., 1997; Provini and Everett, 2000; Constantino, et al., 2001; Constantino, et al., 2002; McKinnon and Chonody, 2014).

Postvention is an important strategy to support those affected by suicide as survivors are at risk of suicidal ideation and suicide themselves (HM Government, 2012; PHE, 2016a; 2016b; HM Government, 2017). Government national and local strategies are prioritising promoting mental health wellbeing, reducing suicide which includes copycat and suicide clusters (DH, 2012b; HM Government, 2012; 2017). Postvention needs to be wide-ranging and offered across communities which includes promoting mental health and supporting employers, educational institutions and community services (PHE, 2016a). Postvention and its effectiveness relies on partnerships and supporting them in communities such as employers supporting survivors. Survivors following suicide bereavement are likely to drop out of work or education at a high rate of 80%

(PHE, 2016b) which can create high economic costs. The implication is that support has to be offered on different levels and from agencies which is beyond the sphere of healthcare services.

Postvention can be immediate and ongoing support for survivors of suicide. McKinnon and Chonody (2014) reported immediate support provided by first responders who are typically the police, ambulance staff, GPs and the coroner with mixed experiences. Van Dongen (1991) found that participants expected the GP to know how to support them, be sensitive, understanding, and not to feel disappointed and unsupported. For some, their local doctors had been helpful because of their humanistic skills and referring survivors onto other services (McKinnon and Chonody, 2014). An explanation for this is the competence and attitudes of professionals or lack of vigilance (HM Government, 2012). The GP is a key healthcare provider in providing both immediate and ongoing support, but they must be skilled and have a professional attitude to ensure effective support and engagement of services (Nic an Fhaili, et al., 2016). This encounter is likely to determine the level of survivor engagement and impact on their ability to cope. McKinnon and Chonody (2014) reported that ongoing support was provided in postvention groups with mixed results as some felt they were unproductive but also found understanding through shared experience. Shared experiences with other survivors provided identification and normalcy (Van Dongen, 1990; 1991; Aronson, et al., 2017). This suggests that different survivors have different needs (Begley and Quayle, 2007) and therefore require assessment of specific needs and offered suitable postvention strategies (Nic an Fhaili, et al., 2016; PHE, 2016a; 2016b).

Four of the studies reported on postvention groups for suicide survivors (Constantino and Bricker, 1996; Constantino, et al., 1997; Constantino, et al., 2001; Constantino, et al., 2002). Suicide survivors reported less depression, distress and grief symptoms for up to twelve months' post-intervention (Constantino and Bricker, 1996; Constantino, et al., 2001). However, the two postvention groups were underpinned by different theoretical frameworks, and facilitation style and group dynamics amongst participants may have varied. Each intervention was conducted in smaller sub-groups, but the results were reported collectively, thereby obscuring potential differences amongst groups. The authors were not explicit about how the groups were facilitated and how the postvention

addressed the grief related symptoms of participants and what coping strategies were implemented (Constantino, et al., 2001). The recovery of survivors may have occurred naturally as part of the grieving process over time and the use of a non-active control group would have strengthened the rigour of the studies.

Barriers to postvention can determine how a survivor copes. On an individual level, survivors' physical and mental health can influence their ability to search and engage with support (McKinnon and Chonody, 2014). Furthermore, complicated grief can also adversely impact survivors (Van Dongen, 1991; Provini and Everett, 2000; De Groot, et al., 2006; Pompili, et al., 2008). Pre-existing factors such as mental and physical health problems, misuse of substances, vulnerable social and economic problems may further complicate grieving (HM Government, 2012). Social issues related to stigma (Pompili, et al., 2008; Foggin, et al., 2016) and health care issues such as GPs' confidence and competence in supporting survivors (Foggin, et al., 2016; Nic an Fhaili, et al., 2016) also play a role in coping. There is a lack of specialist support available as bereavement postvention strategies are still relatively new (PHE, 2016b). Distance and accessibility of services can be a problem from a time and cost perspective (Provini and Everett, 2000) which can prevent survivors getting help particularly those living in rural communities (McKinnon and Chonody, 2014; Nic an Fhaili, et al., 2016). These findings reinforce the need for supportive resources to be local, timely, effective and address additional factors unique to survivors (HM Government, 2011; 2012).

There are tensions and disagreements in families about how best to cope (PHE, 2016). Survivors, on average, had two concerns which were likely to be related to: family, grief symptoms and money (Provini and Everett, 2000). These created barriers such as agreeing on types of help need within the family and practical issues such as time and money (Provini and Everett, 2000). These difficulties apply particularly to spouses who not only have to cope themselves but also help their dependents to cope, meet their emotional and physical needs, maintain family routines and manage the financial burden (Wertheimer, 2014). Spousal coping is complicated, complex and needs to be understood so postvention strategies can be tailored around their unique needs.

Support was a key factor in coping following spousal suicide. Generally, survivors

felt less satisfied with emotional support received (McNiel, et al., 1988; Farberow, et al., 1992b). Survivors undertake considerable cognitive and emotional work to adjust to their new circumstances (Wertheimer, 2014). Symptoms of depression were common. It could be that depressed feelings contributed to survivors perceiving less support (Ali, 2015). Furthermore, blame is often commonly experienced by survivors and may contribute to avoidance of family members (McNiel, et al., 1988; Wertheimer, 2014). Perceptions of being blamed by family members could account for confiding with friends as a common form of support (Pennebaker and O’Heeron, 1984; Cleiren, et al., 1996) or communication difficulties and differences of opinions (Wertheimer, 2014). Confiding in others was evident for all survivor groups but was perceived as difficult and most challenging in the first six months post-suicide (Farberow, et al., 1992b).

Support is often considered to be provided by others whether it is informal or formal to help survivors cope. Survivors also support themselves by what they do in daily life activities. Only two studies gave some examples of what coping looked like that was not in response to grief symptoms such as crying when feeling sad. Some survivors engaged in religious activity, keeping busy with routines (Van Dongen, 1990) and going to the pub to read a book to distract themselves (A. Smith, et al., 2011). The two studies provided limited understanding on how these activities actually helped survivors cope. Understanding the details of the religious activity could have explained its role in coping. A survivor could have experienced either spiritual comfort (Praeger and Bernhardt, 1985) or a ‘listening ear’ by the priest and parishioners. This information can be helpful for healthcare professionals when considering the development, provision and referral to postvention resources.

Children were identified as common sources of support, followed by friends, and other family members (Farberow, et al., 1992b; Schneider, et al., 2011). However, some children may be coping with their own grief and unable to provide the quality of support needed by the surviving parent. Talking with friends facilitated better coping, had a positive impact on health, and reduced rumination about the death (Pennebaker and O’Heeron, 1984). Confiding with friends can feel safe and preferential and enable the person to avoid burdening family members (who may be also grieving) (Wertheimer, 2014). However, the nature, quality and dynamic of confiding with friends was rarely reported in detail (Pennebaker and O’Heeron,

1984). Lack of social support is a psychosocial risk for suicide survivors. Issues of social isolation, as well as reduced, and/or complicated family relationships need to be assessed by healthcare professionals, and emotional postvention strategies implemented.

Women reported receiving more support than men. Women usually have better coping skills and larger informal and formal support networks than men (De Leo, 2002). However, feelings towards people in the relevant support network were found to change over time particularly amongst male suicide survivors (Farberow, et al., 1992b). This implies that the nature and availability of support is crucial and needs to be monitored in an on-going way. Findings of the review also reinforce differences in gender coping and abilities of individuals to access and utilise support at different stages of bereavement.

The findings of the review support the need for postvention and the role of healthcare professionals to help survivors cope following suicide. It is clear that support is often provided at different stages of bereavement. Immediate support is often provided when the survivor is in shock and needing to provide information to formal investigators about the death (Wertheimer, 2014). There are also immediate, pragmatic decisions to be made that can be overwhelming when a person is in shock and disbelief about the death. On a longer, ongoing basis, postvention groups need to promote therapeutic elements of group processes that are beneficial such sharing experiences, addressing misconceptions, enhancing social support and promoting healthy coping behaviours. Confiding has a role in coping, but longer-term support mechanisms are also needed. Symptoms of depression, grief, and adapting to changing roles within the family, as well as cultural and gender factors can influence support seeking behaviour. Having a full assessment of survivors' needs is required and postvention should be accessible, timely, cost effective and provided by confident and competent healthcare professionals (PHE, 2016a; 2016b).

3.4.6 Methodological limitations

Most of the studies in the review used quantitative methods but the quality of some studies was weak. The majority of these studies had limited generalizability as sample sizes were small (Demi, 1984; Pennebaker and O'Heeron, 1984;

McNiel, et al., 1988; Barrett and Scott, 1990; Gilewski, et al., 1991; Constantino and Bricker, 1996; Constantino, et al., 1997; Constantino, et al., 2001; Constantino, et al., 2002; De Groot, et al., 2006; Schneider, et al., 2011; Aronson, et al., 2017. In the earlier literature review by Henley (1984), methodological weaknesses such as small sample sizes, and absent or poor control conditions were noted. Henley (1984) also reported that most studies were conducted amongst clinical populations, but the current review had more studies conducted with community-based samples. Methodological rigour was also compromised due to psychometric properties of measures not being reported (Pennebaker and O'Heeron, 1984; Schneider, et al., 2011); non-standardised measures being used (Barrett and Scott, 1990; Aronson, et al., 2017); reliance on self-report measures without gold standard validation of reported symptoms; data collection inconsistencies were identified (Provini and Everett, 2000; McKinnon and Chonody, 2014); research question/s were always not provided (Provini and Everett, 2000; Aronson, et al., 2017); self-report questionnaires could have been completed with family members, affecting results (De Groot, et al., 2006); and the lead researcher being personally bereaved by suicide which could influence data analysis (A. Smith, et al., 2011).

Most studies did not report the relationship of kinship to the findings (Van Dongen, 1990; 1991; Provini and Everett, 2000; De Groot, et al., 2006; A. Smith, et al., 2011) or the quality and emotional attachment to the deceased (Van Dongen, 1990; 1991; Provini and Everett, 2000; De Groot, et al., 2006; Schneider, et al., 2011; A. Smith, et al., 2011; Mc Kinnon and Chonody, 2014; Aronson, et al., 2017). One study reported the highest relationship group (28%) was unknown to the deceased (Provini and Everett, 2000). These studies provided some understanding on suicide bereavement but did not identify what was necessarily shared or unique amongst the kinship groups including spouses. More research is required to understand the unique coping following spousal suicide bereavement.

With the exception of two studies (Farberow, et al., 1992a; Farberow, et al., 1992b), there was limited cultural and ethnic diversity amongst participants. Most studies were conducted in the USA with homogeneous groups. In most studies, Caucasian participants were the majority; with some studies having exclusive Caucasian samples (Demi, 1984; Pennebaker and O'Heeron, 1984; Van

Dongen, 1990;1991; Gilewski, et al., 1991; Farberow, et al., 1992b; Mitchell, et al., 2009). A limited number of studies were conducted outside of the USA (Provini and Everett, 2000; De Groot, et al., 2006; Schneider, et al., 2011; A. Smith, et al., 2011; McKinnon and Chonody, 2014) with only one cross-cultural study (Cleiren, et al., 1996). The political, social and religious systems of a country may impact on community beliefs about suicide and support services offered to spouses. These studies therefore contribute to our understanding of grieving in different social and cultural contexts, but more research is warranted.

Longitudinal study designs revealed the impact of time on spousal coping and are recommended. However, the Hawthorne effect of knowing that the research team would make contact at a future date may have provided a sense of reassurance for participants and assisted their bereavement process. The age of survivors, their life experiences and responsibilities, as well as social context inevitably contribute to the coping strategies adopted by survivors (Demi, 1984; Cleiren, et al., 1996; Constantino, et al., 1997). The dates of studies included in the review spanned a thirty-year period with over half being conducted fifteen to twenty years ago. How cultures and communities viewed and managed the aftermath of suicide is likely be very different to current times, highlighting the need for more research in this field.

Although time since death and context surrounding the suicide are significant, there are other variables to consider. Most of the samples were highly representative of women (Farberow, et al., 1992a; Farberow, et al., 1992b; Constantino, et al., 2001; Mitchell, et al., 2009; McKinnon and Chonody, 2014) with some studies including all female samples (Demi, 1984; Farberow, et al., 1987; McNiel, et al., 1988; Barrett and Scott, 1990; Constantino, et al., 1997; Constantino, et al., 2002; Aronson, et al., 2017). This homogenous approach to recruitment does not provide an understanding of the impact of suicide amongst men as well as women, and perhaps also reflects the difficulty of recruiting diverse samples. Three studies recruited participants of both genders, but the details of gender representation were not reported (Constantino and Bricker, 1996; Provini and Everett, 2000; Constantino, et al., 2001). Although studies with women provided some useful insights, the results are limited and inconclusive. It is necessary to conduct further research to understand the influence of gender and culture on coping. Furthermore, the spousal relationship in most studies were

heterosexual which does not reflect different partnerships such civil or same sex relationships. Understanding the experiences of survivors in other types of relationships may inform specific postvention strategies.

There was a lack of available qualitative studies included in the review (Van Dongen, 1990; 1991; A. Smith, et al., 2011; McKinnon and Chonody, 2014). Some limitations identified in this review could be addressed by the use of interpretative qualitative methods or mixed method studies to complement statistical data and gain a deeper understanding of spousal grief following suicide.

There are limitations associated with this structured review. The review only accessed papers published in English and some work outside of non-English speaking countries may not have been accessed or published. There is some likelihood that not all appropriate studies were located if they were not published in indexed journals. It is also possible that some literature may not have been accessed because of the limitations of the search terms in the search strategy used in the review. The quality of the review also needs to be considered in light of methodological limitations of the included studies.

3.5 Conclusion

The research designs for the majority of included studies were descriptive or correlational designs. Samples were often small, there was an under representation of men, and limited diversity of ethnic and cultural groups. The notion of appraisal of events surrounding suicide was consistently reported by researchers and had a significant impact on bereavement and grieving. Kinship to the deceased and impact on coping was often compared but findings did not always explicitly report kinship categories. There is limited understanding of how coping by survivors of suicide are shared or differ amongst kinship groups.

Suicide bereavement like any other bereavement is profoundly devastating and complex. The impact of suicide is significant to the individual, their families, communities including the workplace. The scale is considered a national public health concern with high economic costs prompting governments to provide tailored, accessible, timely and cost effective postvention strategies.

The review findings suggest that spouses affected by suicide bereavement often

experience additional complex factors that could hinder their coping. Spousal survivors experience complicated grief reactions, which are influenced by perceptions of events surrounding the suicide, the spousal relationship, and support. There is insufficient data to draw conclusions about the impact of these factors on spousal coping. Spouses who have been bereaved by intimate partner suicide are likely to experience extra demands and responsibilities related to providing emotional, financial, and practical support to others while meeting their own work commitments.

The blame, guilt and stigma experienced by survivors complicate their coping. Having more contextual information about the spousal relationship, the nature of support for survivors, and how this supports effective coping has not been addressed in sufficient depth. It is evident that interventions and support are helpful to the recovery of those bereaved by suicide. Health and illness rates for spouses following suicide improved with talking, but counselling/talking were more beneficial when undertaken with non-family members or professionals.

There is limited evaluative data on postvention activities with survivors due to their recent emergence. Healthcare professionals are well placed to provide holistic, comprehensive assessments, refer survivors to services and offer various postvention activities. Healthcare professionals need to be confident and competent in offering health education and support to bereaved survivors, their families and friends. Their health promotion activities need to be extended to raise public awareness which includes training other frontline workers. Health professionals may also offer support and education to employers and members of the community to reduce stigma and discrimination towards those affected by suicide and mental illness, contribute to better mental health outcomes, and reduced morbidity.

3.6 Summary

The review of the literature found limited data on the nature of spousal coping following suicide. Events surrounding the suicide and the nature of the spousal relationship has received relatively little attention. Grief responses by spouses varied and some negative coping strategies were identified. There are limited qualitative studies on spousal coping following suicide. The next chapter will

discuss the chosen research methodology for the proposed study. The term 'spouse' has been used consistently in the literature under review and studies cited in the preceding chapters of this thesis. However, to reflect a modern representation of the notions of 'spouse bereaved by suicide' and 'people in intimate partnerships' the terms 'survivor' and 'partner' respectively will be used in the proposed study.

CHAPTER 4: METHODOLOGY

4.1 Introduction

This chapter presents the methodology chosen to address the research question: How do bereaved survivors make sense of their coping experiences following intimate partner suicide? Interpretative Phenomenological Analysis (IPA) was the chosen methodology. The underpinning ontological and epistemological perspectives of IPA are described and how these connect with my personal background and position. The rationales for the decisions made in relation to the research study are outlined. The design of the study will be discussed with consideration given to the principles of human research ethics, reflexivity and research rigour.

4.2 Choice of research methodology

Research methodology is a way of thinking and studying a phenomenon in great detail (Creswell, 1998). There are aspects within the methodology that need to be considered such as the underpinning philosophy, the researcher's position, the research question and the aims and objectives (Flick, 2014). Research methods are based on the chosen methodology. Research data collection and analysis methods are the tools used in particular way to find out more about the phenomenon being studied (Taylor, 2013).

Research methodology is also a process and requires a transparent, systematic approach in how the research is designed, developed and carried out (Creswell, 2009). This includes being practical and realistic in what can be done in light of resources, logistics, and skills of the researcher. The process requires careful decision making, reflexivity and planning that is underpinned by a good understanding of the philosophical basis of the research design for a number of reasons (Silverman, 2009). It assists with the development of research design, provides validity in the study and contributes to the world of knowledge underpinned by an epistemological paradigm.

All individuals hold basic assumptions or ways of thinking about their world. These sets of beliefs are a personal framework where we create and construct our ideas about knowledge. In research, these are seen as ontological and

epistemological beliefs underpinned by a philosophy (Tracy, 2013). It determines how researchers understand the nature of reality and then on which basis knowledge claims can be made. The individual's personal framework and their philosophical beliefs will lead to the chosen paradigm in which an individual situates themselves, often referred to as a researcher's position. This will influence and guide their methodology, methods used, and process choices in undertaking a research study.

4.3 Researcher's position

I am a Registered Mental Health Nurse and obtained my degree in a nursing curriculum based on psychosocial models, with a focus on the 'client as expert' in the therapeutic relationship (Tee, Brown and Carpenter, 2012). My undergraduate experiences have been a catalyst in my approach to acknowledging and appreciating subjective experiences. Reflective practice was heavily embedded in both the theoretical and clinical components of the degree. As a consequence, my clinical practice in both inpatient and community settings within different job roles adopted the use of reflection in delivering client-centred care. As a result, such reflective approaches became embedded and natural for me both professionally and personally.

Maintaining and developing self-awareness has continued as a fundamental element of my work. In my professional practice as a nurse I engaged in reflection in action with decision making and interventions, and on action during clinical supervision (Johns, 2010). In more recent years as a university lecturer I incorporated and developed reflective practice in a nursing degree curriculum to facilitate safe and competent practice. To support my teaching in this role I utilised a critical friend, a mentor and peer support in the framework of reflection to develop awareness of 'self' to learn and improve (Taylor, 2010). Furthermore, I maintained personal reflective diaries, undertook an eight-week Mindfulness-Based Stress Reduction (MBSR) course (Kabat-Zinn, 2005), practiced yoga, and attended meditation retreats for the purpose of adopting and incorporating self-awareness into day to day life.

My experiences both professional and personally are relevant to my role as a researcher. A researcher's self-awareness is crucial in research design (Tracy,

2013) and is discussed further in the reflexivity section of this chapter and supported by reflexive notes (Appendix B). Conducting research regardless of being a novice or expert is an ongoing learning experience. Determining positionality within any study demonstrates what a researcher brings to the study, however, having an understanding of how positionality is being used and applied is equally important (Elliot, Fischer and Rennie, 1999). The research process moves, and changes as does the researcher as an individual in that process (Woolgar, 1988).

Whilst the use of reflection/reflexivity in my lifeworld is critical within the research process of this study, this approach will not exempt me from certain challenges. I am a practicing Roman Catholic where the church views suicide as a mortal sin (Holmes and Holmes, 2005) but at times, I have understood why suicide can seem like the only option for some people.

During my clinical practice, I have nursed clients who have attempted suicide and, in some cases, have known that some individuals later succeeded in completing suicide. These clients had an impact on me as a person, as well as in my clinical and academic practice. I still remember them and often think about my experience within each therapeutic relationship. My holistic approach in nursing each client had been challenging for me as their behaviour contradicted my own belief system and contravened current health policy, social norms and presented legal issues. Therefore, being aware of my beliefs and how they affect me has been important in managing my research and making fundamental decisions about the study.

My professional and personal beliefs and experiences are a reflection of my epistemological position. This has led me to frame the research question in a particular way and adopt a qualitative interpretivist approach which underpins the type of knowledge I believe is critical to an understanding of the phenomenon.

Ontology and epistemology as philosophical assumptions are linked, and a researcher takes a position in what they want to know and how they want to know it (Flick, 2014). My aim within this study is to understand more about the coping experiences of bereaved survivors following intimate partner suicide. This understanding seems intuitively accessible through accounts of subjective lifeworld experiences shared by the survivors themselves.

Epistemologically, to explore these subjective experiences, I adopted a position within a non-positivist paradigm. In particular, my personal experiences already locate me within an interpretivist paradigm. Specifically, I chose a constructivist approach with a specific position on contextual constructivism because experiences cannot be measured but only really understood through the subjective account of individuals. Individuals construct meaning and knowledge which is contextualised to their experience. Constructivism acknowledges that interpreted experiences are constructed in the mind of individuals (Ponterotto, 2005). I support this epistemological position as experiences are perceived by individuals and they are perceived differently according to the situation and time. What makes the experiences and their meanings unique for individuals is the context in which they are experienced (Finlay, 2014).

I recognise that my personality and my own lifeworld experience both personally and professionally are brought to the research process and guides me in how I addressed the research question. It is fair to claim that the use of 'self' is important in research and is very much part of me in both my personal and professional life. Therefore, this awareness and the use of reflexivity will contribute to rigour in the research study (Taylor, 2013). Reflexivity is discussed later in this chapter.

I have made my position known, but a researcher also has to know how they use their position in the research and the implications for the research process. Being aware of the researcher's position ensures that all parts of the study meet the criteria for rigorous and ethical research (Munhall, 2012). My professional experiences are based on a philosophical paradigm that is aligned more with an interpretivist rather than a positivist position. An interpretivist approach is aligned to a qualitative methodology which also underpins the research question being asked. Therefore, a qualitative research methodology such as IPA has been selected as it is based on context and how individuals interpret their experiences.

The IPA process recognises that as the researcher I will be making sense alongside the individuals making sense of their experiences. This process to some extent mirrors the therapeutic relationship in the context of the clinical setting. A researcher's background and their experiences influence their interpretation of the participant's lived experience (Creswell, 2013). Every qualitative researcher undertakes a process of exploration and discovery which

will affect the researcher in some way (Munhall, 2012). The process of reflexivity will assist the researcher during this process (Silverman, 2009).

4.4 Research methodology

Research methodology is the approach or principles that guide a research study and is based on theories and concepts, developed by philosophers and theorists, and informed by philosophical assumptions and paradigms (Streubert and Carpenter, 2011). The underpinning components are not conclusive or completely explicit in every research study (Creswell, 2013). Research methodology and all of its components are unique to each study. However, when exploring individual experiences, as is proposed in this current study, there are assumptions made about how knowledge can be generated which in turn, underpin methodological choices (Guba and Lincoln, 1994).

4.4.1 Philosophical assumptions

Philosophical assumptions are often known as ‘positions’ and they form the basis of our ideas and how we see the world and understand it (Creswell, 2009). What is important about philosophical assumptions in research is knowing in the first instance where the researcher and their question are positioned. An alternative explanation is understanding what is believed and how we believe it (Guba and Lincoln, 1994). This gives emphasis to recognising the researcher as a human being who comes with their own belief system and has their own experiences in their world. Therefore, knowing the ‘position’ from the beginning can be a critical step in making methodological decisions across the research process.

Philosophical assumptions are often referred to as being based on ontology or epistemology (Tracy, 2013). Ontology is an assumption about the nature of reality and how it exists, whereas epistemology is an assumption about what we know and how we know this reality. (Holloway and Wheeler, 2010). It can be argued that both ontology and epistemology are linked and inform a researcher’s position based on how they view it and what question they are trying answer. There is no attempt to be exhaustive in providing what position is supposed to be adopted or to give an account of philosophy, but a researcher’s position needs to be explicit in both the development and conduct of research (Tracy, 2013).

The researcher's assumptions or position is also underpinned by objectivity or subjectivity. Objectivity in reality is determined by nature or science whereas subjective knowledge can be seen perceived or interpreted by individuals (Merleau-Ponty, 1962). These approaches are often perceived as opposites and influence how to answer a research question. Being explicit about one's position, as a researcher, underpins the type of knowledge being sought, and determines the type of question and how it is asked. In this research study adopting a qualitative research methodology supports the generation of subjective knowledge, emerging from the desire to understand the lifeworld from the perspective of those who have experienced the phenomenon (Merleau-Ponty, 1962). Philosophical assumptions are not one step or one part of research but a complex and complementary component that is interwoven and embedded in research (Langdridge, 2007). These assumptions are developed further by the chosen philosophical paradigm (Creswell, 2013).

4.4.2 Philosophical paradigms

Philosophical paradigms or frameworks are important but often not made explicit in research studies. Philosophical paradigms are linked to philosophical assumptions because they underpin the methodology of a research study (Flick, 2014). The paradigm building on from the philosophical position shapes and informs the nature of inquiry from the beginning and puts the researcher in the research process (Creswell, 2013).

There have been ongoing debates about philosophical paradigms which continue to evolve within different disciplines (Langdridge, 2007). The focus is to acknowledge how a paradigm brings a research study together (Finlay, 2014). Philosophical paradigms are theoretical ideas and the use of generic procedures that are rooted in a philosophical position underpinning the chosen research design (Lincoln and Guba, 1985). There are different philosophical paradigms and discussing them in detail is not the purpose of this chapter. However, the understanding of positive and non-positivist paradigms in a broader sense will be discussed to provide context to the discussion and the methodological decisions being made.

A positive paradigm is seen in science as the traditional approach in research.

Positivists aim to test theories and hypotheses following a scientific line of inquiry to present an objective view on the world (Holloway and Wheeler, 2010). This approach claims that there is only one answer to a question which is, the absolute truth. This approach is often seen in quantitative research and much of the research related to survivors following intimate partner suicide. The studies in the preceding literature review were limited by small sample sizes and a full understanding of the impact of events on survivors' coping and coping experiences were rarely considered.

My beliefs about knowledge and that the world is constructed by subjective experiences is not underpinned by a positive paradigm. These experiences can only be understood through individuals' accounts of those experiences and hence limiting those accounts to measures based on scientific constructs is neither aligned with my beliefs and not the focus of the question I am choosing to ask. Therefore, the positivist paradigm as a framework is not suitable for this research study as it will not adequately answer the research question.

Qualitative research is inductive in nature and often driven by a problem about which little is known (Taylor, 2013). This approach aims to explore and understand a phenomenon with a focus on individual meaning and the various complex factors in that phenomenon (Creswell, 2009). The aim of the current study has been informed by the literature review and limitations of existing studies in this field. Previous studies have predominantly relied on quantitative assessment of spousal experiences. While measurement of responses and effects of interventions on coping are important, the individual experience is hidden, and little is known about the factors that assist or hinder survivor recovery following partner suicide. This identified gap in the literature supports a qualitative methodological approach. Qualitative methodology aims to understand the individual's perception of their experience which is subjective and connected to their experience (Green and Thorogood, 2004).

Non-positivist paradigms seek to find and understand knowledge that cannot be measured (Green and Thorogood, 2004). Methodologies within this paradigm seek to know more about experiences first-hand from the individual, how they experienced it, how they feel about it, and how these experiences interact within their world. Based on this, qualitative research rejects the philosophy of positivism

or a post-positivist paradigm (Guba and Lincoln, 1994). The focus is on how individuals perceive their experiences in context (Ponterotto, 2005). The non-positivist paradigms evident in qualitative research include interpretivist/constructivist, transformative, and pragmatic (Creswell, 2009).

4.4.3 Interpretivist/constructivist paradigm

An interpretivist/constructivist paradigm is related to my epistemological position in that individuals' construct meaning and knowledge about their experiences within context. This paradigm supports that individuals construct their own understanding and knowledge of their lifeworld, through experience and reflecting on those experiences (Lincoln and Guba, 1985). Therefore, this paradigm has contributed to the development of the selected research methodology. There are different qualitative methodologies underpinned by an interpretivist/constructivist paradigm (Ponterotto, 2005). Qualitative methodologies based on constructivist theories such as Grounded Theory, Discourse Analysis and Phenomenology were potential methodologies considered for this study. The respective merits and weaknesses of the various approaches will be discussed and a rationale for choosing IPA will be provided.

4.4.4 Grounded Theory

Grounded theory involves the construction of theory through the analysis of data (Glaser and Strauss, 1967). Grounded theory aims to address a problem by generating a theory thereby providing an alternative approach rather than deducing a hypothesis from existing theories and then testing it (Glaser and Strauss, 1967).

Grounded theory was originally underpinned by symbolic interactionism but recently there have been shifts in paradigms particularly in the founders' later separate works and the rise of other grounded theorists (Ghezeljeh and Emami, 2009). Glaser was considered a critical realist and his work continues to align closely with the original approach which is often known as 'classic grounded theory' (Hall, Griffiths and McKenna, 2013). Glaser focused on the relationship between the researcher and participants whose experiences are grounded in objectivity (Charmaz, 2006).

The collaboration of Strauss and Corbin demonstrated a shift towards a relativist approach with constructionist underpinnings. They claimed that multiple perspectives can be identified through a systematic process (Corbin and Strauss 2015). They argued that theory is created through interpretation and construction by the researcher through analysis (Corbin and Strauss 2015). Grounded theory is often based on a constructionist paradigm but other grounded theorists' work from different philosophical paradigms including a constructivist paradigm can be used. Grounded Theory is often used in psychology as it does consider a psychological problem but does not adopt a psychological focus (J. Smith, Larkin and Flowers, 2009). Grounded theory based on a constructivist paradigm generates grounded theories with rich data that reflect individual views or feelings, as well as the contexts and structures of their lives (Charmaz, 2006). Essentially this methodology focuses on explaining theories of social processes from an individual's experience (Starks and Trinidad, 2007). This methodology however was not selected as the aim was not to explain human interaction in the individual's social world or develop theories that are derived from the data and explain human interaction.

4.4.5 Discourse Analysis

Discourse analysis studies language in context and evolved from linguistics (Starks and Trinidad, 2007) and semiotics (Chandler, 2002). There is a particular focus on examining the relationship both speech and behaviour in a particular situation (Harris, 1952). There is a wider consideration of world views, use of language, and different cultural context (Paltridge, 2012).

The main goal of discourse analysis is to understand how individuals use language to achieve their goals in their everyday lives but also suggests that language is meaningless unless everyone agrees about the attached meaning of it (Starks and Trinidad, 2007). Discourse analysis is also used on a broader level to understand language and how it achieves outcomes in societies such as public health promotion policy (Gee, 2005). Therefore, discourse analysis recognises that language provides an action or influence.

Discourse analysis does describe language in use and analyses it to identify themes or roles (Biggerstaff and Thompson, 2008). However, discourse analysis

does not consider the meaning attached to the individual's experience and how that meaning shapes their social world (Biggerstaff and Thompson, 2008). Discourse analysis is positioned in context but does not draw out the meaning of an experience for an individual and that meaning is not always shared. This is also evident in different cultural meanings of certain experiences and use of language. The current research study does not aim to describe the use of language or how language is created to shape or influence the individual's lifeworld. The participants in this study will be asked to recall and reflect on their experiences of coping after the suicide of an intimate partner, therefore the fundamental premise of discourse analysis was not coherent with the aims and objectives of the proposed study.

4.4.6 Phenomenology

Phenomenology is both a philosophy and a methodology concerned with the lived experience of an individual (Starks and Trinidad, 2007). There are notably four key phenomenological philosophers: Husserl, Heidegger, Merleau-Ponty and Sarte (J. Smith, et al., 2009). However only the works of Husserl and Heidegger will be discussed to differentiate between descriptive and hermeneutic phenomenology.

Husserl, a mathematician offered an alternative approach to positivism (Reiners, 2012). According to Husserl (1931), phenomenology was about understanding the essence of conscious experience which was directed towards something. This is essentially the objects of the lived experience before we even think about them or try to understand them. By knowing this consciousness, a careful examination of the lived experience is required by going back to the things themselves to make sense of the actual experience. This examination would identify the key objects of the experience and these would transcend and show itself (Lavery, 2003).

Husserl's descriptive phenomenology was about 'going back to the things themselves' to make sense of the lived experience through adopting attitudes and the use of reductive approaches (Husserl, 1931). A natural attitude was required to examine everyday experience by stepping out of it or putting it aside. Acquiring a phenomenological attitude is more reflexive and provides an inward

focus on individuals' perception of the objects of their lived experience.

To describe the lived experience, a process of reduction also known as bracketing or epoche was used (Finlay, 2014). A series of reductions were used to provide different insights into the way of thinking about the phenomenon and to do this the natural world and any thoughts about it had to be put aside.

For the purposes of the current research study, descriptive phenomenology does not provide an interpretation of the lived experience because the focus is on the experience and not the individual's position within it. Epistemologically, I do not accept that a full understanding of a lived experience can be achieved through pure description and that the natural world can be suspended. I believe an individual and their lifeworld are connected and informs each other through their understanding at the time in a particular set of circumstances. Furthermore, I consider Husserl's work was developed at a conceptual level, objectively looking at lifeworld experiences, and rooted in mathematical sciences to be quite distant to understanding an individual in their lifeworld.

Heidegger, with a background in theology, was a former student of Husserl and moved away from the notions of 'consciousness' towards 'being', with an emphasis on understanding how the individual connects with their lifeworld (Lavery, 2003). Heidegger's phenomenology became known as hermeneutic or existential phenomenology as 'being in the world' (dasein). Heidegger suggested that 'person in context' and intersubjectivity are key to understanding 'being' (Reuther, 2014).

Hermeneutic phenomenology claims that the world already exists and is concerned with how an individual relates to their lifeworld (Heidegger, 1927). Individuals have fore-understandings of their lifeworld and by engaging with their lifeworld provides an interpretation of what it means to them (Dahlberg, Dahlberg and Nyström, 2008). Heidegger's worldliness did not accept that reduction could occur because an individual has a perspective of their lifeworld which is time bound and always related to something or someone (Reiners, 2012).

Hermeneutic phenomenology is positioned in the interpretivist/constructivist paradigm but was not selected as a methodological approach for this research study. Heidegger's work specifically focused on being an interpretative approach

with a strong connection with the theory of hermeneutics and understanding through text (Lavery, 2003). He was absolute about fore-understandings not being bracketed, and rather than be completely be immersed in the analysis 'interpreters' are involved in making sense of the individual's lifeworld (Dahlberg, et al., 2008). Interpreting text requires a full understanding on what the text actually means to an individual's experience of the context in which it is experienced. Furthermore, it is impossible to completely bracket fore-understandings and researchers cannot be completely be immersed in the analysis. An interpretative researcher has to manage their fore-understandings to ensure that the analysis of the individual's meaning of their lifeworld reflects the person's interpretation of it as much as possible. Lastly, Heidegger was not explicit about how fore-understandings from both the individual and the researcher were relevant at different stages of their lifeworld and how this influences the research process.

Three qualitative methodologies underpinned by an interpretivist/constructivist paradigm have been discussed in relation to my epistemological position. Each methodology was considered and have some valuable aspects but were not aligned with my epistemological position. Furthermore, the principles of these methodologies could assist the study of the phenomenon but not their overall approaches were not aligned with my epistemological position. IPA is influenced by Husserl and Heidegger but aims to operate in psychology and answer psychological questions. The rationale for choosing IPA as a methodology will now be discussed.

4.4.7 Interpretative Phenomenological Analysis

IPA is concerned with an individual's perception of a particular experience in their psychological and social world (Larkin, Watts, and Clifton, 2006). An individual's understanding and meaning attached to their experience are core to IPA research (Biggerstaff and Thompson, 2008). IPA is a qualitative strategy of inquiry within psychology (J. Smith, et al., 2009). IPA engages in double hermeneutics and is often used in psychology-based studies but is also widely used by other disciplines that are driven by psychological questions (J. Smith, et al., 2009).

IPA is underpinned by three theories: phenomenology, hermeneutics and

ideography (J. Smith and Osborn, 2008). The relevance of phenomenology to IPA is significant. IPA recognises the works of key phenomenologists such as Husserl, Heidegger, Merleau-Ponty and Sarte (J. Smith, et al., 2009). The key features of relevance are notions of the individual, their experience, and perceptions of it (Husserl, 1931); interpretation of their lifeworld (Heidegger, 1927); embodied nature of their relationship to the lifeworld (Merleau-Ponty, 1962); and individuals 'becoming' rather than just 'being' (Sarte, 1943).

Hermeneutics, the theory of interpretation, also informs IPA (J. Smith, 2011c). The works of Heidegger as a hermeneutic theorist as well as others are acknowledged in IPA (J. Smith, et al., 2009). Hermeneutics was founded to interpret biblical text in a systematic way to give readers an understanding of the author and not just the text (Schleiermacher and Bowie, 1998). This was later by developed Heidegger as part of his work in phenomenology to interpret meanings (Heidegger, 1927). Meanings can be shown as they present themselves, but some are hidden (Heidegger, 1927). Therefore, the implication is that the researcher through analysis can reveal these hidden meanings in the text.

Hermeneutics is a circular process of analysis which involves going back and forth amongst the data to make sense of key ideas (J. Smith, 2011c). The 'parts and the whole' are interpreted through the identification of meaning and context which are reflected in words and sentences that might have connections and meanings throughout the text (J. Smith, 2004). The focus of IPA is sense making and acknowledges both the participant and researcher in the process. This is often referred to as 'double hermeneutics' because the participant reflects on their experience and then the researcher makes sense of it through the process of analysis (J. Smith, 2011c). The hermeneutic circle requires the researcher to be aware of their preconceived ideas of the phenomenon and attempt to bracket them during the analysis stage. Engaging in reflexivity will assist in this process as well as combining an approach of hermeneutic empathy and questioning (Larkin, et al., 2006; J. Smith, et al., 2009). Therefore, the researcher adopts two positions in analysis by understanding the phenomenon from the participant's point of view but also seeks to question and make sense of it.

For an IPA study, the works of Heidegger are significant since he was both a phenomenologist and hermeneutic theorist (J. Smith, et al., 2009). Essential

hermeneutic elements that underpin IPA include: how the phenomenon presents and making sense of it (Heidegger, 1927); a holistic, systematic and detailed analysis of the transcript (Schleiermacher and Bowie, 1998); and a focus on the meaning of the transcript with recognition of the point in time when it is interpreted (Gadamer, 1975).

Ideography is the third theory that underpins IPA. Ideography involves the identification of a pattern that emerges from the data and from which an overarching theme can be constructed (J. Smith, 2004). Ideography involves being focused and examining in detail, each participant's experience, which is achieved at two levels (J. Smith, et al., 2009). Firstly, this requires a detailed understanding of the participant's experience and the context in which it was experienced (J. Smith, et al., 2009). This process requires a case by case focus and then through further analysis all cases are examined to determine patterns of meanings through the shared experiences (J. Smith, et al., 2009). The individual and shared cases speak for themselves, which could highlight differences as well. Furthermore, to be able achieve an ideographic approach, IPA requires a small and homogeneous sample, so convergence and divergence can be fully addressed (J. Smith, et al., 2009).

4.4.8 Rationale for using Interpretative Phenomenological Analysis

IPA as a methodology has been chosen for this research study for several reasons. Firstly, my epistemological position as an interpretative constructivist is well situated in IPA as well as the theoretical frameworks of phenomenology, hermeneutics and ideography that underpin its approach. An IPA researcher's epistemological position needs to be flexible and open but requires consideration (Larkin, et al., 2006). It is the researcher's question alongside other factors that determine a good research study (Larkin, et al., 2006).

IPA is concerned with individuals and their everyday lived experience (J. Smith, 2011a). The process focuses on a significant event that requires an individual to reflect on how they feel and think about it. This includes how individuals see their world, what is happening for them, relationships, environmental factors as well as their physical and emotional health. The focus is on their awareness of the experience and how they make sense of it.

The proposed research study is concerned with the coping experiences of bereaved survivors following intimate partner suicide. IPA will facilitate, in the first instance, a rich description of the individual's lifeworld recalled through an interview, the individual's recollections of their coping experiences and the factors influencing them. These parts are connected with the whole experience which creates meaning (J. Smith, 2004). This is part of the double hermeneutic process with the individual making sense of their experience (Finlay, 2014). The researcher then interprets those first-hand accounts from the individual to help understand the meanings attached to the experience and the individual's lifeworld as a third person in the hermeneutic cycle (J. Smith, 2011c). Each case is analysed in great detail with a focus on each individual experience (J. Smith, 2004). To be able to achieve this, the homogeneity of participants also meets the criteria for an IPA research study. IPA considers people, their experiences, and the context. This reflects my psychosocial approach in both my personal and professional experiences. As a researcher, I have an ethical responsibility to do 'good' by understanding participants' stories accurately with the intention of sharing this information to influence change.

4.5 Study aim

The aim of this study is to explore the coping experiences of bereaved survivors following the suicide of their intimate partner.

Objectives:

- Identify the coping experiences of the bereaved survivor following the suicide of their intimate partner.
- Interpret factors influencing coping experiences using IPA.
- Develop recommendations for improving information and support to survivors bereaved by intimate partner suicide.

The research question is: How do bereaved survivors make sense of their coping experiences following intimate partner suicide?

4.6 Study design

4.6.1 Sample

The study was conducted in the UK with a non-clinical population predominantly living in the Yorkshire region. This was a pragmatic decision as the study was unfunded and costs, such as travel, needed to be minimised. Although survivors can be at risk of suicide, a non-clinical sample was sought in order to provide insights into the experiences of 'coping' following suicide of an intimate partner that could inform healthcare practice.

4.6.2 Sampling strategy

Sampling strategies are required to be consistent within the research design (Creswell, 2013). The participants had been bereaved by intimate partner suicide and were therefore a purposive sample. A purposive sample has shared knowledge (Taylor, 2013).

It was also expected that recruitment would occur through current participants sharing information about the study with other survivors. This method of sampling is known as snowballing (Noy, 2008). This approach to finding a sample was useful as the phenomenon being researched is sensitive because suicide is associated with stigma and discrimination (Holmes and Holmes, 2005). Feelings of shame and stigma may hinder potential participants from making contact with the researcher or wanting to participate. Recommendations to participate from a known bereaved person may therefore be helpful. Furthermore, recruitment of the sample was assisted through a referral system from local organisations and various social media platforms.

4.6.3 Sample Size

As in most qualitative studies sample sizes are small (Morse, 1994; Creswell, 1998) though guidelines for determining non-probable sample sizes are hard to find (Guest, Bunce and Johnson, 2006). There are no specific criteria for sample size in qualitative research but what is required is the understanding of the phenomenon and the analytical capabilities of the researcher (Patton, 2002).

Sample size in IPA studies is not based on quantity as the aim is not to generalise

the findings (Creswell, 1998). IPA research is about a concentrated focus, depth and commitment to the analysis of rich detailed subjective accounts (J. Smith, et al., 2009). A sample of eight participants is considered to be a significant sample size for an IPA research project to allow for a detailed, depth analysis of the data collected (J. Smith, 2004, J. Smith and Osborn, 2008; J. Smith, et al., 2009, J. Smith, 2011b).

4.6.4 Sample selection

IPA studies are usually based on homogenous samples although homogeneity classification varies and depends on the research question (J. Smith, et al., 2009). The studies in the literature review, highlighted homogeneity in shared characteristics such as gender and background. In the current research study, the homogenous sample were representative of women from a western culture that had a shared phenomenon. They were survivors bereaved by intimate partner suicide and had this lifeworld experience.

Determining the criteria for inclusion was challenging because of the sensitivity of the phenomenon being researched. The inclusion criteria for this study were derived from the literature review, recommendations from the University of Hull Human Research Ethics Committee, and expert consultation. These experts included an experienced researcher in suicidology and two survivors I had met in the early stages of method development. One suggestion included not imposing a maximum bereavement period for inclusion.

Consenting adult survivors of a minimum age of eighteen years old were invited to participate and no capped maximum age was stipulated. This minimum age reflects the legal age of marriage or civil partnerships without permission in the UK (GOV.UK, 2017). Additionally, those bound by legal responsibilities such as marriage, financial responsibilities and/or raising children are likely to be adults in an emotional connected relationship (Clarke, 2010).

The selected term 'intimate partner' has been discussed in previously. Therefore, it was important that participants self-assessed their intimate partner relationship to the deceased. The rationale for this was to avoid imposed views on what constitutes an intimate partner relationship (Clarke, 2010). However, the term was also chosen to capture the coping experiences of all survivors who had been

bereaved by a partner's death by suicide to whom they were emotionally connected in an adult relationship. Finally, the term 'partner' in isolation may be taken to represent partnership related to business ventures.

In this research study participants, could be representative of any gender, ethnic or cultural group, with or without any religious orientation, and in any social or economic group. However, the diversity of background could not be determined until potential participants made initial contact. As mentioned IPA works with a homogeneous sample, homogeneity is determined in different ways (J. Smith, et al., 2009). What was important to consider was the participants' language and location regardless of their background. A participant's command of English and living in the UK (a western society) was similar to my own position. This was vital if a double hermeneutic approach was to be used whereby the participants and I shared the same language and cultural understanding as well amongst the participants themselves. This homogeneity would be significant in data analysis with sense making in context to provide accuracy (J. Smith, et al., 2009). This inclusion criteria intended to provide focus on coping experiences and the factors that influence coping following intimate partner suicide. As coping styles are variable and depend on several factors, an extended in-depth understanding of the phenomenon would provide recommendations for developing better information and support to survivors who are bereaved by intimate partner suicide.

A further challenge was to consider the bereavement period. Informed choice in any research study is a personal one however the suitability of when to participate might be more difficult. Every participant was able to exercise their right to determine their own suitability to participate or not, a minimum period of bereavement was stated. However, no maximum bereavement period was imposed based on feedback from the consultations mentioned previously. Both survivors reinforced that 'you do not completely get over it' and both had been bereaved twenty-three and fifteen years respectively and both had remarried. This pattern of experience was consistent with the literature review reporting that complicated grief following suicide was prolonged and longer than other types of bereavement (Demi, 1984; Farberow, et al., 1987; Barrett and Scott, 1990; Gilewski, et al., 1991; Farberow, et al., 1992a; Cleiren, et al., 1996). The decision to stipulate a minimum bereavement period, was based on recommendations

from the consultations and findings of the literature review where a minimum of one-month post bereavement was reported (Constantino, et al., 1997; Constantino, et al., 2001; Constantino, et al., 2002; Mitchell, et al., 2009). Therefore, a minimum bereavement period of one month was included. To safeguard potential participants, they would be excluded if they verbalised or planned to seek counselling or support during their initial contact with the researcher. Other measures to support participants during the recruitment and data collection processes are discussed further in this chapter.

Furthermore, on a pragmatic level participants were also required to communicate in English, as I am only fluent in English and there were no funds to employ an interpreter if needed. Participants needed to sufficiently comprehend English to give informed consent to participate.

4.7 Recruitment

Recruitment for this study initially was driven by developing links with local organisations such as Survivors of Bereavement by Suicide (SOBS, 2017) and Hull & East Yorkshire Mind (Mind, 2017) to assist in the recruitment process.

Recruitment also took place through various organisations and communication channels predominantly in Yorkshire. This was done by seeking permission to advertise with voluntary, charitable, mental health-related organisations with a focus on suicide prevention. The main contact methods were by telephone, email or face to face. I visited community centres, local religious organisations, libraries and trading shops to place the advertisement on a display board where appropriate. Additionally, I contacted local active armed forces or organisations supporting those who have served. The research study was also aired on BBC Radio Humberside as a top local story, West Hull FM Community Radio and Talk Radio Europe. Recruitment advertisements (Appendix C) were also placed with local groups or office branches, on notice boards, in local newspapers and/or social media platforms where appropriate into small regions in London and Kent. I also contacted organisations on their twitter and face book pages or official organisational websites which was done on a national level.

One survivor who provided advice in the research design stage also volunteered to take on the role as referrer. This survivor is an activist and was keen to work

towards change. As a referrer for this study this individual assisted by telling other survivors about the study and provided introductions with relevant voluntary and/or charitable organisations that support those bereaved by suicide.

Potential interested participants were invited to make initial contact through either email or telephone. Interested individuals who met the inclusion criteria were sent the participant information sheet (Appendix D) by email or by post, as preferred. The potential participant was encouraged to take their time to consider their participation and read through the participant information sheet. It was agreed that the potential participant would inform me within a mutually agreed negotiated time frame of their intention to take part. During this time, potential participants were invited to seek clarification or any further information about the research study. If the potential participant chose not to participate or they did not meet the inclusion criteria they were thanked for their interest and time. They were also offered a NHS comprehensive resource pack called 'Help is at Hand' (NHS Direct, 2008). This resource pack is for people bereaved by suicide and other sudden, traumatic death.

Individuals who decided to take part in the study were asked if they had any further questions about the study. The participants were then offered a choice to be interviewed in person or via skype based on their preference, suitability and convenience. The interview method via skype was also pragmatic, as it minimised time and financial burden of travelling for both participant and researcher.

Participants were reminded they could withdraw from the study at any time without giving any reason or explanation. Participants were reminded that the interview needed to be held in a place where there was no interruption. This was to ensure confidentiality and privacy. Furthermore, participants were reminded that around one and half hours of their time was needed for the interview. This minimum time was deemed necessary to ensure the development of rapport and for participants to speak freely in sharing their detailed experiences (J. Smith, et al., 2009).

Consent was sought before the interview. In most cases the participant consent form (Appendix E) was sent by email several days in advance of the interview and brought to the interview and signed by both. For skype interviews time was needed for forms to be sent and received back in the post or by email. Written

consent was required, and verbal consent was sought again before the actual interview started.

4.8 Ethical considerations

This research study obtained approval from the University of Hull Human Research Ethics Committee. Due to the nature of the phenomenon being researched, sensitivity was crucial and careful consideration was given to how participants were recruited.

Participants were volunteers and were given information about the research study on their initial contact. Participants were fully informed about the purpose of the study, the data collection method and processes of the study, the advantages and disadvantages to them and a requirement to provide informed consent. Informed consent is about the participant being able to make a decision by comprehending the information and the accuracy of the study information provided (Hammersley and Atkinson, 1995). However, consent is an ongoing process and was sought at recruitment and confirmed at the beginning of the interview (Streubert and Carpenter, 2011). Participants were reminded that they could withdraw from the study at any time up to the point of analysis with no reason or explanation.

Ethically as a researcher I had a responsibility to ensure that the information provided by participants, would be confidential and private. Participants were informed about how confidentiality and privacy would be maintained through anonymising data, securely storing data and who would have access to it and why. Participants were also informed that the audio recording would be securely destroyed once the interview had been transcribed. Information giving both verbally and written and seeking consent demonstrates respect for a participant's autonomy (Biggs, 2009).

The researcher has an ethical responsibility to safeguard participants, the public and themselves (Green and Thorogood, 2004). Participants were advised that in some situations, confidentiality may have to be breached. Participants were informed that their confidentiality would only be breached if they disclosed a crime or expressed harming themselves and/or others. If this became apparent I was required in the first instance to report this to my supervisor(s) and other authorities

including emergency services where appropriate.

Beneficence, another ethical principle, was also applied in this research study. Beneficence is an action done for the benefit of others (Biggs, 2009). Participants were advised at the beginning of the interview that if they became distressed at any time during the interview would be stopped. Reminding participants that they were volunteers and could withdraw from the study at any time also demonstrated beneficence (Wiles, 2013). Beneficence is also about safeguarding the participant's welfare and recognising that they could feel distressed or feel they need some support (Moule and Goodman, 2014). This was done during and after the interview. Participants were reminded of the contact details for support services.

Ethical safeguards were also extended to me as the researcher (Moule and Goodman, 2014). To address safety in conducting the interviews I developed a lone working protocol with my supervisors for the purpose of meeting participants to conduct the interviews. Furthermore, the nature of the topic discussed in the interviews can be distressing for the researcher (Munhall, 2012). Psychological safety measures included keeping reflexive logs, attending regular supervision meetings and being aware of resources available to me.

What is not often considered is the researcher's ability to competently conduct research. The ethical principle of justice is demonstrated by being skilful to conduct the research interview and analyse the findings (Hyams, 2004). Examples of developing competence and confidence are discussed in the reflexivity section of this chapter.

4.9 Data collection method

Semi-structured in-depth interviews were selected as my data collection method. In-depth interviews provide rich first-hand accounts of a participant's experience which is consistent with theoretical underpinnings of IPA research methodology (J. Smith, et al., 2009). Some IPA studies have used focus groups as a data collection method, but it was not selected due the sensitivity of the phenomenon (J. Smith, 2004).

IPA in-depth interviews can be either semi-structured or unstructured. IPA

interviews offer a 'sideways approach within a discussion' type interview (J. Smith, et al., 2009). As a novice researcher and new to IPA methodology, semi-structured interviews would provide some structure for me to follow (J. Smith, et al., 2009). Given the sensitivity of the phenomenon being explored, providing some structure would ease the flow of the interview for the participant. The interviews were also based on an in-depth frame which encourages the exploration of a subjective lifeworld experience of coping and the factors that influence it following suicide of an intimate partner (J. Smith and Osborn, 2008). The semi-structured interview guide (Appendix F) was not developed to be prescriptive and provided topics to be explored. These topics were developed from the key findings of the literature review. The interview guide had questions and several prompts but essentially the participant was encouraged to take a lead in telling their story (Larkin, et al., 2006).

The interview started with an opening question asking the participant to tell their story from any point in their life experience related to the phenomenon. This was done to develop rapport and encourage comfort for the participant (J. Smith and Osborn, 2008). Given the sensitive nature of the phenomenon, a descriptive starting point led by the participant is crucial (Biggs, 2009). The opening started with 'I would like to hear about what life has been like after you lost your partner to suicide. Where would you like to start?' The topics that followed were: events surrounding the suicide, relationship, coping, support, individual. If the participant covered all of these topics no questions or prompts were used. The aim is for the interviewer to speak very little and be an active listener (J. Smith, et al., 2009). Additionally, the interview was based on a facilitative approach that encouraged an interviewee-led discussion with flexibility. Therefore, the interview guide needs to be fluid with consideration given to the type of questions, possibly the order of the questions but with an openness (J. Smith, et al., 2009). This also encourages the participant to share their coping experiences and the factors surrounding their coping in everyday life (J. Smith, 2004). The interview concluded with: Is there anything else you would like to add?

4.9.1 The Interview

Before each interview I audio recorded my own thoughts to be consciously aware of how I was feeling at the time and any thoughts I had about the upcoming

interview. This is one reflexive approach that supports hermeneutics, the researcher needs to be aware of their preconceived ideas and manage them effectively in the research process to encourage a true representation of the participant's experience (J. Smith and Osborn, 2008, J. Smith, et al., 2009). I did this to raise awareness of the 'self' and how this could influence the interview. This is discussed further in the reflexivity section of this chapter. Interviews were conducted once and were held in different settings.

Most interviews were held in the participant's home via skype, as was negotiated and considered suitable for the participant. The main considerations were to ensure privacy and safety within an environment that had no interruptions. For participants who chose to be interviewed by skype, they were asked for their skype name and added as a contact on the day of the interview. Contact details were removed after the interview. Participants were asked where they were located at the time of the interview as a safety precaution if in the event that emergency services might be required. This was explained to the participant before the interview started.

At the beginning of all interviews, I started a general conversation to foster ease and comfort, this also establishes rapport (J. Smith and Osborn, 2008). Participants were asked if they would like any further clarification from the participant information sheet. I discussed the research study with the participants again and gave them an overview of what to expect in the interview and answered any questions they had. My approach was also based on permission seeking to provide continued ongoing informed consent (Hammond and Wellington, 2013). I generally asked the participant: Is that okay or are you ready to start? Participants were then asked to sign a consent form before the interview commenced (except for skype interviews as signed consent was received prior to interview by post or email) and were reminded that their participation was completely voluntary, and they could withdraw from the study. Participants were given a clear explanation of confidentiality and privacy and how that was maintained with pseudonyms (Moule and Goodman, 2014).

Participants were also advised that if they felt distressed at any time they could stop the interview. For skype interviews a detailed plan was discussed such as stopping the call, giving ten minutes to have private time with then returning to

me and advising me if they wanted to continue or not. Participants were also reminded that they could withdraw from the study at any time, up to the point of the analysis of the interview without giving any reason or explanation. Participants were then asked for some personal details to provide some contextual information (social demographic form shown in Appendix G). The rationale for this is because an IPA research study is concerned with an experience that is based in context (Larkin, et al., 2006). This also compliments my researcher's position as a contextual constructivist with the aim of interpreting participants' experiences in the context that they were experienced.

Each interview is different, and the researcher cannot predict the response for the participant. During the interview, some participants might have found talking about their experiences helpful. Additionally, some participants might have learnt more about themselves through their self-disclosure and it could assist the process of grieving. The need for flexibility has been highlighted and being attentive listener enabled me to identify the needs of the participant and how best to support them at the time. I did also consider that after the interview a participant might have felt distressed or felt they needed some support additionally after the interview.

It was anticipated that participants could leave the interview and reflect on the experience and become distressed. Therefore, I asked participants about any general plans they had for the remainder of the day and to ensure they had some support if needed. Participants were thanked for their involvement and a conversation took place to provide reassurance and bring the conversational interview to a gradual close.

As consistently highlighted the nature of the topic being explored is sensitive and this proposed additional interview method would provide participants with further choice of being interviewed in the comforts of their preferred surroundings which might make a participant feel more secure in their chosen environment. Also, participants might want to stop the interview and if they become distressed they will have the option to have private time and space in their chosen environment without me, the researcher being there.

4.9.2 Pilot study

Pilot studies can be used in both qualitative and quantitative research and are considered to be a crucial element of a good research study. However, pilot studies in these two approaches are used differently. A pilot study in a quantitative research study is often for the purpose of developing and testing adequacy of a research instrument such as a questionnaire (Curtis and Drennan, 2013). Alternatively, a pilot study in a qualitative research study could be trying out the interview guide (Griffiths, 2009). This is one of the reasons why a pilot study was used.

In this research study a pilot study was used to develop my competence and confidence in using the interview guide and identifying any logistical problems which might occur (Griffiths, 2009). It enabled me to consider the environment, prepare myself in the use of a Dictaphone and the quality of the interview guide.

One participant volunteered to undertake the pilot process. I commenced the pilot interview with a casual general conversation at the beginning, which acted as an icebreaker and then led onto the formalities, in a conversational way. This helped establish rapport and the participant seemed more relaxed.

At the start of the interview the opening question encouraged a free flow for the participant. It was descriptive initially, somewhat superficial, but as time passed the content became deeper, both as rapport developed and by the nature of the subsequent questions (J. Smith and Osborn, 2008). Interestingly the sequence of the topics in the interview guide seemed to go in order though it was not developed that way. I noticed that the participant relied on me to prompt her to continue after she had said what she wanted to on a particular topic. Therefore, I had to use the interview guide to prompt her to discuss the next topic. I observed limited eye contact when the participant was talking, and it made me think of the sensitivity of the topic. As a consequence, participants being interviewed on skype were given the option of speaking with or without the video facility.

I received some feedback from the participant which was very useful. The participant did not find the interview questions or the order of them problematic in anyway. She did not feel 'over talked' but felt heard and appreciated quietness at times so she could think. This feedback was considered and adopted in

subsequent interviews.

4.10 Data analysis method

An IPA research study focuses on participants' sense making of their experiences which requires a flexible approach to analysis (J. Smith, 2011b). IPA offers a step by step approach to analysis which is not prescriptive, but open and moveable, consistent with a hermeneutic approach (J. Smith and Osborn, 2008). IPA analysis aims to move from the descriptive to the interpretative to understand the participant's experience within context, what it means to them, and with a psychological focus (J. Smith, 2004). The result is a reflection of how the analyst interprets the participant's understanding of their experience (J. Smith, et al., 2009). IPA adopts a 'case by case' approach within the analytical steps which reflects the idiographic component, and encourages rigour (J. Smith, 2011a).

The analytical stages are: reading and re-reading, initial noting, developing emergent themes, searching for connections across emergent themes, moving to the next case, looking for patterns across cases (J. Smith, et al., 2009). As a novice researcher and new to IPA, I followed the stages closely and consistently to ensure rigour.

4.10.1 Transcription of interviews

At this first stage all interviews were transcribed verbatim by me which included any crying, tearfulness, pausing, laughing and sighing. Each transcript was checked again against the recording to ensure accuracy. The next stage required reading of the interview transcript several times including listening to the audio recording (J. Smith and Osborn, 2008). This approach encourages familiarity with the data as much as possible. This provides an active engagement of being with the participant in their lifeworld. I considered that for a deeper emersion in the data, I needed to transcribe the interview at this beginning stage of analysis. Listening, typing the transcript, listening to the audio recording, and making notes with further reading and re-reading of the interview transcripts provided a deeper recall of the participant in the interview. Additionally, I listened to audio recordings of my reflexive accounts after the interview and recorded any other thoughts that came to mind about the participant and their interview.

4.10.2 Formatting and reading of transcripts

I compiled my word document so that the transcript was centralised with two outer columns. The transcript was lined and paged number to aid location of quotes for further re-reading and checking to aid deeper analysis. The interviewer was identified as 'I' and the participant as 'P' with an extra line space to reflect change of speaker. The left column was headed 'emergent themes' and the right column was headed 'exploratory comments'. The participant was then allocated a pseudonym to protect confidentiality. All transcripts were read at least two to three times before analysis commenced to gain a fuller understanding of what was said by the participants (a case transcript example in Appendix H).

4.10.3 Initial noting

This stage is reflected in the right column headed 'exploratory comments'. This stage is non-prescriptive in capturing the researcher's thoughts during the initial stage of analysis (J. Smith, et al., 2009). To ensure that the exploration captures different levels of analysis in a comprehensive manner, descriptive, linguistic and conceptual elements within the transcript are considered. Some comments described certain words or events (descriptive), specific use of language such as idioms or change of grammar (linguistic) then moving on to interpretation by questioning what has been said by the participant (conceptual) (J. Smith, et al., 2009). I adopted a colour coded system of yellow (descriptive), green (linguistic) and blue (conceptual) to ensure that I conducted a detailed level of analysis within a free-flow approach. This approach enabled further immersion in the participant's lived experience as I worked through the transcript and my analytical thoughts of their experience (see Appendix H).

4.10.4 Developing emergent themes

This stage of analysis requires working from the initial notes and moving to emergent themes. Working with parts of the interview transcript and initial notes in chunks means the natural flow of the interview transcript is interrupted (J. Smith and Osborn, 2008). The emergent themes were documented in the left column of the transcript (see Appendix H). The emergent themes capture the claims or patterns and provide a higher level of abstraction. This a reflection of the hermeneutic cycle of working with 'parts' of the interview transcript and when put

together again, becomes a new whole (J. Smith, 2011c). The double hermeneutic is also present at this stage as the participant's original language and thinking is present but also the analyst's interpretation of them (J. Smith, et al., 2009). A shared understanding of the participant's lived experience develops. As a consequence, the chronological themes are more succinct and expressed through phrases to demonstrate this mutual understanding. During all stages, themes are revised, reworked or collapsed following a developed understanding of the lived experience. Documentation of the decision making is discussed in the reflexivity and audit trail sections of this chapter.

4.10.5 Searching for connections across emergent themes

At this stage, the whole transcript has been worked through chronologically and the emergent themes have been identified. The chronological emergent themes were copied into another document and organised into clusters (a case example of clustering themes is shown in Appendix I). This requires a mapping approach to identify patterns and connections across the emergent themes and super-ordinate themes (cluster name for the themes) (J. Smith and Osborn, 2008).

Each super-ordinate theme contained themes that emerged from individual cases and cross-case analysis. A super-ordinate theme provides a description or labelling of the emergent themes that have been clustered. There are different approaches to achieve this such as subsumption, polarization, contextualization, numeration and function (J. Smith, et al., 2009). Despite my researcher's position based on contextual constructivism, the contextualization method was not chosen. This approach is concerned with temporal themes and framing an understanding of the lived experience (J. Smith, et al., 2009) which I considered would result in framing the time events. I chose the abstraction method which considers the possibility of emergent themes having some similarities or shared meanings (J. Smith, et al., 2009). The super-ordinate themes were given a new name to capture the clustering of the emergent themes. This approach was selected for different reasons such as the research study's question and my researcher's approach to organising data.

This stage is lengthy as it is iterative in nature and encompass thinking and re-thinking about what has been claimed by the participant and their lived

experience. This involves ongoing checking of each transcript for: duplicated themes, themes labelled slightly differently or being labelled the same but checked for meaning to remove, re-label or identify new themes. This process completed the connection of emergent themes at a case level.

4.10.6 Moving to the next case

This stage requires the same approach to the one adopted in the first case. Following the same systematic approach maintains the idiographic commitment and rigour (Hefferon and Gil-Rodriguez, 2011). It is at the stage of 'looking anew' at each subsequent case that the attempt to bracket is required to encourage a trueness to each (J. Smith, et al., 2009). To support this, I captured further thoughts in my reflexive accounts to assist my own focus and clarity through the stages of analysis applied to each case.

4.10.7 Looking for patterns across cases

At this stage, each case was printed and placed on a wall. The wall provided wider, clearer thinking and 'seeing' across cases which assisted a conceptual approach to the analysis. This stage also leads to further reorganisation of themes and super-ordinate themes if they are evident in shared cases, known as convergence across cases (Hefferon and Gil-Rodriguez, 2011). This analysis is at a higher level because it requires a more theoretical approach. Patterns and connections, convergences and divergences were identified once all the interviews were analysed case by case and across cases.

Once the themes and super-ordinate themes were identified they were written up in a 'case within theme' style which required going back to the transcripts to check meaning and context, relabel, and collapse themes. This process took time with decisions and rationale being documented. A master table of themes (see Appendix J) was formed to capture the themes and how they 'sit' under their super-ordinate themes. This table assisted the presentation of results. The systematic approach undertaken at case level was adopted across cases to ensure rigour was upheld through the process.

4.11 Reflexivity

The terms reflection and reflexivity are often confused or used to mean the same thing (Bleakley, 1999). Reflexivity is a continual process of being self-aware, with reflection at one end of a continuum and reflexivity at the other. In order to become a reflexive researcher, I needed to engage with critical self-reflection (Finlay, 2003). Reflection focuses on generic processes whereas reflexivity is a detailed self-evaluative process (Woolgar, 1988). As a researcher, I recognise and acknowledge that reflexivity is critical reflection and a detailed self-evaluative process which requires a focus.

A researcher has to look introspectively first to gain insight about themselves and what they bring to the research process (Nicolson, 2003). Reflexivity is intersubjective reflection with mutual meanings within the research process but there has to be elements of critical analysis for it be effective (Finlay, 2003).

From an interpretivist/constructivist paradigm individuals have subjective contextual experiences (Shaw, 2010). This is coherent with both my researcher position and the principles of IPA methodology. Furthermore, as IPA is underpinned by hermeneutics, the theory on interpretation, the use of hermeneutic reflection as an approach to being reflexive is appropriate (Shaw, 2010). The researcher in this approach, is engaged in experiential qualitative research which encourages awareness. This is double hermeneutics where two individuals are making sense of a new understanding of the problems being explored (Shaw, 2010). Hence, the researcher attempts to make sense of the participant making sense of their contextual lived experience.

Researchers have their own experiences and engaging in research is another experience that is influenced by many layers of interpretation from the past and in the present (Nicolson, 2003). The researcher's interaction with participants provides more meaning for both individuals, which then requires more interpretation. This can be described as another interaction, experience and context which is not separated from each other and reinforces that reflexivity is not just done, or needed in research, but is required to be embedded (Shaw, 2010).

Reflexivity is often undertaken during both the data collection and analysis stages of the research process (Birks, Chapman and Francis, 2008). However, to develop this further, as a researcher, you must follow yourself in the research process by using critical reflection within a detailed self-evaluative process. This supports decision making and problem solving throughout the research process. 'Doing reflexivity' is not isolated activity and is used at every stage of the research process (Flick, 2014).

The qualitative interview can be the catalyst for thought provoking and emotional responses by both the researcher and participant because of the first-hand sharing and insight into the phenomenon. Engaging in reflexivity helps guide the researcher through the participant's understanding of their experience and the researcher's response to it (Silverman, 2009). This process helps the researcher to connect their preconceived ideas or assumptions with the here and now, how they can confront judgement or strong emotion that have been provoked and by doing so maintain rigour (Shaw, 2010). As a reflexive researcher, I adopted a conscious effort to engage in reflexivity before and after the interview, so I could capture my thoughts and feelings that occurred before, during and after the interview. By doing so I could identify how my engagement in the dual experience of sense making could influence further interviews and the analysis of them.

Reflexivity in the qualitative interview can help to manage bias and reinforces the need for analysis, respecting the different meanings that both the researcher and the participant brings (Nicolson, 2003). Reflexivity is about balance and focus and if that is not achieved it is likely to jeopardise the research process and its rigour. The researcher's subjective self-analysis in reflexivity is not a process for getting lost in or permitting an in-depth personal self-journey (Finlay, 2003). This reinforces the need for focussed critical reflection.

Reflexivity is individual and non-prescriptive (Birks, et al., 2008) but a framework is required to evaluate how the researcher brings and uses themselves in the research, and how this has influenced the development of the research study to the completion stage. The 'doing' of reflexivity in the research process demonstrates rigour. However, there is no right or wrong in applying reflexivity and every researcher will have their own way based on learning style, experiences or preferences. It is often demonstrated through narratives such as

diaries to capture any thoughts or feelings during different stages (Bolton, 2014). What it does mean that reflexivity is adaptable and flexible and used for a purpose for ensuring rigour. Reflexivity can also be part of the audit trail (Finlay, 2003).

My own reflexivity process started from the conception stage of my research study. It had evolved and developed as I progressed throughout my research study. Reflexivity started as notes and ideas were written down (Birks, et al., 2008). Later as I became more immersed in the experience, the frequency and depth of entries developed. This also coincided with my increasing level of competence and confidence during the different stages of the research process. I started to critically reflect on my thesis chapters and what the current literature presented and what it meant for me and my research. It was a constant ongoing evaluative process for both me as a researcher and my research study. It was the development of the interview guide and preparing to conduct interviews that influenced a change in how I captured my reflexivity. I started to audio record my critical reflections to enhance the free flow of thoughts, emotions and observations. I found when I wrote, it limited my thoughts and the focus became less on 'what' and more on 'how' I wrote it. I needed my reflexive accounts to capture what was really going on for me in that moment and how this would translate into my research study.

My framework was to consider what I was feeling and thinking before, during and after the interview. I considered what themes were generated and the dynamics between me and the participant. Some questions I asked myself: What do I think I brought to the interview? How would that influence the data? This personal framework was also used in subsequent reflexive accounts especially during data analysis. The use of reflexivity in the analytical process helped me evaluate what I thought, helped manage my fore-understandings, and how they influenced the findings. This sense making enabled me to manage rigour, bias and ethical principles.

The use of reflexivity highlighted the role of 'self' in research but also made me conscious of what I was not able to bring to the research process. This was predominantly related to competence and confidence. In this regard, I completed specialist training in IPA methodology; and I networked with IPA researchers at

a local, regional and national level for advice and guidance (Hefferon and Gil-Rodriguez, 2011). Training and networking assisted the development of the interview guide, preparation and conduct of the interviews, and understanding IPA principles and techniques.

4.12 Assessing validity

Assessing validity in qualitative research is achievable and in IPA methodology two generic qualitative approaches to assessing validity are considered favourable such as Elliot's seven main criteria (Elliot, et al., 1999) and Yardley's four principles (Yardley, 2000). Elliot's framework for assessing validity was not ideal as the fourth step in the criteria is related to credibility checks (Elliot, et al., 1999). This requires the researcher to check with the participant if the interview data was an accurate account of what was said. This method is adopted in some other qualitative methodologies to demonstrate rigour but does not meet the principles of IPA research. There is no purpose in checking with participants as the researcher is engaged in double hermeneutics (J. Smith, et al., 2009). This is a key theoretical underpinning feature of IPA methodology as the researcher is interpreting the participant's perceptions of their experience. I adopted the four broad principles by Yardley (2000) that include sensitivity to context, commitment to rigour, transparency and coherence, and impact and importance.

Sensitivity to context was reflected in the ethical safeguards that were implemented such as giving participants contact details for support services and a resource pack (NHS Direct, 2008). Sensitivity to context also guided the development and choice of research methodology.

The researcher is required to consider the design carefully to ensure the study from beginning to end is robust and of good quality (Flick, 2014). A purposive sampling and the process of recruitment required the use of referrers therefore provided sensitivity (Hammond and Wellington, 2013). Those bereaved by intimate partner suicide can be challenging to recruit and establishing rapport and maintaining networks with referrers were crucial. Furthermore, sensitivity to context occurs by conducting an efficient interview (Flick, 2014). This is evidenced in this research study by engagement with relevant training to develop skills and being reflexive. Establishing rapport with participants also fulfilled the

principle of sensitivity to context (J. Smith, et al., 2009).

Yardley's second principle to assess validity is commitment to rigour (Yardley, 2000). In this research study commitment is evidenced by an explicit path to appropriate study design, and close interaction with the data in both data collection and analysis methods (Patton, 2002). All interviews and their transcriptions were done by me to achieve a closeness to the participant's experience and was supported by ongoing reflexivity. Rigour was also achieved by appropriate sampling in relation to the research question, aims, and objectives (Curtis and Drennan, 2013). Additionally, thoroughness can be seen through a comprehensive approach to data analysis and a transparent audit trail of the analytical process (J. Smith, et al., 2009).

The third principle in assessing validity is transparency and coherence (Yardley, 2000). Transparency is demonstrated through clear and explicit steps taken in the research process (Griffiths, 2009). This chapter provided a detailed account of what was done, when it was done and why it was done. The audit trail complements transparency and coherence as part of the research process. The principle of coherence is also supported in the write up of the research study (Tracy, 2013).

Finally, Yardley's fourth principle in assessing validity is impact and importance (Yardley, 2000). As a researcher, this principle is ultimately about purpose and contribution. Exploring the coping experiences of bereaved survivors following the suicide of their intimate partner is an under-researched area and the findings will contribute to change by identifying useful coping strategies, informing the role of health professionals, and the development of better information and support services for survivors.

4.13 Audit trail

A researcher is required to provide an electronic and paper trail of evidence of what they have done (Moule and Goodman, 2014). The audit trail requires a logical and systematic order for someone to follow but also provide evidence of rigour (Hammond and Wellington, 2013). The trail should demonstrate the actions of the researcher and how they ensured that participants' views were represented truthfully and accurately (Woolgar, 1988). An audit trail is based on

ethical principles and doing justice (Griffiths, 2009). The audit trail needs to be transparent.

In this study the audit trail was evidenced by:

- Books containing notes and ideas;
- The supervision process and meeting records;
- Reflexive logs both written and recorded (Appendix B);
- A professional development plan based on the Vitae Researcher Development Framework (RDF) (Vitae, 2009);
- Attending relevant training events;
- Engaging in peer forums and discussions;
- Thesis draft revisions reviewed by supervisors;
- Final thesis document; and
- Maintaining a systematic, clear and coherent approach to records in different formats.

4.14 Conclusion

This chapter critically discussed different methodological approaches available to undertake the research study. A rationale was provided for an IPA methodology based on an interpretative constructivist paradigm which is related to my epistemological position. The design was discussed in detail with justification provided for decisions made. The principles of ethics, reflexivity and rigour were discussed and evidenced in the research processes. The next chapter presents the findings of this thesis.

CHAPTER 5: RESULTS

5.1 Introduction

This chapter presents the findings of this thesis. The details of the five super-ordinate themes that emerged from the study are presented. The findings provide a rich detailed account of the participants' lived experience of how they coped following the suicide of their intimate partner. The findings address the research question: How do bereaved survivors make sense of their coping experiences following intimate partner suicide?

The chapter will first provide a description of the approach to presenting the findings. The chapter will then provide some characteristics about the participants to give some context to their individual life experience followed by a summary of the results.

5.2 Presentation of the findings

The findings in this chapter will be presented by a 'case within theme' approach and follow a logical order of the participants' lived experience. This approach involves an outline of each super-ordinate theme and the themes clustered within them. Each theme attempts to capture participants' lived experience through a detailed narrative account of both the evidence from extracts of the participants' transcripts and the researcher's interpretation.

5.3 Participants' characteristics

Eight female participants took part in the study. Participant information was derived from both their social demographic forms (Appendix G) that participants completed at the recruitment stage and information gleaned during the interviews. The participants were aged between twenty and fifty-two years with an average age of 41. All participants were employed with an exception of one student and one participant being unemployed. All participants were British Caucasian with one participant being American and of mixed race. Participants have been given a pseudonym to provide anonymity. Firstly, participants' characteristics are provided (table 2) followed by case descriptions where each participant will be introduced by their pseudonym, the term they used when

referring to their intimate partner and the bereavement period at the time of recruitment. Any factual information presented by participants during the interview itself is reflected in quotation marks and the researcher has provided a narrative.

Table 2: Participants' characteristics

Pseudonym	Age	Relationship to the deceased	Relationship at the time of the suicide	Relationship length	Bereavement length	Mode of death
Louise	44	Wife	Living together	1 year, 1 month	13 years	Hanging
Annie	43	Wife	Living together	15 years	1 year, 1 month	Jumped from a cliff
Cheryl	20	Wife	Living together	3 years	1 year, 2 months	Not disclosed
Rachel	52	Wife	Separated	7 years	15 years, 3 months	Jumped in front of a train
Sharon	31	Girlfriend	Living separately	8 years	2 years	Not disclosed
Christine	47	Partner	Living separately	2 years	4 years, 6 months	Suffocation
Tracey	48	Partner	Living together	20 years	3 years, 4 months	Burning
Diane	42	Partner	Living together	1 year	3 years, 4 months	Jumped from a bridge

‘Louise’

Louise's partner was her husband and she had been bereaved for thirteen years. Louise and her husband were 'childhood sweethearts' but separated and went on to marry other people. Louise had three sons with her first husband. When her first marriage ended, she was reacquainted with her childhood boyfriend through a 'mutual friend' after many years. Louise learnt that he had problems with 'alcohol and drug use' and underwent rehabilitation. He used to 'make attempts

at killing himself'. Louise married her new 'husband' but was 'widowed within thirteen months'. Life together was happy and fun, and he loved her and her children. Looking back, she had a 'role as a 'carer' and described her husband as 'unstable and an alcoholic' but did not see it at the time. Louise 'actually found him' hanging from a tree but 'didn't see any warning signs' even though he had told her 'I'm not going anywhere'. Louise is currently married to her third husband.

'Annie'

Annie's partner was her husband and she had been bereaved for thirteen months. Annie and her husband had a son together. She described having a 'strong and good marriage' and they 'didn't really lead separate lives'. Annie's husband had 'anxiety for years' but it 'didn't affect his life all the time'. It got worse 'six months leading up' to the suicide and Annie became 'more of his carer'. She found it 'hard to deal with him'. He had 'threatened suicide' and also received 'support from mental health services' over time. Leading up to the suicide he seemed a 'bit happier and kept to his normal routine'. On the day of his suicide Annie stated, 'He didn't return and I didn't think anything of it'. Later, the police confirmed that he had jumped from a cliff. It was 'out of the blue' because no one thought he really would.

'Cheryl'

Cheryl's partner was her husband and she had been bereaved for fourteen months. They married young after being together for two years. They were married for one year. Cheryl was busy with work and studying and 'paid the bills' and did everything' and in her opinion, he was 'lazy' but also provided her with 'relaxation'. Cheryl's husband was diagnosed with 'bi-polar depression' and 'started medication'. Around the time of his suicide Cheryl recalled thinking he was in an 'amazing mood' and 'talked about how the year was going to be amazing'. Cheryl found this 'refreshing' and thought they were in a 'good spot'. Cheryl's husband died by suicide in their apartment.

'Rachel'

Rachel's partner was her husband and she had been bereaved for fifteen years and three months. Rachel had a brief relationship with her husband previously,

but they got back together a few years later and got married. He had an 'underlying personality disorder', 'chronically alcoholic' and 'had tried suicide many times before'. Alcoholism caused a 'lot of the problems' between them. They went 'through various separations' and Rachel reported a 'physically abusive' element to the relationship but more 'mentally abusive'. At times life with her husband was 'chaotic' and his 'bizarre' behaviour sometimes caused embarrassment for her at work. Rachel felt they were 'happy in each other's company' and got on at 'an intellectual level'. At the time of the suicide they were separated but planning to 'get back together'. Rachel was informed by the police that her husband 'thrown himself under a train'.

'Sharon'

Sharon's partner was her boyfriend and she had been bereaved for two years. Sharon was in a long-term relationship with her boyfriend and had known him for some time previously. They lived separately and were planning to move in together. Sharon worked 'long hours' and spent most of her free time with her boyfriend at his place. She had lost contact with friends because of 'time' and because how their relationship was. Sharon 'thought it was depression' but 'couldn't quite figure it out'. He seemed to have 'silent moods' but would 'snap out of it' if a friend called. Sharon thought she 'caused' the moods. At the time of the suicide Sharon had a 'kind of feeling' that things were 'coming together' as they viewed homes together.

'Christine'

Christine's partner was male and she had been bereaved for four years and six months. Christine and her partner were long-term friends before entering a two-year relationship together, they lived separately. Christine's partner was 'funny' and the 'sanest person' she ever knew. There was not 'any evidence of mental illness' but Christine suspected there were 'clues' when they 'rowed' or when 'he need to talk about when his mum died'. There was an incident where he behaved badly and did the 'testing thing'. Christine took a 'break' from seeing him as she had just started a new job. After resuming contact, he made her 'angry' and she left. Christine had received a message from her partner saying that he left her a 'note' and she went to his place and found him with a 'bag taped around his head'. Christine was not her partner's next-of-kin and his brother blamed her 'completely

for the whole thing' and was 'not allowed any input in the funeral'.

'Tracey'

Tracey's partner was female and she had been bereaved for three years and four months. Tracey had been in a long-term relationship with her partner and recently moved to a more insular community leaving their previous social network behind. They did everything together and Tracey wanted something for herself as she 'did not have anything'. Tracey felt their relationship was 'co-dependent' and not 'healthy'. Tracey's partner 'had a history of post-traumatic stress' and 'suicide attempts' with ongoing 'physical problems'. Tracey became her 'carer' and took her to her 'multiple appointments' while working 'full-time'. Tracey reported that the day itself seemed 'mundane and normal' and planned to have dinner at home cooked by her partner. Tracey's partner set herself on fire in the garden and Tracey attempted to put it out and called the emergency services.

'Diane'

Diane's partner was male and she had been bereaved for three years and four months. Diane was friends with her partner for years before having a one-year relationship with him. Diane had started a new full-time job and her partner was 'stressing about a change of jobs'. In a very short amount of time he 'completely' changed and became 'not very communicative at all' and 'stopped sharing his feelings and thoughts'. She was not his next-of-kin as he was still married to someone else. His former partner notified Diane of the suicide which was later confirmed by the police. It was 'three months' before his body was found after he 'jumped from a bridge' and during that time it was 'horrific'. Diane never 'got any sense' that he had 'any mental health condition' and/or 'suicidal' tendencies. After the suicide, Diane lost friends as they 'no longer wanted to be friends' and was 'harassed' by his former partner.

5.4 Summary of results

The analysis identified five super-ordinate themes: manageability, attaching meaning, relating to others, changed perception of self, and changed philosophy of life which captures the interpretation of the participants' coping experiences following the suicide of their intimate partners. The themes clustered under the

super-ordinate themes are summarised in Table 3.

Table 3: Summary of results

Super-ordinate theme	Themes
Manageability	<ul style="list-style-type: none">• Reactions to suicide-related grief• Supporting self• Helpful support offered by others• Unhelpful support offered by others
Attaching Meaning	<ul style="list-style-type: none">• Rumination• Motivation to survive• Changing relationships
Relating to Others	<ul style="list-style-type: none">• Need for a humanistic approach• Identifying with other survivors• Developing compassion for others
Changed Perception of Self	<ul style="list-style-type: none">• The changed self• New possibilities in life
Changed Philosophy of Life	<ul style="list-style-type: none">• Appreciation of life• New priorities• Living in the 'here and now'

5.5 Super-ordinate themes

The super-ordinate themes will be presented in the following order: manageability, attaching meaning, relating to others, changed perception of self and changed philosophy of life (as shown in Table 3). The order of these super-ordinate themes reflects the journey of participants lived experienced following the suicide of their intimate partners.

5.5.1 Manageability

The super-ordinate theme of 'manageability' illustrates how the participants managed in different ways following the suicide of their intimate partners. All participants reacted to the suicide and coped by 'managing' activities and relationships in their daily lives. To support their coping, all participants described being offered helpful and unhelpful support which contributed to their individual coping experiences.

5.5.1.1 Reactions to suicide-related grief

Reactions to suicide-related grief varied for all participants based on their individual experiences. These included previous experience of mood related symptoms, suicidal ideation, and psychological and physical reactions. Rachel, Christine and Diane talked about having depression before their partners' suicide and how it impacted on their coping after the suicide. Rachel in particular, talked about how her partner's suicide triggered a depressive episode that necessitated inpatient care and continued to affect her life for many years later:

Rachel: Yes. I mean I hadn't had the depression for quite some time before he died. But after he died it really set in very badly and it's continued now for nearly fifteen years and I, I still have regular treatment for it. (Page 9/211-213) ... Erm, I, when I, I, when Adrie died I was admitted to hospital. I went to Hospital Z which I'm still treated, treated by. (Page 12/277-279)

Depression symptoms were a comfort for Christine in some way because they were familiar, enabled her to withdraw, and not have to manage her new life circumstances. She talked about receiving treatment and how it did not help her. Her bout of depression following her partner's suicide was very distressing:

Christine: It's much more comfortable I think, to be depressed. Having been depressed, I know what it's like. I think it's, and I know it's not easy, but you can, I believe, with effort, scoop yourself out of it before you get there. Well I can. I know a lot of people can't. (Page 19/476-479) ... That distressed, I was on, what did they give me? I think she gave me two point five milligrams by mistake. It's a lot, isn't it? So, I was taking a couple of those and ten milligrams of a benzodiazepine and still running round the house screaming like a loony. It didn't help me at all. (Page 5/124-127)

Diane talked about grieving rather than being depressed. However, Diane explained further that her grief was changeable and she began to view depression as an inevitable outcome. She knew the signs because of her previous history of depression:

Diane: I suppose I was, I was grieving as opposed to being depressed but I, you know, th- the kind of end result was the same thing in my mind. Erm, and I did become depressed eventually. I g- I did suffer from depression and still do. Er, about a year after it happened, erm, because I've suffered from depression in the past, I knew it. I picked it up. (Page 14/373-377)

Diane later talked about how her depressive symptoms developed further and she was diagnosed with Post-Traumatic Stress Disorder (PTSD). The symptoms of major depression and severe anxiety adversely affected her ability to cope with her partner's suicide as well as other issues at the time. Her reference to the length of time and impact of her depression demonstrates how impactful her depression was:

Diane: Erm, I was suffering from PTSD at the time and all sorts of other horrible-iss symptoms that I was experiencing because of what had happened and that was obviously making it, you know, a lot, lot worse. Erm, so I, I was, I was pretty much on my knees for a long time and it took me a long time to work my way back from that. (Page 6147-151)

Post-traumatic stress type symptoms were also described in response to suicide by Cheryl and Tracey:

Cheryl: Really, [Sigh] right now it's just getting through the day without I guess panic attacks, without flashbacks, without anything to do with his death then I am happy. (Page 1/19-21)

Tracey: Can I just say I, er, I've had flashbacks to that and particularly, erm, strong smells and talking about burning... (Page 6/156-157)

Tracey then explained how she was frustrated and resistant to medication. She felt that her experiences of deep sadness and low energy were in response to the suicide rather than an acute mental illness:

Tracey: All they were interested in was getting me on anti-depressants and it's like I just wanted to scream at them. You know, it's a reactive, it's a reaction to something that's happened.
(Page 6/147-149)

Interestingly, Tracey later described how her reaction to her partner's suicide prompted suicidal ideation because of the guilt she felt. She later realised that her grief reaction was more serious as she considered taking her own life:

Tracey: And I think also I [Sigh] struggle with the guilt because I wasn't there for her and I let her down and I actually did have suicidal ideations afterwards.
(Page 11/291-293)

Suicidal ideation was also experienced by Sharon and Louise but they mentioned different motivating factors that prevented their own attempts at suicide:

Sharon: And so obviously, you kind of, you think about suicide yourself a lot but the thing that's kept me going through it all I guess is, it's weird, it's like because it's like, it's like he's kept me going even though he's not here.
(Page 26/678-691)

Louise: Without my kids, I wouldn't be here and I, I mean that, hand on heart. If, the, the amount of times I contemplated suicide myself afterwards was unbelievable and it becomes a fixation in your head. So it's suicide, suicide, suicide. All the time.
(Page 19/476-479)

Louise described further the psychological nature of her reaction and how painful it was. This suggests that her pain was somatic in nature as her body as a result of repressed emotions:

Louise: Erm, it was very difficult at the time and, even thinking back now, I can't even describe the pain of what happens. You have this disbelief. It is raw. It is like somebody has put their hand down your throat and ripped your insides out.
(Page 1/10-13)

Sharon's shared her experience of a severe psychological reaction but couched this in terms of a shock and feeling disconnected from her surroundings:

Sharon: I think the months like I swear for months at the beginning I was just in shock. Like I found that I kind of couldn't feel anything like I was

like saying to a friend it's like as if you know like if there's a bit of an explosion you can lose your hearing and your sight and it's like, you know, people say that, you know, just for a second you really can't hear anything for a while or there's just, you know, just white light and then slowly your sight and hearing comes back. (Page 18/462-468)

Sharon later described that these symptoms of dissociation impacted on her ability to function in her daily routine. There was a sense of being 'taken aback' by her inability to do very simple and limited activity:

Sharon: I can't even remember, like the weeks, months, some days I just couldn't even function like, you know, all I could achieve in a day was, you know, it was an achievement if I'd get up and have a bath and that was it and then I'd be tired and then I'd want to go back to bed. (Page 12-13/315-318)

Reactions to the suicide event were also physical as described by both Louise and Cheryl. Their physical symptoms contributed to sustained loss of appetite and significant weight loss. Louise reported a dramatic weight loss in a short amount of time:

Louise: I went from probably being a size eighteen down to a size ten within the first few months. That, I couldn't eat. The thought of eating just absolutely, no, forget it. (Page 18/445-447)

Cheryl's account focused on the severity of the impact on her health and how long it took to get back to her usual self:

Cheryl: I mean right after my health was just completely deteriorated in shambles and only now am I able, you know, to be eating properly and working out properly and getting away from the medicines and getting my body on track so it definitely had an impact on me. (Page 28/669-672)

Annie, in contrast, did not talk directly about her reaction to her husband's suicide but described engaging in behaviours that masked how she felt. Annie also believed she had not, as yet, grieved and remained in anticipation of suicide-related grief:

Annie: They know that and they know that the, the smiley face isn't always what's, what's really going on. Page 8/212-213 ... I've accepted that he's

not here, erm, and that what happened, happened, erm, I don't know that I've dealt with what he did yet. (Page 11/283-284)

5.5.1.2 Supporting self

All participants described different ways of managing their daily lives following the suicide of their intimate partners. Participants supported themselves through routines, occupation, behaviours, seeking information and engaging in different activities. Having a routine was particularly important for Louise, Christine, Annie and Diane. Louise already had a routine but unlike other participants, she needed to deliberately change her routine because continuing with her previous daily routine was painful, and potentially linked to reminders of her husband and the routine they once shared:

Louise: You had, breaking the routines had to be, erm, you couldn't keep things the same because it was too painful. (Page 45/1134-1135)

Employment provided Christine with a routine outside the home. Her daily routine and interests, however, narrowed significantly. Christine described that going to work was all she did apart from sleeping. This new routine gave little room for other activities but there was no inference that this lack of work-life balance was an issue for her:

Christine: Erm, do you know, I can't think of anything I was doing other than working. I really can't. I would have been sleeping because we used to do long days so we do three long days and a day off. So, I would have been basically asleep. So, sleep and work really. (Page 8/198-201)

Employment also provided routine for both Annie and Diane who shared a need to return back to work after their partners' suicide. Annie found herself desperate to leave the house and would have returned to work sooner if not for medical advice:

Annie: Yes. I, I was desperate to get back to work really. My Doctor wouldn't let me go back for a while but, yes. (Page 26/635-636)

Like Annie, Diane had a need to get back to work quickly. Their accounts implied a need to avoid thinking or feeling emotions about the suicide. Work environments would provide distraction. Diane questioned if she was really ready. She was not sure if she actually coped at work but believed that being at work regardless of her performance was important, suggesting that being occupied was a key factor in her coping:

Diane: But the fact that I managed to go back to work four weeks later, erm, you know, I wasn't really back on it in terms of my job but I managed to sort of scrape by. I suppose means that I probably did cope with it reasonably well but it was, it was so all consuming it didn't necessarily feel like that at the time.
(Page 15/397-401)

The notion of forward planning was reinforced by Sharon, who talked about being busy with events and future activities and the sense of security that these plans created:

Sharon: Because also with both of those trips it's, it's partly just getting away from it all so it's, they both required a lot of planning to go before so it just kind of keeps you busy doing stuff. Erm, so I think by putting, putting dates in the diary for stuff to do so it's not just a big kind of endless gap of nothingness is good.
(Page 17/434-437)

On a short-term basis, Annie used a similar coping strategy by planning activities for her days off. Annie highlighted that having nothing to do could be lonely and she attempted to always have something to do. Being with others alludes to the notion of keeping distracted:

Annie: Erm, I didn't spend a day off on my own for the first six months probably. I always had something in the day. So whether it was meeting somebody for lunch or coffee or whatever, there was always something.
(Page 5/127-130)

Behaving in a particular, structured way was shared by Cheryl, Tracey and Louise. Cheryl described how her 'normal' behaviour was observed by others as a benchmark for them to suggest she coped. Cheryl was not always 'okay' despite how she appeared, but suggested that appearing as her normal self, facilitated a return to her usual self over time:

Cheryl: They have said extremely, extremely well and all this but, you know, I think that part of it is faking it until you can make it. (Page 20/485-486)

Tracey talked about forcing herself to do things but with the intention of punishing herself. However, as a consequence of repeating her forced behaviours, she found that the activities were no longer a punishment and in fact helped her. Reaping some benefit from this was a complete surprise as her intention was to make herself suffer:

Tracey: I'd walk through the town. I'd, you know, challenge myself, not challenge myself, force myself to do things. In one way, it was like a punishment but the paradoxical effect is it enabled me to actually move forward which has been difficult to actually, yes, come to terms with because it's like that self-punishment has been the thing which has actually got me through it which, y- I mean, yes, it's almost like self, you know, it's almost like, erm, self-harm being a good thing. (Page 11/306-312)

The behaviour of selectively sharing experiences with others was a coping strategy that Louise adopted. She became worried about what people thought about the comments she made in relation to her partner. She normalised her thoughts and comments about her husband as a part of her grief but remained wary about the opinions of others. This protective behaviour may be attributed to possible consequences of sharing her real feelings:

Louise: I don't want to be here and I just want to be with James. I just want to see James, you know, that kind of thing. I would say things like that, erm, but I was very wary about things that I said and I know when I went to, erm, maybe at first I wasn't but then you became aware that people are looking at you and thinking, you know, she's cracking up, you know, and things like that and it wasn't. I just think it's the grieving process. (Page 28/692-698)

For some participants, undertaking an activity was an effort but external factors could be helpful. Rachel talked about doing very little but was able to walk her dog:

Rachel: Days where I just, I just don't do anything at all. I just stay at home and I can't be bothered to do anything other than maybe take the dog for a walk or there are days where I don't do housework. (Page 8/182-184)

Louise talked about how she needed to collect her children from school each afternoon but had to use an alarm clock to prompt her:

Louise: I used to set an alarm for quarter past three in the afternoon so I, I went to pick the kids up from school. (Page 19/466-468)

Cheryl coped by thinking about how the external world was still there and required her participation, but she also highlighted the need for protected time to grieve:

Cheryl: Oh, definitely like, erm, because, you know, I say I like to have my grieving days and get down but maybe there's a day where I have an exam or I have to go to work and there's not that option, you know, the world doesn't stop just for you grieving. (Page 21/501-504)

Being well informed was useful for both Cheryl and Diane. Diane needed lots of information so she could understand more about suicide and how she could help herself. The varied emotions were an unusual and fearful experience. Being informed provided some reassurance that she was not alone in her experience and that what she was experiencing was normal:

Diane: I wanted to soak up information. I wanted to try and understand why this had happened as much as I could and I found it incredibly helpful and it does feature stories, people's stories of how they were moved and how they dealt with it, what they found useful and the, the emotions that you're going through and... It just kind of made me feel, okay I'm not a freak that I'm feeling like this. So, one minute I'm angry, next minute I'm incredibly feeling guilty for feeling angry, the next minute I'm- and it's like a, I don't know. It's like a pinball machine. You're being shot all over the place all the time, erm, and that just helped me to understand that that was normal and I was going through exactly the normal process, which was helpful. (Page 9/241-251)

Sharon also found advice from other suicide survivors who had lost their partners helpful. Their advice provided hope:

Sharon: Mmm. I guess, also I, erm, I went on to a, I found an online forum and that was for people that had lost partners, not just like it was for any kind of cause of death, erm, but I found a lot of stuff on there, quite, er, helpful and a lot of that was even just people talking about, it wasn't necessarily how, you know, advice on how to get through it. (Page 15/384-388)

The nature of some information sharing was not helpful to everyone. Rachel, for example, decided to start sharing her own experience online because the focus of the support groups she accessed did not offer a positive way forward for her:

Rachel: And I frequented that for quite some time. Erm, but I found that that was a little bit too, erm, too depressing because it focused on death all the time. So, I branched out and I actually founded my own support group which I think I mentioned to you and, erm, I ran that for about six years and I, I, I, through that I met an awful lot of people worldwide and it helped me and it helped them.
(Page 10/222-227)

Louise described how her mood impacted on her ability to engage in usual activities; how her mood was not always helpful and could result in frustration. Her perseverance in using some coping strategies did help her in some way:

Louise: Certainly, in the early days, what helps you cope one week might not another week. I know certainly with my writing I threw books at the wall and never said I'll write, I won't write another word. Erm, but, yeah, I did go back to it.
(Page 60/1566-1568)

Different moods, particularly anger and frustration, influenced Christine's behaviours. Her moods were also influenced by alcohol, but were part of a destructive coping behaviour pattern:

Christine: Lots of alcohol. And after the plate glass window kicking in accident, accident, incident. I did it on purpose, I wanted to smash something and I wanted to smash it again. I went on an anti-depressant grudgingly because there was nothing else.
(Page 13/331-334)

Louise also used legal stimulants to cope:

Louise: I coped with coffee and fags probably.
(Page 57/1468)

Some other participants discussed adopting positive strategies to help support them through their suicide-related grief. Annie reported that she used positive self-talk and focused on what she had achieved particularly when her mood was low:

Annie: And so, feeling sort of down, erm, and I find looking for the positives helps me better so, so thinking, 'Yes, actually I've hung a picture today. I'm, I'm, I can do this,' or 'I've sorted out the, the roof, the hole in my roof and I've done it on my own,' or managed to buy a new car without anyone's help.
(Page 9-10/237-241)

For Cheryl, positive coping strategies included exercise and making sure she exercised regularly as it helped regulate her feelings:

Cheryl: Yes. Normally I, I have to work out. That is my release. (Page 2/27)

Both Christine and Tracey talked about how they regulated their feelings by being able to recognise them and supporting themselves with helpful strategies. Christine adopted several strategies and while these strategies helped her, she believed she would never be her normal self again:

Christine: But I recognise, because I'm not on the fluoxetine any more, I've been off that a couple of years, but I recognised in my head when I'm going to start getting like that and I can take measures whether it be a long walk in the countryside, a razz and a dance, a read, a scream, a run down to the beach and throw stones at the sea, I can kind of pull myself out of there but I don't think I've ever got back to being completely okay.
(Page 19/479-484)

Tracey adopted mindfulness techniques which facilitated acceptance of her feelings. She alluded to experiencing negative feelings or thoughts and the need to be alone at the time:

Tracey: Erm, but afterwards I just need to, I, I disappear and I go into the staff room and I just literally stare at the wall or stare at the tree out of the window and I practise that, mindfulness and I just allow whatever I'm feeling, whatever I'm thinking, I just accept it and just feel it and I don't not try and fight it or, you know, if I cry, I cry right if I don't, I don't.
(Page 20/566-570)

5.5.1.3 Helpful support offered by others

Various forms of support offered by others was discussed by all participants. Helpful support generally was underpinned by the notion of 'time' and included availability and flexibility of others. Support was offered by professionals,

community figures, employers, colleagues, relatives and even strangers. The concept of time underpinned the help received by Christine, Diane and Rachel. For Christine, the concept of time was about having someone available to talk to and the unconditional support she received:

Christine: I rang the Samaritans quite a lot. I would be on the phone to them for every excuse like the cats [Laughs]. (Page 13/321-323)

Being able to just talk with no time restrictions was beneficial for Diane:

Diane: Erm, and then I spoke to the woman that ran that group and, erm, a lady called Veronica, and she was amazing and I must have been on the phone to her for about three hours. Huh, poor thing. On a, on a public holiday. (Page 6/165-168)

Rachel talked more about support being available and timely. She also mentioned how this support had also been continuous over time with no expectations for financial compensation:

Rachel: She saw me within a week of Adrie's death and at that time I had private health care and after seven years my health care ran out and she has continued to see me ever since it ran out, free of charge. (Page 15/354-356)

Continuous support was something that Cheryl valued from her mother who was always there for her unconditionally:

Cheryl: You know, I'm like I would be fed up with me if I were you and she just laughs and, you know, goes on caring about me. (Page 19/456-457)

Rachel and Louise both talked about the value of unconditional support, albeit from different sources:

Rachel: she doesn't understand my depression per se, she gives me the unconditional love that only a mother can give and nobody else in my life has been able to do that. (Page 15/348-350)

Louise: My statement with Peter, because everything was quite complicated, took three days to do one statement and, erm, I know, you know, he was 'ring me any time'. He was absolutely brilliant. (Page 25/604-607)

Other participants, such as Tracey, didn't need such explicit support but needed to know that someone was looking out for her and support was available. There was a sense of vulnerability when expressing emotions or appearing to be needy:

Tracey: Don't do emotional strokes, erm, and I certainly don't ask for them. And in fact, if people give them I actually feel uncomfortable but it's that recognition and somebody actually saying, 'I can see you're struggling today. Is, do you need anything?' and I'll go, 'That's all I needed.' That, that's, you know, the fact that you've realised that I exist, you know, and, yes. (Page 19/531-536)

For some participants, support was received from people in their communities. Louise talked about the village community being protective and trying to safeguard her privacy:

Louise: It's, you know, the village where I was, was fantastic. They closed ranks completely, you know, erm, we had reporters around, nobody would say a thing, you know. Mind your own business. You leave her alone. No we don't know where she lives. (Page 37-38/935-938)

Unexpected support from strangers was also received by Christine, Louise and Cheryl, which was helpful to them. Christine had not told anyone about the suicide with the exception of a person previously unknown to her. The anonymity of talking to a stranger created a sense of relief as she talked:

Christine: So she was just like this complete stranger and one day we were walking across town Y and I came pouring out to her so. So she was good. She was like the only person there that knew. (Page 14/349-352)

Louise was touched by strangers' thoughtfulness and kindness, particularly from those who were from vulnerable age groups. Acts of unexpected kindness reinforced a sense of genuineness:

Louise: The cards I got from people and the cards I got from total strangers and I, I know there was once I got an envelope which had ten pounds in it and it just said, 'Get something for the boys.' And it was obviously an old person who'd written it because the handwriting was really shaky and things like that. (Page 38/949-953)

Acknowledgement of helpful support that at the time was unrecognised due to timing or context was highlighted by Cheryl:

Cheryl: I'm, I'm not ready for that at all but I realised that someone had come to the site for me when everything, you know, when it happened at, I th- it was like eleven pm when he or when I arrived and so, to know that someone would come out that evening to help me. I, I didn't even know that was a service I was even using. I mean at that time you're not thinking about that at all but just thinking oh my gosh they, that guy completely made a difference. (Page 16/368-374)

There were elements of surprise in how supportive some people were which led to ongoing friendships. Repeating the word 'amazing' reinforces how valuable and beneficial the support was:

Diane: My, my boss became, erm, through this situation, he became a very good friend of mine and he was absolutely amazing. He was, he was probably the most amazing support through all of it, which I really didn't expect. Erm, so that was sh- that was a surprise to me but, erm. Very quickly they rallied round as a support network even though I'd only known them for an incredibly short period of time. (Page 16/436-431)

Support from employers was also received by Annie, Sharon and Tracey. Annie and Sharon received more formal support in assisting their return to work. Annie used 'we' and was probably referring to her son as well as herself in regard to resuming their lives. There was a tone of achievement in her account:

Annie: I did a month's phased return at work where I had admin rather than patient contact but from early March we were, we were back. (Page 26/642-644)

Sharon: Work were actually very, erm, they were quite supportive. They're very good in that, like, well I was just off work for four months, I think. I think it was in total and then when I went back they let me go back for the first three weeks just part time. (Page 16/418-421)

In Tracey's professional role, she acknowledged the informal and sensitive support she received in the workplace when she found it difficult working closely with patients who were suicidal. Her senior colleagues on duty would accommodate her needs and be flexible by reallocating duties for her:

Tracey: I had a patient who was particularly suicidal and was quite openly talking about it which is the unusual bit and they put me down for this to actually be this person's nurse for the day and it was like no. It took the person a minute just to realise why and then suddenly you could see the penny dropping and they were able to say, 'Actually, ah, okay.' I'll give you somebody else and somebody else can deal with that person. (Page 20/550-556)

Tracey explained further how flexibility in the health services she accessed was very helpful. Such support involved minimizing her waiting time when she needed to see the doctor, and encouraging her to make regular, face-to-face contact:

Tracey: Anyway, I had that, that was okay. I had to come in the next time. They wouldn't let me do it over the phone again so she just said, 'Come in any time today,' she says, 'Come in, just tell me who you are and I'll just get you in,' and she did that for me because they insisted I went every week to the Doctor and I'd just turn up when I could and she, she'd get me in and, and there were no questions or anything asked. (Page 16/427-432)

Annie also found her doctor flexible and quick to respond:

Annie: My GP was fantastic. She, she wasn't in on the Monday so she didn't find out until the Tuesday when she went in and she rang me. She came round. She spent forty-five minutes with us. (Page 4/96-98)

Receiving help at home for Annie extended further to other practical forms of support. The help Annie received to run the household relieved some of her burden:

Annie: I, I, erm, sort of about once a week somebody would come round with a big sort of bag full of meals and just stuck them in the freezer. So, I didn't have to think about that. (Page 7/185-188)

Christine described the value of receiving practical support from her sister who

helped with her daily living and emotional needs. Being alone was unbearable:

Christine: She would make sure I was eating, for a start. Made sure I was going to the doctors. That kind of thing. Just holding my hand or a couple of nights would be with her for about a week and I just couldn't be on my own. I had to sleep in the bed with her. I just couldn't be alone. It was just too bad. (Page 8/186-189)

Sharon also shared how her needs were supported by her doctor who provided care from a holistic perspective:

Sharon: So, he was kind of like, because I saw him almost every week he was kind of like holding my hand through it and how little things changed and what, what. So, he was kind of looking at the whole thing. (Page 28/729-732)

Receiving information from various sources was significant for Annie, Sharon and Tracey. Annie mentioned a resource that prepared her about what to expect and what would happen following the suicide of her husband:

Annie: I can't remember what it's called, Help is at Hand, which was, was a really useful resource. (Page 4/101-102)

Sharon received information directly from experts to help her make sense of her partner's suicide. Receiving factual information could mean she was able to relinquish some blame:

Sharon: I went to their annual meeting which was like a daylong kind of workshop where they have, erm, kind of, they have someone, erm, she was at University X and she researches into like causes of suicide and she kind of came and talked and there were some other people talking and I kind of felt that very helpful because it was kind of a scientific kind of side to it and also because where she'd done so much research into it... (Page 14/357-362)

Receiving information from 'third parties' was essential for Sharon. A priest also helped her to understand more about death and she was reassured by this. Their relationship with her was seen as impartial, yet underpinned by an ability to confide which seemed important:

Sharon: Erm, [Pause] I think the Priest because at first I was very kind of

like, like panicky, like, because the whole act, kind of act of dying and what happens to you after and stuff I was quite panicked and didn't know what to do, erm. Er, I think he was also quite good I guess with them because they are, both of them I guess, the Priest and the counsellor, they're, they're not people that are invol- like they're third parties.
(Page 13/336-341)

Support from someone impartial and external to her workplace was also important to Tracey. She referred to her 'paranoia' and attempt to minimise gossip in the workplace:

Tracey: I phoned Occupational Health and I basically went, I didn't, I just told them I needed to see, I needed to see a counsellor. Erm, but I said, you know, I don't want to see anybody in house because again that was back to the paranoia and the fact that, you know, everybody knew.
(Page 17-477-480)

5.5.1.4 Unhelpful support offered by others

All participants discussed receiving unhelpful support from others. Unhelpful support included barriers to support, types of communication, limitations of support and unmet expectations of services and people. Barriers to support were mentioned by Christine, Diane and Tracey. Christine, in particular, experienced difficulties accessing professional support because of her shift work patterns and a lack of support from her workplace. She felt pressured to return to work but also suppressed from talking about the suicide:

Christine: I'd just started my first nursing job at a hospice in town Y and they were badgering me to come back to work. I did have four months out but when I went back to work I said I need to find some counselling or some bereavement counselling or something. And everybody does it, it's a set day, it's a set time, that's how counselling works. And I said to them please can I have X day off every week? No. By the way, please don't tell anybody what happened.
(Page 4/97-103)

Diane only managed to access support by being on sick leave at the time:

Diane: It was a, it was a drop-in, erm, reception. It was in the middle of the day but at that point I was still signed off work. I wasn't at work so it was okay.
(Page 10/261-263)

Diane and Tracy had also tried accessing different sources of support but encountered barriers of distance, availability, and lack of options:

Diane: Oh no, I rang the Head Office, that's right, and asked them for my nearest group which was over an hour and a half drive away. That was the closest.
(Page 6/163-165)

Tracey: I got told if I wanted to see counselling it would be six months' waiting list so I wouldn't be able to see anybody. I couldn't contact, the, there was nothing else they could do for me.
(Page 16/450-452)

Diane was able to obtain counselling quite quickly through privately funded sources and talked about the financial implications for her. She mentioned being disappointed and unsupported:

Diane: Erm, and, yeah, so the rest of the time I, I think I must have been, I found a counsellor quite quickly myself, erm, and I think I must have had counselling for pretty much a year. I spent an awful lot of money on it. Erm, so, yeah, I'm not particularly happy that I had to do that myself to that extent. I would have liked to have help in, you know, some other way but that was, that was the only route that I could find at the time that would work for me.
(Page 9/251-257)

Christine's legal status in relation to her partner proved to be a barrier to receiving help. She also mentioned how depersonalised the legal system felt and how that contributed to her distress, even impacting on her grieving.

Christine: Yes, because I just think there is. There seems to be nothing for people in my situation. If we'd have been married or we'd have been living together I would have got help. Because I wasn't his next-of-kin, and it's a horrible thing to know that when, once you're dead that body belongs to your next-of-kin. Did you know that? That's legally the, you are legally their possession once you're dead. (Page 21/527-532) ... Yes, I would love to ring the bank, yes I would absolutely love to go the registry office and get ten copies of the death certificate. That would be lovely. I'd love to organise the funeral. Love to tell the benefits office. I'd love to tell work but I wasn't permitted to do that.
(Page 7/166-170)

Feelings of being disregarded, insignificant, and lacking control was extended in the workplace for Christine as she was being policed and monitored:

Christine: I had two mentors but they were more interested in controlling me and making sure I didn't say the wrong thing. (Page 14/352-353)

Louise and Sharon found that some people chose to avoid talking about their partner's suicide all together. Louise used an idiom to amplify how problematic and difficult this was:

Louise: People who thought they were trying to be helpful by pretending James never existed. That didn't sit well with me, you know, having a conversation and it's the elephant in the room. Nobody mentions him. (Page 36/899-901)

When Sharon returned to work, she expected some communication both informal and formally in the work place but did not receive any:

Sharon: Erm, and the weird thing is, is, since I've kind of gone back it's like no one has said anything ever. Like I kind of expected HR to email me or something but they never did. (Page 16/421-423)

While participants described many examples of sensitive and caring communication, not all communication was positive. Insensitive communication, whilst not deliberate, was not helpful. The laughter reflects Sharon's disbelief:

Sharon: Like someone who was saying to me, I think the week after his funeral, saying oh, so, what are you going to do with all his stuff? Er, if it was me I'd want to get rid of it all. I can help you do a boot sale if you want. There's one coming up soon. So I was like, no. [Laughter] I just, and then, I don't know like there's, I think and I guess it's just, it's people like, and I do know people don't mean bad. (Page 16/398-403)

Insensitivity from professionals was evident too. Diane discussed one particular exchange that had ramifications for her access to counselling services as well as contributing to feelings of hurt and powerlessness:

Diane: And he said, 'Well, you could go and see a charitable bereavement service. The problem is we don't actually know that you're bereaved because, you know, his body hasn't been found.' Which I thought was an incredibly insensitive thing to say but at the time I was so upset that I just kind of walked out and went, 'Okay, fine,' and accepted it. (Page 8/225-229)

Tracey experienced insensitivity from medical staff. Her care by medical staff was further hindered by a lack of continuity of care. Having a different doctor at each appointment meant that Tracey needed to go into great detail about the suicide over and over again. Ultimately, this constant retelling added to her distress, and left her feeling devalued and possibly discriminated against:

Tracey: I'm sitting there, crying, physically my, it doesn't happen now but my leg literally would be shaking because, from the trauma and I had to tell them that my partner died and I needed a sick note and they just, made me tell the story and it was a different Doctor every time. (Page 16/437-440) ... And the final straw for me was a female GP who kept referring to Jennie as he and I was saying Jennie, she took her own life. (Page 16/442-444)

The lack of continuity of support in many health and community services was also shared by Christine:

Christine: But the full-time Chaplain said she would try and look out some help for me, didn't bother. (Page 6/143-144)

Unhelpful support came in different forms for Christine, Diane, Louise and Annie with a shared inference of feeling insignificant:

Christine: The Police gave me a victim support leaflet but there isn't anything. It's like boom! They're dead. Deal with it yourself. Nothing at all. Nothing, nothing. There was nothing. (Page 7/165-167)

Equally Diane mentioned the distress she experienced from the way she was questioned by police and the information they shared with her:

Diane: Erm, and the Police weren't, wouldn't come, weren't very forthcoming. They weren't very helpful. She was giving me information which I wasn't sure if it was accurate, true or not and so I was making phone calls. (Page 16/421/424)

Annie needed some help but felt denied that help when she needed it:

Annie: And they, erm, they know who to signpost people to, you know. They, the- the phone, the phone line. You just give them a, erm, but there's, there's nothing. (Page 5/112-113)

Louise acknowledged that the limitation was the lack support available rather than the quality of the support being offered:

Louise: I do- I can't say there was really negative support because there wasn't an awful lot of support. (Page 37/932-934)

Annie talked about how the nature of support can be limiting due to the focus, the setting of the support, and lack of variety. Annie mentioned the word 'misery' and inferred that she stopped going to one particular support group to avoid placing herself at risk of becoming depressed. This reflected a feeling of fear:

Annie: Erm, but through that I did find out about the Survivors of Suicide group but, erm, some other people who'd had experience of their local groups and said sometimes you just sit around and everybody's miserable and, and, er, sort of feeding off each other's misery and I, I thought I really, I don't want to risk that, erm. (Page 7/174-178)

Annie later talked about not fitting into a group setting but pointed out the counsellor's interest in bereavement which was the main reason for going:

Annie: There's a counsellor that works out of there who, erm, her interest really is bereavement so I, I saw her for a few weeks, erm. I'm not so sure. I'm not the sort of, I'm not, I don't fit into the counselling, counselling group very well. (Page 8/195-198)

The skill set of professionals was also important to Rachel, Cheryl and Christine. Rachel was looking for specialist skills in suicide bereavement but believed that the counsellor had to be personally bereaved by suicide to be able to help her. This suggested that the pain was so great she doubted the possibility of recovery:

Rachel: Erm, and while I was there I contacted a support group for people that, erm, they said they specialised in bereavement by suicide and I had one meeting with them and I didn't find that helpful at all because the person that I saw was a grief counsellor but she hadn't been bereaved by suicide. And I didn't feel that she, she could help me. (Page 12/279-283)

Cheryl also identified with needing specialist support:

Cheryl: So, I met up with a counsellor but I realised that it was very, it was

how do you get over test anxiety and how did, and I don't feel like she was able to take on such a, you know...
(Page 16/882-884)

Christine pointed out that upon reflection she realised her counsellor was not helpful and the sessions offered were not enough. The term 'quick fix' implied an easy problem-solving approach which was unlikely to be helpful in the longer term:

Christine: I'm beginning to think, having learned more about it now, is that she wasn't a particular good counsellor and was, you know, doing an NHS quick fix on me, which isn't really a helpful thing. Sorry if you don't agree but I don't think you can cure or make anything any more manageable in six weeks.
(Page 17/427-431)

Christine described how she expected support services to be person centred and professional but found this was not the case. Again, there was a sense of feeling devalued:

Christine: So, I got stories of other people's suicides. I was preached on more than one occasion and told to turn to God which I think is entirely inappropriate from the helpline, really.
(Page 13/329-331)

Personal views of others were particularly hurtful for Louise and Diane. Louise talked about others blaming her for her husband's suicide and being let down and avoided by people who mattered to her:

Louise: People looking, people blaming, you know, something must have gone on that morning. You must have had an argument. We didn't. I wish we bloody had because at least then I could ta- justify, you know, erm. People avoiding you. That support isn't good and people who you really thought would be there for you, weren't.
(Page 36-37/908-912)

Diane echoed Louise's experience and talked about the misconceptions, stigma and discrimination surrounding the topic of suicide. The views of others 'shocked' Diane and she credited this to ignorance and stigma. She described how she lost confidence in people. Her use of the idiom 'brutal way someone can pull the rug from under your feet' suggested an aggressive tone from others and the loss of

support:

Diane: I faced all sorts of really horrible conversations and were being very ignorant and sort of adhering to the common stigma that you hear around mental health and suicide from work colleagues, from people that I'd known, his work colleagues, all sorts of people. It was really quite, I was really shocked and the only way I can describe it is like, it's the most brutal way someone can pull the rug from under your feet and I literally, genuinely did not understand a single thing about the world any more. (Page 5/118-125)

5.5.2 Attaching meaning

This super-ordinate theme illustrates how participants attached meaning to make sense of their intimate partner's suicide. All participants ruminated over the suicide during their grieving and attached meaning to their motivation to survive. During their journey of grief, relationships with others changed for different reasons and impacted how they coped.

5.5.2.1 Rumination

All participants, except Annie, experienced rumination which was both brooding and reflective in nature as time passed in their grieving experience. Brooding rumination was commonly described by participants as being consumed with thinking about the suicide. Louise described being consumed with thoughts about what happened and her need to dissect the suicide into parts in order to make sense of it:

Louise: The next day deal with, okay, he hung himself. The next day deal with - it was his choice. You know, and you have to break it down because you cannot, you can't get your head around the whole thing. It's massive. (Page 29/725-728)

Christine also shared how being consumed with thoughts about the suicide led her to think about all areas of her male partner's life in order to make sense of what happened. There was a need to have an external explanation for the suicide to avoid any self-blame:

Christine: I think there was something else going on which then blends into the conspiracy theory. Was there something going on at work that I didn't know about? So I don't know that. (Page 11/270-271)

Rachel talked about the rumination being so consuming that she couldn't do anything apart from thinking about her husband and needed to connect with others who knew him:

Rachel: I just don't do anything at all and I obsess about Adrie and [Sigh] I want to make contact with anyone who may, may know him or knew of him or I, last week I wanted, it was his seven- it would have been his seventieth birthday last Saturday and that affected me quite badly and I wanted to make contact with his son. (Page 8/185-189)

Consumed by thinking about the suicide was also intrusive and controlling as Sharon explains:

Sharon: I guess that's all when it's more in my head of when, you know, I think about Harry or think about stuff in the past or [Pause] I know, and that's the some, that can either be like at home, just thinking or it can be anywhere. It can just, it's just when your kind of thoughts kind of overtake what you're doing. (Page 12/302-306)

Tracey's experience differed in that she would immerse herself in thinking by visualizing what happened from her female partner's perspective. Visualising was an attempt to experience what her partner may have been experiencing. 'She just stood there' infers that her partner wanted to die and this sense of perspective enabled Tracey to alleviate some of her guilt. She checked sources on the internet to understand more:

Tracey: But I would stand there and I would imagine what it felt like and what she saw and, and try to actually physically put myself into that position and imagine, you know, the feelings, the emotion, the, that detachment because she, there's pictures if you see people burning on the internet, they run round. She didn't. She just stood there. (Page 12/330-334)

The time required to ruminate and attempts to look for answers needed protected space. Rumination was an important process that enabled participants to make sense of it all. Diane explains:

Diane: Erm, I couldn't stand music being played. I couldn't watch television. I, I couldn't stand any kind of mental stimulation because I had so much, I think, going on in my mind that I was trying to work my way through. (Page 13/356-359)

Annie and Cheryl described how there had to be a time to move on from thinking about the suicide. This implied they had a choice about moving forward:

Annie: I've withdrawn a bit from that now because I feel actually I, I need to start moving forward rather than keeping going over and over it. (Page 7/170-172)

For Cheryl, moving away from brooding rumination was due to exhaustion but also recognition that she had to accept what had happened and had no control over her husband's suicide:

Cheryl: I mean there's only so many times that you can just replay and replay a scenario in your head before you just get exhausted and I just think that exhaustion of, okay, I'm helpless, there's nothing I can do to change this and then just realising, okay you have no control. (Page 7/142-146)

Rumination eventually changed from brooding or being consumed by thinking to a more reflective thinking about the suicide over time. This was evident in Cheryl's experience:

Cheryl: Where now it's a lot, I think it's becoming, I would like to say I think it's becoming easier to get out of it whereas before it just was whenever it happened, it happened whereas now I think I have a little bit more control of my, even of my bad days. (Page 6/433-436)

Having more control of thinking was also shared by Tracey. She pointed out that she now chooses when to think about it and how much. She also explained how thought of the suicide will always be there too:

Tracey: But a good day is that I can actually leave that and that's in its own, that's, I wouldn't say it's, it's certainly not in a box or anything like that but it's there but I don't have to immerse myself in it now. (Page 13/353-355)

Thinking about the suicide was always there for Louise, but now she had to remember to think about it sometimes rather than all time. She talked about her visual memory and described how a trigger could bring back images of the

suicide:

Louise: And I thought what does she mean by that because every day for I, I couldn't even tell you how long, the only ima- image I would see, constantly, even, I can see it now, even as I'm sat talking to you I can see what I found, there. But it's not there all the time now and it moves to the side but it just takes...
(Page 34/843-847)

Reflective thinking also involved remembering the partner and connecting these memories with social activity. When Christine danced with another man she remembered this was something she had wanted to do with her partner. These thoughts made her tearful but she had not cried:

Christine: I thought I was quite brave but I haven't cried yet. I did once, last week. I did cry because I danced to Jail House Rock with a man and that was a thing I'd wanted to do and so I had a little weep then but. That was odd.
(Page 11/258-261)

Changing emotions over time was also shared by Diane. She started to enjoy herself and noted how her feelings changed about herself in response to the enjoyment, and how she remembered her male partner. The emphasis on being at 'peace' indicates some acceptance of the suicide with guilt reducing over time:

Diane: I remember the first time I realised I was actually enjoying myself in, in, socially in some way and I hadn't thought about it. I hadn't thought about him and I hadn't felt guilty about the fact that I was happy. And that was a real shock. Erm, but that came, I don't know, maybe eighteen months afterwards. So, it's, yeah, the days that are good are just the ones where I, I'm at peace with what happened as much as possible and I don't feel such, so, consumed by it still.
(Page 12/324-331)

Remembering for Sharon was more selective:

Sharon: And just like trying to remember like the positive times with him.
(Page 26/690)

Rachel differed from other participants in her reflective thinking. She required some respite from thinking all together. Not thinking about her partner, even for a short time, gave her some contentment and freedom:

Rachel: Erm, a good day is one where the sun's shining and I can just forget about things for a while and do something nice. (Page 7/170-172)

5.5.2.2 Motivation to survive

All participants shared a motivating drive to survive and move through their suicide-related grief. The motivation to survive was driven by internal and external factors. Internal motivation was experienced by Louise, Cheryl, Christine, Tracey and Diane. Louise described how there was no option but to survive with a commitment to move forward:

Louise: And that's when I had to make a turning point because life had to go on. I was left without choices. I had to go on. And you almost make these pacts with yourself which is right, okay, pull yourself together. (Page 25-26/627-630)

Cheryl shared a similar motivation because the alternative was to be 'stuck in the past'. Cheryl believed that focusing on the past would not be helpful to her now:

Cheryl: I'm like I don't like it, well, like I want to just think about him and be stuck in that time where everything was great. But it's just, that's, that's not ideal. (Page 21/494-496)

'Being stuck' was also evident for Christine which she believed hindered her grieving, isolated her from others, and was the easy option. Interestingly, she said 'being black widows' as it was an expected role in grief. In contrast, being motivated to move forward was hard work:

Christine: I decided I've got to go out and get a life because I'd just been sitting in this house being black widows basically and not socialising and not getting out and not seeing anybody else and just sitting there thinking shall we go out? It was easier just to stay in. So I had to make a conscious effort to get out, even into work again. (Page 10/228-232)

Similarly, Diane talked about keeping herself on the 'straight and narrow' and her motivation was to prevent another depressive episode. She talked about still experiencing depressive symptoms but made attempts to control or at least limit

the severity of her depression:

Diane: I did suffer from depression and still do. Er, about a year after it happened, erm, because I've suffered from depression in the past, I knew it. I picked it up. I went to the Doctor's and I, you know, had some counselling, had some tablets and got myself s- sort of back on the straight and narrow again.
(Page 14/375-379)

Tracey explained how she needed to rely on herself with an emphasis on being independent to get through her grief despite any help she might have received:

Tracey: The, the only person you can rely on is yourself, you know, but many people can hold your hand or anything else but you've got to do it yourself. There isn't, there isn't a magic pill, wand or, or anything else.
(Page 11/289-291)

Annie described her internal and external drives that motivated her to get through her grief. Annie talked about how she, her son, and her job were the motivational factors. Despite others expected that both she and her son would be psychologically damaged by the suicide, the expectations of others potentially acted as an external motivator:

Annie: And I thought, 'No, he won't. I'm going to make sure that me and John come out of this experience as well as we can do and that it's not going to ruin the rest of our lives.' Page 12/303-305 ... I have a job to do. I have a son that needs me. Erm, you can't just go to bed and stay in bed and feel sorry for yourself. You have to get up and get on with life...
(Page 12/297-299)

Rachel believed that others were integral to her survival. She described how her mother and her psychiatrist were the ones who kept her from taking her own life and appreciated what they have done for her:

Rachel: There are two people in my life that without them I wouldn't be here. One is my mum and the other one is my Psychiatrist... (Page 15/351-352) ... I was thinking this morning I wish I wasn't here but I, I was also, was thinking this afternoon but what that would do to my mum and I couldn't put that, her, put her through that and I couldn't put my Psychiatrist through that because it would be a real slap in the face to her.
(Page 23/524-527)

Sharon had also considered suicide but her motivation to not act in this way was a desire to keep her boyfriend's ashes and his personal items safe. Sharon developed a sense of wanting to keep connected with him in some way:

Sharon: But just kind of the desire- like just kind of wanting to be the one that's like, because I've got all his stuff at my house, like I've got his ashes, so I wanted to be, knowing then if I died then who would look after his stuff. (Page 26/681-684)

5.5.2.3 Changing relationships

Relationships changed for all the participants following the suicide of their intimate partner. Relationships were represented by friendships or close relations. Friendships were either lost, found to be true, or new. Losing friends for different reasons were expressed by Louise, Rachel, Christine and Diane. Louise described losing two good friends after her partner's suicide and feeling let down by them. She perceived the loss of their friendship to be due to her friends' grief for her husband and inability to support her. She expressed feelings of disappointment:

Louise: Two have, two people who I really thought were good friends, couldn't deal with it. Couldn't deal with it. Didn't know what to say to me. Didn't, but I suppose they were grieving too. You know, they we- they were friends of James' as well but I felt really let down by them. (Page 37/913-916)

Rachel was 'angry' and believed her response to the suicide contributed to losing her friends, despite subsequent attempts to try and repair this:

Rachel: Erm, fr- as regards friends, I've lost friends because I became the-in my angry stage of grief, er, I fell out with them, erm, because I directed my anger and I regret that very much. I've tried to make amends since but they haven't wanted to reconcile. (Page 14/310-313)

The loss of Christine's male partner affected relationships with their joint friends. As a consequence of the friends 'distancing themselves' Christine felt rejected:

Christine: I did go and see his friends over in county X but one of those is being, well they're all being, you know, they've just distanced themselves from me now so they, you know, I don't really have anything to do with

Long standing friendships were also lost for Diane who did not really know why. There was a sense of expecting more and of trust being violated. She speculated about why the loss occurred:

Diane: Friends that I've known for twenty plus years, decided that they no longer wanted to be friends with me and they, I don't know whether that was fear of what had happened, whether it was ignorance, whether they decided to judge me or him for what had happened. I don't know. (Page 4/114-118)

The experience of 'true friendships' were evident for Cheryl and Louise. Cheryl found after the suicide that she really knew who her true real friends were regardless of their friendship at the time:

Cheryl: Or are you having a good day and just, I found, I mean it's really, it's, it stinks to think this but you really find out who your true friends are when something like this happens. And I had people messaging me that we have, I don't know, years and years ago a feud or this and that or a little argument and we stopped talking and I had people messaging me like hey I know, you know, we haven't talked in forever but I'm here. (Page 18/431-437)

Louise differed from Cheryl and believed that she was the true friend rather than having true friends. She relinquished friendships to minimise pain for others and be cautious in developing new friendships. There is emphasis on being protective of others:

Louise: I think that's because, I think it's because it causes her more pain than me. So you step away from it because you don't want to cause somebody some pain and you don't want to be thought of as the person who is maybe causing that per- person pain. (Page 47/1175-1178) ... It's like you, sometimes you almost feel as though you have this badge which is suicide. Suicide. And I think that's why you get a fear of building up friendships because you don't want it to happen again. You don't want to become friends with somebody because you feel as though you've got this thing what's going to pass onto them and it's, it's not good. (Page 21/510-514)

New friendships were made and found to be very different from previous friendships. Annie's social status changed as she sought friendships with other single mothers whom she can identify with:

Annie: I've got new ones that are single mums. Erm, because I've got more in common with them than I have with a family. (Page 20/489-490)

Tracey mentioned her difficulty in forming new friendships because telling them about the suicide was a barrier:

Tracey: So, I don't have to tell people about that but it's hard to try and build new relationships. I don't, I don't mean relationships as a partner but, but new friendships. (Page /242-244)

Changes for Cheryl and Sharon were family focused. Cheryl became united with her family and the suicide deepened their relationship:

Cheryl: We're in this together and it was very, we're very, very strong and close now. (Page 13/298-299)

Sharon connected with her boyfriend's family but only after he died. She perceived that his suicide united them:

Sharon: I guess a lot has changed with Harry, like because his family were not a part of our life at all before he died. I mean I, he did, like I knew his dad. Even me and his dad, he didn't like Harry did a very good job at managing to keep us apart like, erm, so that's all a bit strange now having this whole kind of extra family that I know though Harry but we didn't know each other before. (Page 22/581-586)

5.5.3 Relating to others

This super-ordinate theme illustrates how 'relating to others' developed or changed following the suicide of their intimate partners. Interacting with others in respectful, unconditional ways were essential for participants during their suicide-related grief. Being able to identify with other survivors bereaved by suicide was important as well as developing compassion for others.

5.5.3.1 Need for a humanistic approach

All of the participants referred to communication/counselling principles that reflected the approach proposed by Carl Rogers and his philosophy of Humanism. Some of these elements were: active listening, comfort, empathy, unconditional positive regard and non-judgemental approach. Active listening was discussed by Tracey, Cheryl and Christine.

The sense of 'just being heard' was significant for Tracey. This level of support was sufficient and enabled Tracey to be independent while working through her grief issues:

Tracey: And just, just hear me. And I say I don't want anything. I don't need anything from you. I don't need you to fuss around me or anything else.
(Page 21/587-589)

Cheryl shared a similar view and although she went to see a skilled counsellor, ultimately, she just wanted to talk and be heard:

Cheryl: I don't think that she is skilled for this and so we ended up going to someone that dealt with PTSD and sort of these anxiety and just these, you know, specific things and I went for, until I came here pretty much I was seeing her once a week regularly and it definitely is just nice to have someone to talk to that's not, that's just there to listen. (Page 17/889-893)

'Being heard' was also something that Christine sought, but her attempts to find help often resulted in her being the listener. The desire to be heard provides personal space for growth. There was some frustration as expectations were not always met:

Christine: I did ring the suicide bereavement specialist phone line but found myself hearing other people's stories and ending up counselling them rather than them helping me.
(Page 13/325-327)

The expectation of receiving comfort from others was not met for all participants:

Sharon: I found that everyone else was coming up to me and just crying on my shoulder and I was kind of the one comforting other people.
(Page 18/474-476)

Comfort enabled a sense of trust and sharing, as described by Rachel. She also talked about being understood ‘completely’:

Rachel: Er, she understands every nuance of my character, of all my problems, erm. I trust her implicitly and she knows everything about me. Absolutely everything.
(Page 16/365-367)

Understanding and empathy were described as important needs by Diane and Annie. Diane did not receive empathy from her parents though hints she wanted it from them. She rationalised the reasons why she thought they could not be empathic, and so refrained from talking to them about how she was feeling:

Diane: My parents, they're quite, you know, they're, they're reasonably elderly and they just, they couldn't really understand what was happening. Didn't really want to know too much about it, I don't think, erm, and found it very, very difficult because, erm, I think a. there was the stigma but I think they thought I might do something similar because I was in such a distressed state. Erm, so I quite quickly learned not to talk to them about it too much.
(Page 17/450-455)

Similarly, Annie talked about being understood but believed that only someone who had a similar experience could truly be able to offer that understanding:

Annie: And I felt cheated because everybody else had the time to say goodbye and I really wanted to speak to somebody in the same situation as me. Erm, be- because I needed somebody, someone else who got it.
(Page 6/147-149)

Unconditional positive regard was evident in Louise’s extract when she explained how her current husband offers her acceptance:

Louise: He doesn't put me under any pressure. He never bad mouths James. He never bad mouths me. Erm, he just accepts my pa- past and he just, you know.
(Page 12/311-313)

Offering unconditional positive regard requires a suspension of judgement. Rachel highlighted this attribute in her mother and implied that this related to being supported:

Rachel: Well we, we're very close and always have been but she's just always there for me, erm, she doesn't judge me. She's just constantly supportive.
(Page 15/341-342)

Tracy identified a similar sentiment and talked about the support she received from another family member:

Tracey: I think my sister-in-law as well, although she lives in town Y, she's somebody I can actually phone and again, she just listens without judgement.
(Page 18/503-505)

5.5.3.2 Identifying with other survivors

Relating specifically with other suicide survivors was important for most participants. Identifying with others was seen as having a shared connection through suicide, being reassured and looking to identify with others who had the most similar experience was important. Having something in common helped participants connect with other survivors. Louise explained how suicide was the only thing they shared but the grief of some survivors was 'worse than hers' because they had lost sons. Despite her pain, she indicates that her pain would be worse if it were her own sons:

Louise: You know, we had nothing in common apart from suicide. That's all we had in common but we found a common ground and I would say some of those people are grieving far worse than I was and the, some had lost sons.
(Page 32/801-803)

Rachel described the 'who' as being irrelevant when identifying with others. Rachel found some benefit from the experience of sharing with others:

Rachel: Erm. Erm, I'm very fond of the people that I have met all over the world. Er, we have this common bond. (Page 14/330-331) ... Hers is a different kind of bereavement because it's her son, erm, but it, it's a similar kind of thing. It's, it's both suicides. Both are a horrific way to die. So as, as tragic as it is, something good has come out of it. (Page 14/327-329)

Despite looking for a shared connection, Sharon and Tracey were disappointed with their specialist support groups. Sharon discussed how different the

experiences of others were and her need to identify with someone who had lost a partner and not a child:

Sharon: Erm, I went to one of the suicide bereavement meetings but I didn't really go again because I just didn't like, I don't know. I didn't like talking about it so much and also, I found that at a lot of those meetings it's always people that have lost kids or sons and daughters. Whereas I found that theirs was a very different experience. (Page 15/371-375)

Tracey looked for a shared connection too but suggested that the timing for her was not right and she was not able to participate fully:

Tracey: Erm, I went to the suicide bereavement group because I thought being around people that have lost people by suicide I, I don't know whether it was because it was too fresh, you know, still too traumatised but I physically couldn't talk. I couldn't talk at all. (Page 17/464-466)

Identifying with other survivors provided some reassurance for Louise, Cheryl Sharon and Annie. Knowing that she was not 'going mad' and that her experience was 'normal' provided some relief as reported by Louise:

Louise: I don't know what my first message was, erm, but it was probably along the lines of hi, I'm Louise, my husband James, and people responded and told you their stories. And then you would ask a question and say, you know, erm, I feel as though I'm going mad and their responses would be you're not going mad. We've all been there, you know, and it was reassuring to know that oh, my God, I'm not going mad. (Page 31/778-783)

Cheryl was reassured by the experiences of others and came to believe that she was going to be okay and get through it:

Cheryl: I didn't have anyone that was really, everyone was very sensitive and it was, that friends and just I even met people out of the blue that were going through similar stuff and that just, that really helped knowing that they made it through. They're ten years down the line. It's going to be okay. (Page 18/437-441)

Normalising her experience and not feeling alone was important for Sharon:

Sharon: So it kind of made you feel that actually well like, yes, I know what

that feels, it helps you recognise that feeling so, you kind, of knew you weren't alone.
(Page 15/390-392)

Annie was reassured because other survivors understood what she was going through. She believed that other survivors would be the best people to learn from:

Annie: Er, people so it was, it was helpful to engage with them because they got it and, and there was also a lot of useful information about inquests and sort of what to expect at an inquest. So that was helpful at the time.
(Page 7/170-172)

Some participants described their desire to have a close relationship with other survivors. Sharon remarked on how she identified with a fellow survivor still keeps in touch:

Sharon: So I'm still kind of friends with her. So that was good I think, to meet someone who's got, had the closest experience to what you've had.
(Page 15/379-381)

Diane commented on how the differences in her circumstances prevented her from finding another survivor to share her experience with. Finding such a person would have made her feel 'completely understood'. Being understood is often a need to be approved or be validated by others:

Diane: Erm, so I've always felt my story is a little bit different to other people's and it's, I've never been able to find some to share that experience with and, and for them to, sorry for me to feel that they really, really, really, genuinely understand, is how I felt. And there's always, obviously, there's always going to be some differences and some unique aspects to everybody's story but, you know, I haven't come across anybody yet where the body wasn't, you know, found straight away.
(Page 7/198-204)

In comparison, Tracey thought it was 'impossible' to find another survivor who had the same experience. The unique nature of her individual experience prevented her from connecting with others and being fully understood. There was a sense of needing to validate her experiences:

Tracey: Erm, but the one thing I would like and the one thing that isn't

there is, and it's impossible, is obviously I saw what I saw and I deal with that and nobody else did. So, nobody can truly have that connection because nobody's experienced it, what I experienced and I think I was searching for that and that's why I looked on the internet because I was trying to find a connection and an understanding. (Page 18/505-510)

5.5.3.3 Developing compassion for others

The majority of participants highlighted the development of compassion for others both generally and to those suffering in some way. Compassion was offered in the form of support to others by most participants. Diane believed her partners' suicide made her a better person by learning more and finding reward in helping others (including other suicide survivors):

Diane: In many ways, it's changed me for the better. Erm, it's certainly made me more compassionate towards others, made me more thoughtful. Erm. It's obviously made me much more aware of mental health issues and suicide and I've, you know, I've become, you know, very interested in that and read up on lots of information about it. Do a bit of volunteering, try and help other people who might, you know, unfortunately, be in a similar situation which I find very fulfilling and also quite therapeutic. (Page 17/460-466)

As part of her grieving process, Cheryl was now able to offer general support to others if they approach her for advice. Accepting her husband's suicide enabled her to help others which was perceived as some good that had come out of it. Cheryl talked of feeling rewarded when helping others and specifically trying to prevent other suicides:

Cheryl: So it's just that I feel like now I have that need to go forward and like I have, have friends now that will come to me and like hey I'm having an off day or so and so's having a hard time and for me to be able to say like, 'Okay,' you know, this is just my experience but this is how, you know, what I think is good for dealing with stuff and I think that just helping others is definitely- It makes me feel like it wasn't, that his death wasn't in vain. That it wasn't, you know, for nothing. (Page 14/316-322) ... That's, it's very hard but it's nice knowing okay, that's a horrible thing but now I might be able to prevent, you know, a couple more people, people who are feeling this and that. You know, I've had people tell me, you know, like oh my gosh talking to you has helped so much and, you know, that just, it feels good. (Page 14/330-334)

Louise expressed the view that she will always help others if needed but had not yet reconciled this helping role with her own needs:

Louise: It's, in, in fairness, I am, if somebody wants me, I'm there. And it's very hard to put yourself first. Very hard to put yourself first. That doesn't sit well with me. Don't do things like that. Don't do things like that. (Page 36/891-893)

Compassion was seen to be displayed by behaviours or attitudes towards others. Cheryl described her approach to others as now being more empathic. She mentioned being non-judgemental completely suggesting that this is a big change for her:

Cheryl: I'm definitely more accepting. Definitely no, no judgement whatsoever. I see people, like I give people, like I don't know I just feel like I'm definitely a lot more empathetic or, you know, I look at a family, you know, like I have no idea what they're going through. I can't, you know, I'm, who am I to judge? (Page 24/566-570)

Christine described how she learnt to avoid judging others and 'giving people the benefit of the doubt' as she believes and trusts people more:

Christine: So, I'm always giving people the benefit of the doubt or wondering why they're doing what they're doing rather than leaping in and assuming this has pissed me off so I'm going to shout about it. (Page 18/466-469)

People as a whole have become more important to Annie:

Annie: That how you look at things is, is different, erm, and the sort of people become more important. (Page 13/338-339)

Tracey extended this idea of valuing and respecting others. She talked about how her experience impacted on those things previously that would have seemed normal and acceptable:

Tracey: Yes. I mean as, a, as an RMN yourself you can understand that we, erm, we use black humour as a coping strategy and you hear things now which I would have said before and I just cringe and it makes me go

5.5.4 Changed perception of self

This super-ordinate theme illustrates how participants experienced a changed perception of themselves following the suicide of their intimate partners. All participants described either character or behaviour changes. Subsequently all participants also reported new possibilities in their lives.

5.5.4.1 The changed self

All participants reported how they had changed as a person following the suicides of their intimate partners. Changes in character and behaviour occurred and could be either desirable or undesirable. Becoming more assertive was described by Louise, Christine and Diane. Louise recognised those changes but did not always find the change to be entirely positive:

Louise: I don't tolerate nonsense. I don't suffer fools. I say what's on my mind. I'm very upfront and very open, probably too much. (Page 15/373-375)

Conversely a new level of patience and refraining from being reactive was expressed by Christine:

Christine: Erm, a lot more patient these days. A lot more tolerant. A lot more looking for reasons why people do things without leaping in and getting, I used to get livid about silly things. (Page 18/458-460)

Diane also talked about her tolerance of others but this level of tolerance was dependant on context. Diane considered how she communicated now and how she was more confident and assertive in doing so. Her ability to be assertive had progressed from the aggressive/frustrated approach she used prior to her partner's suicide:

Diane: Erm. It's made me, it's made me, erm, put up with less crap actually. [Laughter] Erm, if I feel people are not treating me particularly well or there's a situation I'm not comfortable or happy about, erm, I have less, I have more ability now, more compunction to be able to say, 'No,

I'm sorry, this is not for me,' erm, and do it, you know, in a considerate and, you know, proper way rather than just throwing my hands up in the air and going, 'No, sod off everybody.'
(Page 17/467-473)

A new-found confidence contributed to Annie's sense of independence:

Annie: I mean I, I've got a stammer, obviously, but I, I hid behind Patrick. He did all the ringing round, sorting things out, erm, and I've had to do it. I've stepped up and I've become this more confident, er, erm, and I, there's, there's just things that me and John do on our own that we would never have done a year ago.
(Page 12/309-313)

Some participants described changes to self in terms of 'selfishness' but with different connotations. Sharon described herself as 'more selfish' as a means to help herself:

Sharon: I probably care about different things now and I've probably become like I think I've become a bit selfish, not like in a mean way but just to cope. Like I've got to do whatever I've got to do to kind of get through.
(Page 21/551-554)

In contrast, Christine felt she had become 'less selfish' in nature and more open-minded in her thinking. Being more philosophical had altered her outlook towards life and possibly others:

Christine: I'm much more philosophical, much more patient, much more enquiring. I'm not as angry or selfish as I used to be which I suppose could have gone the other way really.
(Page 19/486-488)

A changed outlook was also mentioned by Cheryl. She described her willingness to take risks, but with an element of caution:

Cheryl: I view the world has definitely changed my outlook on it and life's short and I've been, I definitely wouldn't say well my riskiest behaviour since the suicide was I purchased a motorcycle and never rode it once.
(Page 24/574-576)

Louise and Tracey described a change to their inner self. Louise talked about

being fearless and having emotional strength. Whilst she also questioned this change, being a suicide survivor has led her to be different:

Louise: Erm, but I aren't fearful any more either. Erm. I've become an extremely strong person and emotionally strong. It takes a lot to get me down. Erm. Be that I don't know whether that's a, a, you know, it's just a front or whatever. I just, I think I've become very hardened off to life, to a certain extent.
(Page 13/323-327)

A well-developed sense of self was a journey achieved through raised self-awareness and being connected with feelings and emotions. Tracey explained that she still saw a counsellor to facilitate her work on the self at a deeper level:

Tracey: It's, people do and, but I think, for me as well, it's been a journey because I think it's because I've seen the counsellor as well, I'm much more in touch with my feelings and emotions than I ever was before and more self-aware. And I think that's why in some ways do I need to see a counsellor still? No. But it's, it enables me to look more deeply into myself which I never did before. I hadn't got a clue before and I was quite naïve, I suppose, in a lot of ways.
(Page 22/606-612)

For some participants, the 'changed self' has been undesirable. Rachel described how her husband's suicide 'destroyed' her life. In her extract, she talked about the lost social self and a sense of who she once was:

Rachel: It's destroyed my life completely. Absolutely destroyed it. I'm not the person I used to be. I used to be vivacious, life and soul of the party, erm. I d- I told you I wasn't sociable but I was, I say I wasn't sociable, I was, I'm not a party animal but I was always a very outgoing person and a laugh a minute and if I did go out socially I would be the one holding court.
(Page 21/477-481)

Sharon also talked about how her social drinking was now no longer enjoyable. Consuming alcohol contributed to feelings of depression:

Sharon: Yeah. And, whereas before I'd enjoy going out drinking, now I just can't drink, like really, like I kind of have a glass of wine but I just find that it just, I can't go out drinking, drinking because I'll just get too depressed, like it's just not good.
(Page 11/285-288)

Annie was the only participant to express dissatisfaction with the fact that she

now had more responsibility. Previously she shared these responsibilities with her husband and resented this burden. This implies potential anger and the laugh aims to soften the emotion:

Annie: All these things that have, I've had to take on as extra, erm, and life is really busy, yes. And yes, sometimes I resent that, I think. [Laughter] I didn't sign up for this, you know, erm, yes. (Page 14/358-360)

5.5.4.2 New possibilities in life

Envisaging new possibilities in life was something that all the participants talked about. These possibilities were either new relationships, career progression and for some, the possibility of renewing something already known. Being open to the possibility of a new intimate relationship was shared by Annie, Diane and Tracey. Annie mentioned the prospect of a new relationship and not wanting to be alone:

Annie: One of the things I thought in the early days was hang on I'm forty-four and I've got probably another forty years ahead of me and I don't want to spend them on my own. (Page 22/552-554)

Diane expressed hope for another relationship but acknowledged the need to be ready and at the right time:

Diane: I hope that I'll be in another relationship and all those sorts of things. Erm. I don't feel quite ready for it yet so at the moment I'm not worrying about it but, erm, as I said to you, my mum is not very well. (Page 19/519-521)

Tracey used the word 'sad' in a relationship she might have. She pointed out that her female partner would always be present in her life and very much in any new relationship. She expressed a sense of sadness and was beginning to better understand the 'co-dependent' nature of her previous relationship. She was confident that her increased self-awareness would prevent this dynamic happening again:

Tracey: The sad thing is any relationship I'd have, there, there'd be three people in it and it would take a, you know, the right person to, er, to actually be in a relationship with two other people because it's, Jennie's still there and I think that's a lot to do with the co-dependent, you know,

relationship as well. Erm, but I think being aware of that and being more aware as a person that's not going to happen again. (Page 23/630-636)

Career progression was a new possibility for Christine and Louise. Christine was embarking on training to be a counsellor in bereavement. She found her volunteer work with others to be tiring but rewarding:

Christine: I would like to do it. I would, I was considering going on to, erm, volunteer for a bereavement charitable organisation and do bereavement counselling maybe. I still do the charitable support line though that's proving difficult at the moment with a full-time job that's shift work but that's always rewarding once you've done it. (Page 20/510-513)

Louise was seeking promotion into a role that could influence change. She expressed a sense of achievement and progression:

Louise: I'm in the process of buying my house. I've got a good job. Might be a manager this time next week and if I don't get it I've still got a job I love. (Page 50/1279-1280)

Rather than explore new possibilities, Sharon, Cheryl and Rachel spoke of re-engaging in something from the past. There was a sense of 'newness' in how they were engaging in it now:

Sharon: Like just, it sounds a bit weird but like nature and kind of going, like my parents live, live down, they've moved down to County X. So, like actually, whereas I used to hate it because it was boring [Laughter] I kind of don't mind it now. It's just quite peaceful and, and, you know, when I've been travelling, just kind of seeing like pretty landscapes and stuff, I don't know. It's, it's quite relaxing. (Page 11-12/290-295)

Cheryl's goals had not changed but she realised that her goals could be achieved at a 'slower pace':

Cheryl: Yes, I still do pretty much want the same things as when he was, when he was alive. It's just now that's it's going at my pace. It's going at a much slower pace. (Page 26/623-625)

Timing was an important consideration for Rachel. She could see new possibilities but acknowledged that she may not be emotionally ready:

*Rachel: I have thought at times of restarting it but I'm not sure that I'm emotionally at a place where I can deal with it just at the moment.
(Page 10/229-231)*

5.5.5 Changed philosophy of life

This super-ordinate theme illustrates how the participants' philosophy of life had changed following the suicide of their intimate partners. All participants shared an appreciation of life and the new priorities in their lives. Their changed philosophy of life contributed to living life in the 'here and now'.

5.5.5.1 Appreciation of Life

All participants talked about how they appreciate life now as a consequence to their partners' suicides. Appreciating life was important. Living was not to be taken for granted. Sharon believed in her choice to live life:

*Sharon: Like it's funny because it's, it's, because I remember like after he died I just kind of used to think well, like when it comes down to it it's either like you live or you die.
(Page 25/665-667)*

Louise also shared an appreciation of life and explained how making the most of life was important:

*Louise: So, I think it's left me with feeling, you do only have one life so you'd better make the most of it.
(Page 56/1445-1446)*

The majority of participants stated that life was meant to be lived. Cheryl talked about consciously maximising opportunities now and not wasting time:

*Cheryl: Like I want to live every day to the fullest and I really wasn't like that before I, I was kind of like it'll, it'll happen, whenever. And now it's just like I feel like I am pressed for time almost.
(Page 24/584-586)*

Christine now believed that life was to be enjoyed and explained how she only really appreciated this view of life more recently. Her suggestion that death could occur at any time reflected her shock at the suicide:

Christine: Yes, and I think well, do I want that pair of shoes? Yes, I do, sod it. I might be dead tomorrow so I'm going to enjoy what I can while I can but that's really only kicked in, I would say, this year. (Page 19/471-474)

Tracey was eventually able to let go of her guilt for her partner's suicide and start to enjoy life:

Tracey: But now I can actually go out, enjoy myself and then the next day I'm not, my, my body's not punishing me. (Page 13/363-364)

Whilst Annie described being 'reckless' in spending more money to do things she enjoyed, she acknowledged that these new activities were fulfilling and meaningful:

Annie: Erm, and maybe I've been a bit reckless in the last year with what I've spent but it's like, if I can, if I can capture two weeks of a holiday and make memories, that's more important than money in a savings account. (Page 13/334-337)

'Appreciating life' had a different meaning for Rachel. She described her days as either good or bad. This inferred that her moods were still extreme and changeable. Experiencing a good day was appreciated:

Rachel: When, when they're good, they are very good. No, didn't I say very good, that they're, when they're good they're, they're nice. They're, they're just normal. (Page 19/430-432)

Diane described how her changed outlook on life was a benefit of the suicide. Diane highlighted how she appreciated life and made decisions based on what was important to her or not:

Diane: So, as I say, it's kind of a, it's, it's, it's a double-edged sword: some things, you know, I'm, I'm quite grateful for. It's shown me what's important in life and what isn't important in life. It's made me make decisions where, and maybe I've, you know, procrastinated for some time because I didn't know. (Page 18/493-497)

5.5.5.2 New priorities

Having new priorities in life were shared by all participants. For most participants, their new priorities involved supporting themselves or others in some way. Rachel and Diane prioritised supporting their mothers who are both ill:

Rachel: And in February of this year she was diagnosed with breast cancer. Fortunately, they got it quickly and she is to all intents and purposes, cured of it. She had an operation and they got it all out and she's undergoing radiotherapy. At the moment, as we speak, she's, I've taken her today for her third session. Erm, and, erm, she's got fifteen sessions in total but she's, she's clear of that, you know. (Page 22/495-500)

Diane: She has, erm, she has dementia so I'm helping to look after her at the moment and so my life is kind of, you know, I'm working and then I, I'm helping to look after her and it's kind of, it's quite hard to look very far ahead in that kind of situation because obviously, it all revolves around how quickly and, you know, the illness progresses and what happens with her. (Page 19/522-526)

Annie's son is her priority for now and wants to support him as much as possible until he goes to university. After this time, she may consider being open to another intimate relationship:

Annie: He is what comes first and until he goes to university, he's my number one priority. Erm, after that, who knows? I might look for another relationship or, erm, I have certainly not ruled it out. (Page 23/558-560)

Marriage, home and work life are priorities for Louise now. She described how she will always remember the husband she lost to suicide on the anniversary of his death but life has moved on for her:

Louise: I see myself sorting my house out, doing some renovations. Carrying on working, still being with Bill and still, erm, remembering James on the 16th of March. That's how I see it. (Page 50/1286-1289)

Sharon described how she now has a changed outlook if a deadline at work is not met. Her use of an idiom (not the end of the world) implies a changed meaning to the seriousness of work:

Sharon: I probably just, not less effort but I just try not to let it, you know,

it's not the end of the world if something hasn't been done for the client on a certain date.
(Page 21-22/560-562)

New priorities were also about doing something for the self. Cheryl explained how she now has lots to do because life is so uncertain and unpredictable:

Cheryl: I have a lot more need for getting stuff done. Like doing exciting things. Like since he passed away I've travelled all over Europe. I've, I'm going to India in a couple of weeks before I, you know, leave here and I'm like I'm just crossing things off like crazy off my bucket list because it's just like you don't know.
(Page 24/580-583)

Learning to dance and looking after herself was evident for Christine as she hints at an increased self-worth:

Christine: I've taken up dancing. I do jiving and lindy hopping which is interesting. And yes, yes, just trying to get myself, trying to look after myself. Actually, it's the first time I've made a conscious effort to look actually look at how I am and try and look after me. But it's actually taken quite a lot of effort to do that.
(Page 9/216-220)

Tracey also described making attempts to be more social and reduce her isolation. She mentioned a psychological 'block' that still needed to be overcome:

Tracey: Yes, erm, just empty and lonely. Erm, and I'm trying, you know, I've joined a club, erm, you know, just to get out and about and I'm trying slowly to build new friendships but, er, sort of there's like a, a block there.
(Page 9/237-240)

5.5.5.3 Living in the 'here and now'

Living in the 'here and now' was expressed by all participants in different ways and the concept of the future for some participants played a role in how they live now. Life now often meant a new relationship. Louise mentioned being fulfilled in her current intimate partnership:

Louise: My husband and me now, absolutely fantastic relationship.
(Page 11/286-287)

Annie described her desire to give her son a strong foundation in life:

Annie: So, I'm making the most of what we've got now and, erm, attempting to give him really the best sort of life he can have. (Page 13/321-322)

Christine highlighted her enjoyment of things that reflected her desire to living in the now and not too much about living in the future:

Christine: I have no plans other than the cat. Pussy want's his dinner, but it's not time yet. So really just trying to enjoy things rather than make big plans and set myself tasks. Just try doing things that I actually enjoy rather than things that I think I ought to do, if that makes some sense. (Page 19-20/494-498)

Other participants shared their views on the future and how it connected with the 'here and now'. Planning for the future changed for Cheryl and she now has a more relaxed approach for living and the future will shape itself as she knows what she wants:

Cheryl: I mean really, I feel like one of my biggest downfalls used to be that I was living so much in the future but now it's, I feel like kind of relaxed and I'm not planning out every second. That I'm not like on this time line where I need to have a house by four years and I need to have this and that and all in this time line and it's kind of just relaxing to take a breath and say you know what? I know what I want. (Page 26/616-621)

Sharon used to worry about the future but now lives in the 'here and now' and sees this as a benefit. This may be linked to a sense of uncertainty about her future and remembering the past which might be too painful. For Sharon, living in the now reduced negative feelings:

Sharon: I used to worry a lot about the future and it felt like I wasn't living in the present. Well, I guess now I probably live in the present more which I guess is a good thing. Erm, you know, I don't really tend to, I try not to think, to think about the future or the past too much. (Page 10/256-260)

Diane also had some uncertainty about her future because she does not know

what it will look like. She mentioned 'struggle with' implying it is difficult to see the future and so lives in the now. She explained that she plans her immediate future but not the long term:

Diane: Do you know what? I genuinely don't know. I, I, that's one of the things I still struggle with. I, I, I pretty much am a day-to-day person at the moment. I can maybe look a few weeks ahead but, you know, or maybe the rest of this year for instance, but. It's almost like it's taught me, don't look too far ahead because you never know what's going to happen, and I certainly wasn't expecting that to happen. (Page 19/509-514)

Ultimately seeing no future was something both Rachel and Tracey shared. Rachel did not think about a future because she could not see one. She explained that she was living in the 'here and now' as her mother needed her and without her, Rachel considered that there was no future and contemplated her own possible suicide. This reflects feelings of hopelessness and a sense that things could not improve for her:

Rachel: I don't contemplate a future for myself because I can't see one. I actually, erm, see that, as soon as anything happens to my mother, I think that I will probably kill myself. (Page 21/491-493)

Living in the 'here and now' was an absolute commitment to living for Tracey:

Tracey: I haven't really thought that far ahead. (Page 22/623)

5.6 Summary

The results of this study show how participants made sense of their coping experiences following intimate partner suicide. It was evident that coping was complex and different amongst participants. Illuminating the divergent lived experience of each participant was consistent with IPA and its commitment to ideography.

The next chapter explores the issues generated by the results and the ways in which these results connect or differ with the existing literature. The significant contribution of this study and implications of the findings for the provision of health

care, education and policy will be outlined. The chapter will conclude by acknowledging the limitations of the study.

CHAPTER 6: DISCUSSION

6.1 Introduction

This chapter presents a discussion of the major findings. Drawing on relevant coping models, theories of grief and the broader literature, the super-ordinate themes from the study will be explored. A model of coping following intimate partner suicide will be proposed. The findings will also be considered in light of limitations of the study. Implications of the findings for the provision of health care, education and policy will be outlined.

6.2 Strengths of this study

Conclusions from the review of the literature identified a dearth of qualitative studies with survivors whose intimate partners died by suicide. The current study attempted to address this gap by undertaking in-depth interviews with survivors. Studies in this field have predominantly focused on the impact of appraisal of events surrounding the suicide (Demi, 1984; Farberow, et al., 1987; Barrett and Scott, 1990; Van Dongen, 1990; Gilewski, et al., 1991; Farberow, et al., 1992a; Cleiren, et al., 1996; De Groot, et al., 2006; A. Smith, et al., 2011; Aronson, et al., 2017), the nature of the spousal relationship (Constantino, et al., 1997; Constantino, et al., 2002; Mitchell, et al., 2009; Schneider, et al., 2011) and the effects of interventions and other forms of support on spousal coping (Pennebaker and O’Heeron, 1984; McNiel, et al., 1988; Van Dongen, 1991; Farberow, et al., 1992b; Constantino and Bricker, 1996; Provini and Everett, 2000; Constantino, et al., 2001; McKinnon and Chonody, 2014). In contrast, the current study provided a rich and detailed understanding of bereaved survivors’ coping experiences following intimate partner suicide.

A ‘strengths perspective’ was adopted by exploring the coping experiences of survivors rather than possible adverse consequences of intimate partner suicide. It was evident that participants experienced complicated grief as reflected in a longer bereavement period. Suicide is a sudden and unexpected death (Martin and Doka, 2011) and the grief reaction can be long lasting (Wortman and Silver, 1989; Prigerson, et al., 2009). A bereavement period can take up to two years and reconciling feelings could take several years more (Rodger, Sherwood, O’Connor and Leslie, 2006). During the bereavement period survivors are more

likely to be at risk of suicide (Stroebe, et al., 2005; Ali, 2015). Therefore, the 'case within theme' approach was appropriate to reveal different journeys and timeframes for recovery. The in-depth interview process also enabled participants to describe a range of processes that assisted their grieving processes, their experiences of self-discovery, and subsequent growth.

The IPA approach to this study was also a strength as it facilitated an in-depth analysis of participants' experiences (J. Smith, et al., 2009). IPA produced a rich, varied and detailed understanding of survivors' coping experiences and the influence of participant characteristics and context (such as age, relationship status, profession, and time since the suicide) on coping.

The current study also contributes to the conceptualisation of key terms in the suicide field. The notion of 'coping' has been defined as a positive or negative experience (Gloria and Steinhardt, 2016); a process or 'ways of coping' (Werdel and Wicks, 2012); or a temporal state such as 'coping some of the time' (Stroebe and Schut, 1999). The IPA approach enabled these various constructs of coping to be explored. Furthermore, although the terms 'bereavement' and 'grief' are often used interchangeably, there were specific distinctions described by participants. Grieving was seen by participants as the distress from their bereavement which aligns with other research (Geneviro, Marshall, Miller and Center for Advancement of Health, 2004). While some participants reported being described by others (usually health professionals) as depressed, anxious, and withdrawn, participants attributed these symptoms to different grief reactions following their partners' suicide rather than symptoms of mental illness that warranted medication.

6.3 Grief theories

The themes of the current study reflected some known constructs related to grief (as outlined in Table 4), however, a number of key findings emerged from the current study that extends the work of earlier researchers discussed in earlier chapters of this thesis. These grief theories will be discussed in relation to this study's findings. Findings of the current study are consistent with the PTG model (Calhoun and Tedeschi, 2014) and the work of Znoj (2014). An overview of both their work and relevance to this study are provided.

6.3.1 Posttraumatic Growth theories

The PTG model developed by Tedeschi and Calhoun (1995) identified that positive changes could occur as a result of loss, a proposal that most seemingly aligns with the current findings. The three major domains of growth include: perceived changes in self, relationships with others, and philosophy of life (Tedeschi and Calhoun, 1996). The PTG model has continued to evolve and now also includes personal strengths and new possibilities, and changed philosophy on life's priorities, appreciation, and spirituality (Calhoun and Tedeschi, 2014). PTG is acknowledged as both a coping style and a coping outcome (Zoeller and Maercker, 2006). However, little detail is given on how growth is determined/measured and what is meant by 'meaningful objective adjustment' as a consequence of a traumatic event. PTG does imply that trauma occurs first, followed by positive growth but gives little consideration to the possibility that a survivor could experience ongoing traumatisation during their bereavement and that both processes could be experienced in oscillation similar to the dual process model proposed by Stroebe and Strut (1999).

During the development of an observer rating tool for PTG, Znoj and Field considered the prospect of both negative and positive coping experiences. Although they investigated change following life partner bereavement due to natural causes, their specific findings were not published at that time. This work, described by Znoj (2014), consisted of three categories of coping: (1) transformation, (2) meaning and (3) manageability. The coping-change process was proposed to follow a bereavement event in this order. Changes to self were likely to be behavioural and evident in life events (transformation), appraising and psychological work (meaning) and getting through suicide-related grief (manageability) (Znoj, 2014).

The findings of the current study are consistent with the PTG model (Calhoun and Tedeschi, 2014) and the work of Znoj (2014) in that participants described both positive and negative coping experiences. There is an overlap between the domains of PTG (Calhoun and Tedeschi, 2014), the categories proposed by Znoj (2014), and the five super-ordinate themes from the current study (Table 4). These similarities and differences between models are outlined in the following section.

Table 4: PTG related models and the super-ordinate themes

PTG by Calhoun and Tedeschi (2014)	Coping model by Znoj (2014)	Super-ordinate themes	Themes
	Manageability	Manageability	<ul style="list-style-type: none"> • Reactions to suicide related grief • Supporting the self • Helpful support offered by others • Unhelpful support offered by others
	Meaning	Attaching Meaning	<ul style="list-style-type: none"> • Rumination • Motivation to survive • Changing relationships
Relating to Others		Relating to Others	<ul style="list-style-type: none"> • Need for a humanistic approach • Identifying with other survivors • Developing compassion for others
Changed Perception of Self: Strength and New Possibilities	Transformation	Changed Perception of Self	<ul style="list-style-type: none"> • The changed self • New possibilities in life
Changed Philosophy of Life: Priorities, Appreciation and Spirituality		Changed Philosophy of life	<ul style="list-style-type: none"> • Appreciation of Life • New priorities • Living in the 'here and now'

Grief is commonly seen as a psychological response to a loss (Freud, 1961; Granek, 2010). Though it has been recognised that suicide survivors experience a unique form of grief compared to other types of death (Wertheimer, 2014; Ali, 2015), responses have predominantly been reported as quantifiable grief

reactions measured through the use of scales (for example, Demi, 1984; Farberow, et al., 1987; Barrett and Scott, 1990; Gilewski, et al., 1991; Farberow, et al., 1992a; Cleiren, et al., 1996; De Groot, et al., 2006; Aronson, et al., 2017). In contrast, the qualitative analysis of participants' accounts in the current study suggested that the suicide-related coping was varied and complex. These notions are explored in the super-ordinate theme of 'manageability'.

6.4 Manageability

The first super-ordinate theme of coping described by participants was named 'manageability' which was adversely affected by current and past mental health, regulating emotions, suicidal thoughts and alcohol and drugs, but helped by using specific coping techniques; the nature and accessibility of support, and economic resources. These processes align with the work of Znoj (2014) but differ from grief reactions measured by other researchers (for example, Demi, 1984; Farberow, et al., 1987; Barrett and Scott, 1990; Gilewski, et al., 1991; Farberow, et al., 1992a; Cleiren, et al., 1996; De Groot, et al., 2006) who reported levels of grief related symptoms rather than an understanding of lived experience of coping following intimate partner suicide.

6.4.1 Depression, anxiety and trauma responses

Participants described a range of mental health symptoms. Commonly, a history or current episode of depression around the time of the suicide is likely to complicate a survivor's grief by prolonging the grieving process (HM Government, 2012; DH, 2016) hindering the resumption of daily activities and return to work; and adversely affecting self-esteem (Clements, et al., 2004; PHE, 2016b). If the depression is moderate to severe, coping is likely to be complicated (Gilewski, et al., 1991; Pompili, et al., 2008). Several participants with a past history of depression (Rachel, Christine and Diane) experienced a recurrence of their mental health problem and complicated grieving. Complicated grieving is prolonged and characterized by intense symptoms (Prigerson, et al., 2009).

One participant (Rachel) described experiencing complicated suicide-related grief that required inpatient care. Several others required prescribed medication and extensive periods of counselling. However, for Christine and Rachel some treatment options to manage depressive symptoms were ineffective.

Complicated grief affects all areas of functioning (Young, et al., 2012) including somatic symptoms (Lindemann, 1944) and physical problems (Gall, et al., 2014). Louise reported the inability to sleep, rapid weight loss and somatic pain. Feelings of shock and numbness were also experienced by Sharon (Bowlby, 1969). It could be that the prescribed medication regime was not effectively managed or that a full assessment of the individual's complex needs was not considered.

Post-Traumatic stress disorder (PTSD) can be another complicated suicide-related grief reaction (Young, et al., 2012). Symptoms of PTSD such as dissociation, flashbacks and avoidance developed from thoughts of suicide/witnessing the dead body for three participants. Their feelings of horror, anxiety and grieving were subsequently diagnosed as a mood disorder.

Distress and mild depressive symptoms are often an inevitable part of bereavement (Freud, 1961; Kübler-Ross, 1969; Smit, 2015). This response accounts for the high rates of depression amongst survivors. This was evident for Diane who became aware of her grief developing into depression. Another participant anticipated becoming depressed but at the time of an interview was still in shock. This could be due to a possible delay in the onset of depression (Kübler-Ross, 1969). Participants highlighted the important influence of mood on coping. Without exception, participants described changes in mood over time and how their emotional well-being determined which coping strategies were employed and their perceived usefulness. Louise shared her experience of writing to cope but this coping strategy become less effective when she experienced mood changes. This highlights that coping is variable for individuals and perseverance with different coping strategies may be required. This might not be case for all survivors but understanding the relationship between mood and coping is helpful so that risk can be anticipated and appropriate support can be provided in a timely way.

6.4.2 Overcoming suicidal ideation

Loss of a partner increases the risk of suicidal ideation (Stroebe, et al., 2005; De Groot, et al., 2006) and is commonly reported amongst survivors bereaved by intimate partner suicide (Voracek, 2005; Young, et al., 2012). Suicide is often associated with complicated grief (Latham and Prigerson, 2004). Guilt is often

associated with blame for the suicide (Li, et al., 2014). Tracey felt immense guilt and how this made her consider taking her own life. Suicide can stop the psychological pain (Pompili, et al., 2008). Suicidal ideation was discussed by some survivors who described how external factors such as children and memories of the partner provided sufficient motivation to not act on these suicidal thoughts. Louise alluded to the fact that her children needed her which prevented her own suicide. She later explained that she feared suicide happening to others and felt she was a visual representation of suicide. This can be seen as an 'attempt to control' the impact of the suicide by being a protector of others and preventing suicides (Begley and Quayle, 2007). This fear can also be driven by the worry of suicide contagion (Bell, Stanley, Mallon and Manthorpe, 2015b; PHE, 2016b). Sharon felt her boyfriend through a continued bond kept her going and prevented her own suicide. At her home she kept his 'stuff' and ashes with her as she needed to look after them. Having a continuing bond with the deceased could have been a protective factor and help the grieving process (Klass, et al., 1996) particularly if the bond is transformed (Neimeyer, et al., 2006) and integrated into the survivor's life (Klass, et al., 1996; Bell, et al., 2015a).

While all survivors shared certain reactions to their suicide-related grief, some elements were also unique in regard to duration, severity, meaning and resolution. Furthermore, these experiences were non-time specific. Participants viewed their bereavement as an opportunity to focus on the distress-related grief. Due to these complexities, the risk of severe and enduring mood disorders and suicide are high and should be considered as a matter of serious concern by health professionals (Prigerson, et al., 2009).

6.4.3 Regulating emotions

Regulating emotions was an important coping strategy characterised by several elements. One element was underpinned by how survivors managed emotions in their daily lives, a novel finding limitedly reported previously (Van Dongen, 1990; A. Smith, et al., 2011). It is widely reported that suicide-related grief is complicated as this is likely due to the nature of the emotional attachment to the deceased (Crunk, et al., 2017). Emotional distress is linked to broken attachments (Bowlby, 1969) which compromises safety and security (Bowlby, 1969; Jordan and McIntosh, 2011). Unlike Freud's theory on detachment and

severing emotional bonds (1961) attachments remain strong (Bowlby, 1973) which is an explanation to why survivors felt the need to regulate their emotions as a means to cope. Bereavement is a life event and while the facts surrounding the death cannot be changed or altered (Stroebe and Schut, 1999) an individual's emotional response to the suicide can be. Lazarus and Folkman's (1984) theory supported this notion and recommended that survivors should use emotion focused coping as they cannot change 'the problem'.

Regulating emotions as a way of coping aims to control feelings of overwhelming distress after the suicide (Pearlin and Schooler, 1978). In the current study, dealing with the emotional distress was paramount for some survivors and having a routine or structure to their daily lives became a survival strategy. Keeping busy was central to regulating emotions for Louise, while planning events (Sharon) and never being alone for the first six months (Annie) were effective coping strategies for others.

Some participants wanted to return to work as it provided an occupation and distraction. However, Diane did not feel ready for work, whereas Annie would have returned to work sooner if she had received support from her GP to do so. Some survivors returned to work early, but were unsupported, performed poorly, and suffered increased stress as a consequence. This suggests that survivors can be vulnerable in the workplace and returning to work too soon and without structured support can be detrimental to their mental health.

Meeting the needs of others was another strategy that attempts to 'control' grief (Rodger, et al., 2006; Begley and Quayle, 2007). This is consistent with other research findings (Begley and Quayle, 2007) but in this study, participants described in detail their behaviours such as setting an alarm clock as a prompt to collect children from school (Louise), walking the dog twice a day (Rachel) and participating 'in the world' to support others (Cheryl), and keep their emotions in check.

Regulating emotions may also be reflected in certain behaviours that aim to demonstrate 'coping' to others (Perugini and Bagozzi, 2001; Begley and Quayle, 2007). Survivors often mask their emotions by keeping up a pretence and controlling with whom and where those emotions can be displayed (also referred to as 'gaze of others' and 'public guise') (A. Smith, et al., 2011). In this study,

participants provided different explanations of their modified behaviours that represented gaze of others and public guise. Louise reported being wary of what she said and did to promote the appearance of coping to others (public guise) which helps deflect the gaze of others. For survivors with children, the appearance of coping was based on a fear that they could be separated from their children if hospitalised or that social services could remove the children from their care (Diaz-Caneja and Johnson, 2004). Cheryl needed to maintain her 'role' and be normal (public guise) and adopted a 'fake it until make it' approach to help her achieve it.

One participant (Tracey) adopted 'forced' behaviours such as walking into town, so people could see her, which was originally a form of self-punishment. It is not unusual for survivors to ascribe self-blame (Heikkinen, Aro and Lönnqvist, 1992) and have feelings of guilt (Rando, 1988; Ali, 2015) associated with the suicide. Interestingly for Tracey, the outcome of consistently performing 'punishing' behaviours over time were helpful. Benefit-finding as a consequence of experiencing trauma, such as suicide, is not uncommon (Zoeller and Maercker, 2006; Triplett, et al., 2012) and in the current study, some participants found benefits from repeated behaviour such as setting tasks (Louise), diarising events (Sharon) and keeping daily routines (Cheryl).

6.4.4 Achieving mastery

An attempt to achieve mastery is another element of keeping to a routine (Pearlin and Schooler, 1978; Windsor, Ryan and Smith, 2009). Mastery was described by Cheryl who practised behaving 'normally' until she eventually achieved her 'normal' self. This supports the notion of doing something repeatedly to achieve emotional equilibrium. However, 'appearing' to be their usual self-prevented some survivors from receiving much needed support.

While mastery is often viewed as perfecting a skill, it may involve developing new knowledge and skills (Stroebe and Schut, 1999). This was evident for some participants (Cheryl, Diane and Sharon) who sought information to understand more about suicide and self-help strategies. In these cases, mastery was about normalising their experiences and gaining a sense of control in their lives after a stressful event (Infurna and Mayer, 2015). Therefore, control for some

participants was important as it assisted them to move forward in their lives.

6.4.5 Alcohol and drugs

Emotions such as anger and frustration can be detrimental to survivors especially if these feelings are exacerbated by, or contribute to, the use of alcohol and/or drugs (Velleman, 2011). Consuming alcohol can have positive immediate benefits such as helping a person to feel less stressed, better about themselves or more confident (Rodger, et al., 2006). Longer term use of alcohol and drugs can, however, lead to dependence and complications (Myers and Isralowitz, 2011). Christine described how alcohol fuelled her anger and contributed to aggressive behaviour and damage of property. Intoxication could lead to other issues such as unsafe sexual behaviour, committing minor offences and other adverse consequences (Myers and Isralowitz, 2011). This reinforces the need for a full assessment of survivors' legal and illegal substance use to minimise both short and long-term risks to their physical, psychological and social well-being.

6.4.6 Influence of personality traits on coping

Negative or challenging feelings need to be managed to provide some emotional balance for survivors (R. Smith and Ascough, 2016). Participants of the current study identified strategies such as positive self-talk (Annie), exercise (Cheryl) and mindfulness (Tracey) to help manage negative emotions and lift their mood. Though skills may be new or existing, personality traits such as optimism, hardiness and resilience might explain an individual's propensity to adopt such strategies (Lepore and Revenson, 2014). Optimism is often linked with positivity and adopting a problem focused approach when confronted with a crisis (Calhoun and Tedeschi, 2014). Learning new skills or applying existing coping skills to new circumstances could be essential to help survivors through their suicide-related grief (Lepore and Revenson, 2014). Furthermore, optimism and hardiness can influence the likelihood of resilience (Lepore and Revenson, 2014; R. Smith and Ascough, 2016). Hardiness is evidenced by commitment and control in challenging circumstances (Calhoun and Tedeschi, 2014). A hardy survivor is likely to feel a sense of competence and a willingness to take personal responsibility for achieving their goals (Maddi, 2006). The current findings suggest that participants wanted to take actions that would lead to improvements

in their lives. This is consistent with the findings of Calhoun and Tedeschi (2014) who also identified that survivors wanted to adapt and improve their lives. Currently, however, there is limited evidence on the mediating role of personality on coping by suicide survivors and more research in this area is required.

6.4.7 Formal and informal interpersonal postvention

Survivors bereaved by suicide need support, also known as postvention, to help their recovery, reduce morbidity and contribute to better health outcomes (PHE, 2016a; 2016b). In the UK, national and local strategies are prioritising mental health wellbeing and prevention of mental illness and suicide (DH, 2012b; HM Government, 2012; PHE, 2016a; 2016b). There are now a variety of postvention activities across the country for survivors of suicide such as self-help groups and therapeutic support groups (PHE, 2016b). Immediate support provided by first responders are typically the police, ambulance staff, GPs (McKinnon and Chonody, 2014). For some participants immediate interpersonal support was offered by family or friends (Cheryl, Rachel and Tracey). Despite such support often being unconditional due to the nature of family relationships, previous research has identified that confiding with family members is not always helpful and unlikely to be therapeutic (Pennebaker and O’Heeron, 1984). This can be due to how they are coping (PHE, 2016b), the types of help they need which can be different for each survivor (Provini and Everett, 2000) and putting the needs of other family members first (Wertheimer, 2014). The current study found that some participants reported positive changed relationships with family members. A suicide in the family can contribute to stronger and closer relations (Calhoun and Tedeschi, 2014). A deeper, stronger bond (Cheryl) and ‘inheriting’ the partner’s extended family (Sharon) were reported. Connecting with family members can provide emotional support and reassurance to survivors during their grief (Ali, 2015).

Some forms of interpersonal support can be limited or ineffective (Ali, 2015) and prompted survivors to disengage when their needs were not being met. Survivors generally feel less satisfied with emotional support (McNiel, et al., 1988; Farberow, et al., 1992b). Annie, for example, reported that her support group lacked focus and she felt unsafe. Survivors can feel vulnerable when required to share their experiences in certain support settings (McLeod, 2007). This can be

due to different theoretical frameworks and facilitation style of postvention activities (Constantino, et al., 2001).

Suicide is stigmatised (Frey, et al., 2016). Some survivors (Louise and Sharon) avoided talking about their partners' suicide, while others experienced disenfranchisement as they felt prevented from talking about it (Christine) (Doka, 2008). Stigma is often underpinned by ignorance and may contribute to survivors feeling dissatisfied with the quality of interpersonal support available to them. The lack of opportunity to talk about feelings can be counterproductive, contribute to poor mental health outcomes (Stroebe, et al., 2007), and reinforce suicide-related feelings of blame (Peters, et al., 2013; Wertheimer, 2014).

Professional sources of interpersonal support are usually seen to be more trustworthy by consumers (Hough, 2014) and of good quality (DH, 2012b; NHS Choices, 2015; PHE, 2016b; WHO, 2017b), but some participants shared negative experiences particularly in relation to some church-based counselling services. This reinforces that postvention is provided from all areas of a survivor's community. Unhelpful professional support can lead to mistrust of services (Trachtenberg, Dugan and Hall, 2005).

6.4.8 Nature and accessibility of postvention

The nature of various forms of postvention were discussed by all participants. Helpful support was generally underpinned by the notion of 'time' and included availability and flexibility of services and others. 'Timing' was also crucial as survivors have to receive support when needed (DH, 2012b; NHS Choices, 2015; PHE, 2016b). Some participants (Christine, Diane, Rachel) discussed the importance of having access to resources and available services with no time restrictions. Distance can be a problem from a time and cost perspective which can prevent survivors like Diane getting help as her nearest postvention group was an hour and half away by car (Provini and Everett, 2000; McKinnon and Chonody, 2014; Nic an Fhaili, et al., 2016). This finding reinforces the need for postvention to be local, timely and effective (HM Government, 2012; DH, 2016).

The need for support in the aftermath of a traumatic event is a logical expectation (Calhoun, Tedeschi, Cann and Hanks, 2010) but was not always received. Rachel had an appointment with a psychiatrist one week after the suicide and

received support for a continuous period of time. However, Tracey was placed on a counselling waiting list for several months. Support services have to be consistently available, affordable and accessible (DH, 2012a; 2012b; 2016; PHE, 2016b). The inability of some survivors to access professional support contributed to the development of complicated grief responses, an avoidable financial burden, and social costs.

6.4.9 Financial resources and postvention

Finance was a major consideration for survivors as income was often reduced to a single source after the suicide (Stroebe, Schut and Stroebe, 2007; Wertheimer, 2014). Furthermore, suicide of an intimate partner could adversely affect life insurance policy payments, contributing to financial hardship (Hopmeyer and Werk, 1994; Wertheimer, 2014). Rachel was fortunate as support from her psychiatrist continued free of charge, but Diane needed to privately fund her counselling. Support services need to be affordable (DH, 2016; WHO, 2017b) and in many cases, should be free (NHS Choices, 2015; PHE, 2016b). In the current study, affordability determined whether participants sought professional support at all, at the right time, and for how long. Affordability influenced how survivors coped and managed their grief.

6.4.10 Practical support

Helping survivors in their daily lives can be beneficial to coping (Ali, 2015). Postvention is not just offered and delivered by professionals through formal support (PHE, 2016b). For some survivors they rely on community and family members (Wertheimer, 2014). Survivors might have difficulties in accessing postvention due to grief related symptoms (McKinnon and Chonody, 2014) and pre-existing factors such as health problems, misuse of substances, vulnerable social and economic problems (HM Government, 2012; Aronson, et al., 2017).

Managing a household can be overwhelming when the surviving partner becomes a single parent, or when feelings are incapacitating and impact on daily life (McKinnon and Chonody, 2014). Children can be a support (Farberow, et al., 1992b; Schneider, et al., 2011) but are coping with their own grief as well. Some participants talked about different types of practical support such as being: provided with meals (Annie); encouraged to eat healthy meals (Christine), or

assisted to travel to medical appointments. Receiving practical support can minimise stress and enable survivors to adjust to their new lives (McKinnon and Chonody, 2014). Practical support especially provided from friends also provides opportunity to talk and confide as it helps coping, improves health and the distraction reduces rumination about the death (Pennebaker and O’Heeron, 1984; Cleiren, et al., 1996). It can feel safer and provides another support outside of the family (Wertheimer, 2014).

Providing information as a form of practical support not only helps survivors come to terms with the suicide but also increases awareness about possible coping strategies (Young, et al., 2012). One participant (Sharon) mentioned how some written information helped her make sense of the suicide. Information can foster understanding and facilitate acceptance (McKinnon and Chonody, 2014). Advice on who to call following the death; and how to arrange the funeral, as well as requirements when attending the coroner’s court are commonly required (Young, et al., 2012). Survivors who are informed are likely to feel less overwhelmed at a very difficult and unfamiliar time.

6.4.11 Postvention in the workplace

Employers have an important role in supporting survivors bereaved by suicide. Eighty percent of survivors following suicide bereavement are likely to drop out of work (PHE, 2016b) which can create high economic costs. Support can be experienced through the workplace (Ferguson, Carlson and Kacmar, 2015). Some participants reported receiving both formal and informal workplace support. Formal support by employers is now regulated (Health and Safety Executive (HSE), 2017a) and involves assessing, planning and managing employee needs and making adjustments in the workplace (HSE, 2017b). Supportive processes experienced by Annie included the allocation of duties and phased return to work. Employers are not only expected to ensure employees are fit to return to work but provide ongoing support through their employment (HSE, 2017b). Support was varied on different levels. Sharon had four months off, a phased return to work and felt supported. As soon as she resumed full time hours there was no communication or follow up as she had expected. Christine experienced disenfranchised grief as she was not allowed to have her days off to access counselling services and prevented from mentioning the suicide. Employers still

need to improve supporting survivors in the workplace from the outset (PHE, 2016a; 2016b). Employment is good for overall health (PHE, 2016b; Fit for Work, 2017) and can positively improve survivors' wellbeing as they cope with their suicide-related grief.

Informal workplace support is often given by colleagues (Russo, Shteigman and Carmeli, 2016). A supportive line manager and colleagues (Diane) and discreet allocation of particular work duties (Tracey) were described as being positive. However, difficulties were encountered when individual employers determined the nature of support without consultation, decisions were based on the employer's views of suicide, or there was a lack of workplace policies and procedures.

6.4.12 Unhelpful support

Participants identified experiences of unhelpful support. Insensitivity by others (such as friends offering to clear personal items away soon after the funeral (Sharon), or being denied access to counselling because the body had not been found at the time (Diane) were some of the many examples provided. A lack of understanding could underpin the insensitive approaches of others (Hill, Twiddy, Hewison and House, 2014) which could explain Diane's experience as she was denied counselling because there was no proof of the body.

Survivors are entitled to receive compassion and respect (NHS Choices, 2015; DH, 2016; PHE, 2016b) from both formal and informal sources of support. GPs are key in supporting survivors providing support both immediately and ongoing and the key to referring survivors to other postvention services (Van Dongen, 1991; McKinnon and Chonody, 2014). GPs can lack confidence and competence (Foggin, et al., 2016; Nic an Fhaili, et al., 2016) but survivors expected the GP to know how to support them (Van Dongen, 1991). Tracey found seeing her GP extremely distressing as she was often seen by different doctors which meant she had to retell her story every time and having to relive the trauma. One doctor kept referring to her partner as a male. Stigma could explain these experiences. GPs do have their own personal beliefs (Pompili, et al., 2008; Foggin, et al., 2016). This can leave survivors feeling devalued and insignificant. Some participants (Christine, Diane, Louise and Annie) reported feeling insignificant by

the lack of follow up offered by some services, feeling dismissed when given a leaflet in response to their distress, overwhelmed by the approach to questioning by the police, or not being trusted by officials. These early experiences may have contributed to complicated suicide-related grief symptoms and delayed resolution of their grief. This reinforces that all professionals providing postvention need to be confident and competent regardless of the type when they are offering support in the survivor's bereavement.

Postvention is emerging and increasingly available around the UK (PHE 2016a; 2016b) but it can be unhelpful to survivors. Suicide bereavement postvention strategies are still relatively new (PHE, 2016b) with training programmes not currently validated (PHE, 2016a). Local, in-house programmes may not be evaluated or evidence-based (PHE, 2016a). The lack of evaluation and sharing of results can also mean that effective postvention activities are not shared with other services and not available to some survivors. Some specialist postvention are scattered around the UK rather than widely implemented (McKinnon and Chonody, 2014). Although standardisation may improve services consideration needs to be given to characteristics of communities and survivors' needs. Currently, there are bereavement postvention programs available to spousal survivors but not specifically for them.

Additional consideration is required for spouses disenfranchised in their grief because their relationship to the deceased was not recognised by the legal system (Doka, 2008). Both Diane and Christine were not recognised as their partners' next-of-kin. Christine was prevented from dealing with banks and registry offices and Diane felt the police were not forthcoming and unhelpful. Health professionals need to quickly gain an understanding of the spousal relationship, advocate on behalf of the bereaved; and liaise between services to foster survivors' sense of empowerment.

6.5 Meaning

The second and third super-ordinate themes of attaching meaning and relating to others represents meaning following intimate partner suicide. Meaning-making is consistent with appraising and the psychological work required during grieving (Znoj, 2014). Meaning involved processes such as brooding and reflective

rumination, internal and external motivation to survive, losing and gaining friends, need for a humanistic approach, identifying with other survivors, and developing compassion for others.

In this study, participants ascribed a deeper meaning to changed relationships to explain why relationships changed, such as losing and gaining friends. Relating to others is consistent with PTG (Calhoun and Tedeschi, 2014). However, the current study also found that participants identified the importance of humanism in their interactions with others as a means to help them cope and move forward.

6.5.1 Brooding rumination

Rumination is an important part of coping as it assists understanding and attributes meaning to the suicide (Calhoun, et al., 2010). There are different rumination styles but the process of rumination is often viewed as unhelpful, traumatic and exhaustive for survivors and increases suicide-related grief symptoms (Segerstrom, Tsao, Alden and Craske, 2000). This is due to core assumptions or beliefs that have been challenged (Neimeyer, et al., 2006). In the after-math of suicide, fixated thinking can be negative, intrusive and all-consuming (Martin and Tesser, 1996) as survivors attempt to find reasons to why the suicide happened, looking at possible explanations such as events that led up to the death and the nature of their relationship with the deceased (Begley and Quayle, 2007). Some participants described the scale of meaning-making as 'massive' (Louise), 'replaying a scenario' (Cheryl) and 'obsessing' (Rachel). This type of rumination, known as brooding rumination, initially occurs automatically (Van Dongen, 1990; Calhoun and Tedeschi, 2014). Participants reported how thinking about the suicide was overwhelming and consuming as they attempted to make sense of why the suicide had happened in the first place. Suicide challenges survivors' beliefs about their social world (Neimeyer, et al., 2006; Zoeller and Maercker, 2006) which explains the intensity, cognitive demand, and time involved in finding meaning. Women are more likely to ruminate than men (Rodger, et al., 2006). In the current study rumination was characterised by analysing their partner's life (Christine), being controlled by intrusive thoughts at any time (Sharon), visualising the suicide (Tracey), and needing protected time to go over the suicide event (Diane).

Ruminating about the intimate partner is inevitable during the 'loss' orientation phase in grief that is experienced in oscillation (Stroebe and Schut, 1999). Survivors need to make sense of the death. Constructing a story, which is often complex, facilitates understanding of a process which is not linear (Begley and Quayle, 2007). Meaning-making can be both successful and unsuccessful with the latter being an indicator for complicated grief (Neimeyer, 2001) as a search for meaning can take years (Gall, et al., 2014).

Calhoun and Tedeschi (2014) assert that rumination about the partner can be positive and promote posttraumatic growth for survivors. The PTG model proposes that the high levels of distress associated with rumination can challenge survivors' beliefs and prompt resolution and sense-making. Indeed, participants did report how rumination was progressive, suggesting that rumination can be a positive experience. Therefore, an indicator of positive adaptation (Neimeyer, 2001).

Posttraumatic growth is achievable when life for the survivor becomes different in some way (Calhoun and Tedeschi, 2014). This change is often seen in survivors thinking differently about the suicide. Ruminative thinking may lead to a new set of beliefs and goals in life (Martin and Tesser, 1989) and may become more reflective and deliberate as survivors ascribe different meanings to help change and move on with their lives (Calhoun and Tedeschi, 2014).

6.5.2 Reflective rumination

Reflective rumination was evident for some participants. Posttraumatic growth is achievable when life for the survivor becomes different in some positive way (Calhoun and Tedeschi, 2014). This change is often seen in survivors thinking differently about the suicide. Ruminative thinking may lead to a new set of beliefs and goals in life (Martin and Tesser, 1989) and may become more reflective and deliberate (Calhoun and Tedeschi, 2014). Participants described how their rumination became more goal orientated over time, driven by a need to move forward (Annie and Cheryl) and increasing feelings of being in control (Cheryl). Control was about choosing when to think about the suicide (Tracey). This sense of choice changed thinking processes. Finding meaning contributed to reduced distress as survivors engaged in more goal orientated and constructive thinking

(Zoeller and Maercker, 2006).

In line with PTG theory, reflective rumination was a marker of 'moving forward' for most participants. There was one exception (Annie) and this could have been due to her early period of bereavement. In general, most participants reported that they had started to enjoy life and reported positive memories of their partners (Diane and Sharon) suggesting that a level of acceptance had been achieved. Reflective rumination was therefore a positive experience as 'finding meaning' is pivotal to psychological adaptation (Zoeller and Maercker, 2006; Begley and Quayle, 2007).

The frequency of rumination may reduce as survivors come to terms with the suicide, accept what has happened, and move on with their lives (Calhoun and Tedeschi, 2014). Remembering the partner at social events but being tearful (Christine) or specifying time to think about the suicide (Louise) reinforced the reduction of rumination but also suggests that the thoughts continue in some form. The notion of posttraumatic growth and rumination is more positively associated with early stages of grief rather than later (Calhoun, Cann, Tedeschi and McMillan, 2000). This implies that posttraumatic growth is not achieved if rumination still occurs years later. It is difficult to draw conclusions about this phenomenon in relation to some participants given the variability in the duration of bereavement. Rumination styles change and survivors can report a transition from brooding to reflective thinking (Calhoun and Tedeschi, 2014) and happens on different levels (Neimeyer and Sands, 2011).

Rumination is useful if thinking about the suicide moves to a more positive selective thinking experience rather than a static negative and intrusive experience (as described by Rachel). The findings from the current study suggest that rumination styles and meaning-making is not phased but an oscillated coping experience (Stroebe and Schut, 1999; Begley and Quayle, 2007). Over time more reflective rumination experiences which are selective and controlled by the survivor should be expected. It is therefore important to know about survivors' rumination experiences as this can inform health professionals about a survivor's coping abilities and how best to support them.

6.5.3 Internal motivation to survive

Motivation is based on cognitive processes and behaviours (Graham and Weiner, 1996). Participants (Cheryl, Christine, Diane, Louise, and Tracey) described their motivation to survive as 'coming from within'. Maslow's hierarchy of needs could help to explain this as humans have the basic need to fulfil and meet their own survival needs (Maslow, 1987). Motivation was described as 'life needing to go on', 'moving forward', 'relying on yourself' and 'protecting the self' from recurrent depression amongst the participants. Maslow (1987) identified that this internal drive to meet specific needs such as esteem and self-actualisation could demonstrate to a survivor that they are capable of self-development following adversity.

Bandura's theory of self-efficacy could provide another explanation (Bandura, 1977). According to self-efficacy theory, a survivors' belief system influences motivation and perceived capabilities. Self-efficacy is also more likely to develop if the person receives acknowledgement and support from others (Calhoun and Tedeschi, 2014). This suggests that several psychological processes contribute to survivors' abilities to cope. In this study, some participants reported changes in their motivation. Receiving positive comments on their display of strength and ability to cope from family members or other survivors has likely developed their self-efficacy.

6.5.4 External motivation to survive

Responsibilities and demands such as parenting and employment (Annie) or keeping their partner's personal belongings safe (Sharon) provided external motivation to survive. Expectancy theory of motivation (Vroom, 1964) is underpinned by survivors' need to achieve as a consequence of their behaviour or actions (Graham and Weiner, 1996). This theory acknowledges the complexity of coping and that actions are based on beliefs and a desired outcome (Hodgetts, 1991). In this current study, survivors perceived an increased sense of personal strength as a result of the suicide and felt better positioned to deal with future trauma.

6.5.5 Losing and gaining friends

After the suicide of an intimate partner, survivors reported a change in their relationships with others and a loss of friendships is common (Begley and Quayle, 2007; A. Smith, et al., 2011; Calhoun and Tedeschi, 2014). In this study, several participants provided explanations rather than stating facts about losing friends. Such explanations included: friends needing to deal with their own grief related to the partner (Louise), as a reaction to aggressive/blaming behaviour by friends towards the survivor (Rachel), or friends distancing themselves (Christine and Diane).

Friends can be grieving the suicide and coping in their own way (Bartik, Maple, Edwards and Kiernan, 2013). Friends can ascribe blame towards the surviving partner, believing the suicide could have been prevented in some way (Hunt and Hertlein, 2015). As a result, survivors can feel social uneasiness as they are let down by friends and isolate themselves from them and their wider community (Begley and Quayle, 2007). In this study, social uneasiness was experienced differently by some participants. Avoiding others so she did not have to talk about the suicide (Tracey) and displaying and controlling anger with others (Rachel).

Suicide might not be accepted by others in society which could account for the loss of friendships. Suicide is disenfranchising (Doka, 1998) because its judged by the attitudes of society (Doka, 2008). As a consequence, survivors might not have the right to grieve because of the nature of the death or if their relationship to the deceased was not acknowledged by others (Doka, 2002).

Shame and stigma about suicide could also contribute to friends distancing themselves as they struggle to come to terms with the suicide (Peters, et al., 2016). The loss of friends can reinforce negative beliefs surrounding the suicide and complicate the survivors' suicide-related grief.

Losing an intimate partner to suicide generates a change in social roles and leads to changing relationships (Kalekin-Fishman and Denis, 2012). Some participants reported efforts to establish new relationships as they identified new needs (Lawler, 2014). Being a new single mother (Annie) and forming new friendships to reduce social isolation (Tracey) were mentioned. Survivors identified their new status in society and sought to connect with others in a similar social role (Burke

and Stets, 2009).

6.5.6 Need for a humanistic approach

All participants described a need for a 'humanistic approach' in their interactions with others. Humanism considers the lived human experience from a subjective perspective (Prymachuk, 2011). The principles of a humanism are often seen in person-centred or client-centred counselling (Rogers, 1980) and helps survivors recognise their own capacity for self-healing and personal growth (Rogers, 1980). A humanistic approach encourages survivors to develop through unconditional positive regard, empathic understanding, and genuineness (Rogers, 1980). A humanistic approach encourages engagement and develops rapport (Casemore and Tudway, 2012) between survivors and those in a helping role.

Empathic understanding, as a component of a humanistic approach, is a deeper awareness of a survivor's feelings and needs (Egan, 2014). Empathy is achieved through active listening (Brown, 2014) and some participants reported the benefits of being heard through active listening (Cheryl, Christine, Tracey). Active listening fosters emotional, well-being (Rogers, 1980) as survivors resolve personal conflicts and promote change. Genuineness, as another component of a humanistic approach, enables survivors to trust (Green, 2010) and encourages self-disclosure (Tolan, 2012). A person-centred approach to supporting survivors may facilitate growth through the provision of a supportive interpersonal relationship (Brown, 2014). The current study found that a person-centred approach was beneficial to survivors as part of their coping experience.

6.5.7 Identifying with other survivors

Most participants found relating with other suicide survivors helped them find meaning. Identifying with other survivors provided a sense of belonging through a shared experience (Clarke, 2010), feeling safe (Begley and Quayle, 2007) and being 'themselves' (A. Smith, et al., 2011). Having a common experience helped survivors relate with others in similar circumstances (Mead and MacNeil, 2006) and feel supported as a consequence (Rawlinson, Schiff and Barlow, 2009). Relating to other survivors is a two-way exchange of support through mutual understanding (Barlow and Phelan, 2007; Begley and Quayle, 2007). Being understood by other survivors enables a survivor to normalise their suicide-

related grief (Annie, Cheryl, Diane, Sharon) with the benefit of feeling reassured as they hear other survivors' stories of coping (Petty, 2000).

Survivors' search for meaning related to suicide involved identifying with others (Coleman and Neimeyer, 2010). Survivors found themselves with a new identity as they became part of unique community (Van Dongen, 1990; 1991; Clarke, 2010; Aronson, et al., 2017). Often survivors will become members of a virtual community by connecting through social media (Rawlinson, et al., 2009). Having positive comparisons with other survivors provides non-judgemental and compassionate support (Pietilä, 2002) and promotes self-disclosure (Tedeschi and Calhoun, 1996).

6.5.8 Developing compassion for others

In line with PTG, relating to others was also evidenced by compassion (Calhoun and Tedeschi, 2014). Compassion can be viewed as a type of love or affection which requires giving oneself for the good of another (Fehr and Sprecher, 2013). Most participants reported compassion towards others who had experienced similar trauma (Diane and Cheryl) or compassion towards others in general (Annie, Cheryl, Christine, Louise and Tracey). This is similar to other research that found individuals suffering trauma were more compassionate towards others with similar experiences (Begley and Quayle, 2007; Werdel and Wicks, 2012; Aronson, et al., 2017) and in general (Park and Blumberg, 2002). Underwood (2009) proposed that compassion involved being empathic, non-judgemental, valuing, and respecting others or helping others (Begley and Quayle, 2007). One participant (Cheryl) became a volunteer in a community-based support centre. Compassion is a positive change as survivors see some benefit from their own trauma (Cheryl and Diane) and benefit from assisting others in some way. Having first-hand experience of suicide-related grief leads to understanding, knowledge, and compassion towards others with similar experiences (A. Smith, et al., 2011; Wicks, 2012).

6.6 Transformation

The fourth and fifth super-ordinate themes of changed perception of self and changed philosophy of life represents transformation (Znoj, 2014) following intimate partner suicide. Transformation included processes such as the changed

self, new possibilities in life, appreciation of life, new priorities, and living in the 'here and now'.

6.6.1 The changed self

Suicide of an intimate partner contributes to personal change (Werdel and Wicks, 2012). Personal strength is often described as 'feeling stronger' (Tedeschi and Calhoun, 2004). In this study, participants did not report becoming stronger but described a strength of character which translated into new behaviours.

The notion of strength can be emotion based (Calhoun and Tedeschi, 2014). Some participants described being more assertive (Louise), confident (Annie and Diane), having raised self-awareness (Tracey), open-mindedness (Christine) and increased 'selfishness' as a means of putting the 'self' first (Sharon). These findings support the notion of positive benefits from adversity (Zoeller and Maercker, 2006 Triplett, et al., 2012).

Posttraumatic growth often represents 'change for the better' following suicide (A. Smith, et al., 2011). Znoj (2014) suggested however, that change after suicide for survivors may not always be positive. In this study, some participants mentioned negative changes as a consequence of the suicide. Some undesired changes included a sense of the lost 'self' (Rachel), loss of social enjoyment (Sharon), and the burden of increased responsibility (Annie). This finding is consistent with the work of Znoj (2014) and reinforces that the 'changed self' can be both desirable and undesirable and affect coping accordingly.

6.6.2 New possibilities in life

New possibilities in life can occur, but to achieve this, survivors have to be open to new experiences (Zoeller and Maercker, 2006). Some participants reported being open to the possibility of forming new intimate relationships (Annie and Tracey) or hoping for one (Diane). Snyder (2000) suggests that hope-related thinking is connected to achieving goals such as the need of intimacy. A goal is driven by desire (Magyar-Moe and Lopez, 2015) and for survivors it was about changing their life experiences for the better.

Goal setting can be big or small but need to be significant for the individual (Snyder, 2000) and influenced by beliefs and values (Znoj, 2014). Career

progression to promote change (Louise) or career change (Christine) are not unusual amongst individuals following a crisis and may be connected to survivors' suicide related coping experiences (Calhoun and Tedeschi, 2014).

Some participants reported a different appraisal of existing experiences by adopting a 'newness' approach and finding benefit from them. Previously 'boring' walks in the countryside became a relaxing activity (Sharon), achieving goals at a slower pace (Cheryl), and planning to re-engage in online support platforms (Rachel) were examples of appraising experiences differently.

6.6.3 Appreciation of life

In this study, an appreciation of life was facilitated by attaching a different meaning to it. Life can be more purposeful (Begley and Quayle, 2007) and survivors can develop more awareness (A. Smith, et al., 2011). Calhoun and Tedeschi (2014) suggests life becomes valuable and even small things matter now because life cannot be taken for granted. A greater awareness and appreciation in life is about making the most of it (A. Smith, et al., 2011). Some participants re-evaluated and valued life (Diane and Louise) by making the most of it (Cheryl and Sharon), making life more meaningful (Annie) and having a good day (Rachel). An explanation for this approach is the notion of gratitude (Neto, 2007) which is characterised by some positive appreciation and thanks for life. Some survivors can report enjoyment but as a means of distraction and reducing pain (A. Smith, et al., 2011). However, in this study both Christine and Tracey reported enjoying life for different reasons. Christine alluded to increased self-worth as a contributing factor to her enjoyment and for Tracey reduced feelings of guilt and acceptance.

Moving forward also requires forgiveness (Neto, 2007). Survivors need to forgive their intimate partners for 'leaving' them rather than seeing the suicide as a form of rejection (Young, et al., 2012; Wertheimer, 2014). This process requires self-forgiveness and not taking responsibility for the actions of others (Li, et al., 2014). Forgiveness resets a survivor's internal emotional tone and contributes to emotional reconciliation (Ballester, Sastre and Mullet, 2009). Conversely, an inability to forgive contributes to feelings of resentment or anger (Chiaramello, Sastre and Mullet, 2008). Forgiveness enables individuals to move towards

acceptance (Fischer, 2014).

6.6.4 New Priorities

Accepting enables survivors to move on (Hayes, Pistorello and Levin, 2012) and may include reprioritising what matters to them. Losing an intimate partner to suicide may prompt survivors to consider new perspectives (Calhoun, et al., 2010) and seek happiness. Hedonistic theory suggests that enjoying life ultimately leads to a good life (Brülde, 2007) which could explain why some survivors work towards a fulfilling life.

Socially related priorities were experienced by some participants. Enjoying life and doing exciting things like travel (Cheryl), learning to dance (Christine) and being more socially active to reduce self-isolation (Tracey) were some examples identified in the current study. Some new priorities involved putting others first such as supporting mothers who were ill (Diane and Rachel), supporting children (Annie), and having a different attitude towards work related deadlines (Sharon). Heathwood (2006) reinforces the notion of seeking happiness and desire-fulfilment but essentially the main desires of survivors were to cope and change their lives for the better.

6.6.5 Living in the ‘here and now’

Living in the ‘here and now’ is an internal experience (Calhoun, et al., 2010), underpinned by values, social world, and the language used or attached to psychological being at the time (Hayes, et al., 2012). In this study, living in the ‘here and now’ connected with the future in some way. Supporting her son ‘now’ would give him a good start in life (Annie), being fulfilled in an intimate relationship (Louise) being relaxed ‘now’ will shape the future (Cheryl), and living ‘now’ created more positive feelings (Sharon) are some examples. However, the concept of the future provided some uncertainty or did not exist for some participants. The future was unknown (Diane) and did not exist for both Rachel and Tracey. The context of living in the ‘here and now’ influence how survivors’ see their lives as context regulates behaviour and thoughts (Hayes, Luoma, Bond, Masuda and Lillis, 2006) and for survivors their lives were shaped by the suicide, suicide-related grief and coping experiences.

6.7 Proposed new model of coping

The findings from this study suggest that the grieving of survivors bereaved by intimate partner suicide shared some similarities but also differed from those bereaved from other events. Similarly, while participants adopted some useful coping strategies, they were more likely to suffer emotional distress, experience suicidal ideation, and use coping strategies which might not be helpful. Circumstances surrounding the suicide, the nature of the spousal relationship, mental health history, current circumstances, and poor support adversely affected their grieving, but the majority of participants eventually achieved a sense of acceptance, personal growth and future-orientation. Therefore, a model of coping following intimate partner suicide has been proposed.

The model draws upon other grief theories from both traditional and newer theoretical perspectives. It was discussed in the first chapter of this thesis that grief theories and models are likely to reflect an academic's discipline (Davies, 2004). However, it can be argued that the model provides an integration of non-prescriptive traditional and newer grief theory such as symptomology (Freud, 1961; Lindemann, 1944; Bowlby, 1969; Kübler-Ross, 1969), meaning-making (Tedeschi and Calhoun, 1995; Neimeyer, 2001), continuing bonds (Klass, et al., 1996) and social context (Doka, 1989).

6.7.1 Description of The Intimate Partner Suicide Bereavement Coping Model

This model attempts to capture the coping processes used by bereaved survivors following intimate partner suicide. Coping processes included manageability, meaning, and transformation through the bereavement journey. The proposed model supports the notion that the coping process of survivors is not linear, staged or phased but an integrated and interwoven process consistent with oscillation theory (Stroebe and Schut, 1999). For example, survivors could attach meaning as part of their 'manageability' processes or attach meaning in the process of transformation. This proposed model of coping encapsulates the theory of PTG (Calhoun and Tedeschi, 2014) and the three coping categories by Znoj (2014). Furthermore, this model considers both positive and negative coping experiences (Znoj 2014) as part of the lived experience of bereaved survivors

following intimate partner suicide.

6.7.1.1 Manageability

Manageability of survivors is based on the interactions between: their beliefs, knowledge and thoughts (cognitive); actions (behavioural); and feelings and emotions (affect) following intimate partner suicide. The relationship between these domains influence the coping experiences and strategies adopted by survivors (Znoj, 2014). Survivors' emotional and physical well-being is influenced by their social world, the nature and accessibility of support, and economic resources. As a consequence, these factors influence the individual coping experience.

6.7.1.2 Meaning

Meaning-making includes different processes as the individual makes sense of what has happened and why, how their life is now, and how they may move forward in their lifeworld. The meaning experience requires considerable cognitive work (Neimeyer, 2001; Znoj, 2014) and may be experienced through a process of rumination and reflective rumination (Neimeyer, 2001; Calhoun and Tedeschi, 2014). Survivors gain new insights, make sense of their lives, identify both internal and external motivations to survive, cope with changes to relationships, and attempt to rebuild their lives.

Survivors experience changes in relationships after the suicide for different reasons and may go to great lengths to understand why these relationships changed. The PTG model reinforces the concept of relating to others, having a changed view of others, or a deepening existing relationship (Calhoun and Tedeschi, 2014). However, the Intimate Partner Suicide Bereavement Coping Model (IPSBCM) reflects the need of survivors to reflect on why relationships have changed or been lost as a consequence to suicide and make sense of these experiences as part of their own meaning-making.

6.7.1.3 Transformation

The concept of change is a key component of the IPSBCM as survivors demonstrate a changed perception of self and philosophy of life. These changes are often seen through changed behaviour or life circumstances (Znoj, 2014). Although transformation can be a marker of successful coping (Calhoun and

Tedeschi, 2014) it may not necessarily be positive change or growth (Znoj, 2014) and some survivors might refrain from acknowledging any positivity if present due to feelings of guilt (A. Smith, et al., 2011).

The proposed IPSBCM includes the notion of a changed perception of self and philosophy of life but suggest that both domains are interlinked. For example, a survivor's changed philosophy of life is more likely to inform the changed self and visa-versa. A new outlook on life will be influential on the changed self, and the changed self may influence the new outlook on life.

Survivors will often be open to new possibilities (Calhoun and Tedeschi, 2014) as they come to terms with the suicide as a historical artefact of their new life. A changed philosophy of life is likely to contribute to a greater sense of openness as well as appreciating life more, having new priorities, and living in the 'here and now'.

The PTG model describes the development of personal strength (changed perception of self) and the role of spirituality (changed philosophy of life) during bereavement (Calhoun and Tedeschi, 2014). The IPSBCM acknowledges that survivors often experience a new sense of personal strength, and a revised life-world view and philosophy. Transformation suggests a journey which could also be an end point for some survivors. However, the results of the current study revealed that the three coping processes were an ongoing and interwoven experience as individuals changed and evolved in their ever-changing lived experience in their social worlds.

6.7.1.4 Model summary

The IPSBCM attempts to capture the coping processes used by bereaved survivors following intimate partner suicide. The individual survivor's coping experience can be both positive and negative with evidence of posttraumatic growth as part of the coping experience.

The model's flexibility can account for the interwoven interplay of processes of an individual's subjective grief responses to intimate partner suicide and complexities within them such as disenfranchised and complicated grief (Doka, 2008; Prigerson, et al., 2009).

It is significant to highlight that the model is aligned to the researcher's epistemological position of a qualitative interpretivist approach which underpinned the research methodology used in this research. IPA is concerned with individuals and their everyday lived experience (J. Smith, 2011a). What is important about this model is that it explains or describe individual subjective coping rather than prescribe, anticipate or expect grief responses.

This model proposes three coping processes consisting of manageability, meaning and transformation which is underpinned by the interactions between: their beliefs, knowledge and thoughts (cognitive); actions (behavioural); and feelings and emotions (affect) in the context of their lifeworld.

The model's framework is based on survivors oscillated lived experiences rather than being a prescriptive, staged approach. The model considers survivors' cognition, behaviours and affect which could be reflective of the past (pre-suicide related events, the relationship to the deceased), in the present (home, interpersonal relationships, employment and social) or the future (planning and safeguarding the future for themselves and others).

6.8 Limitations of this study

This study focused on exploring the coping experiences of bereaved survivors following the suicide of their intimate partners. There are limitations associated with this study that need to be considered.

The participants were all female, and predominantly from the UK. One participant was from the USA but residing in the UK at the time of the interview. All participants shared a western culture and were interviewed in English. Recruitment was open to all genders and cultural groups to understand the unique coping experiences for those bereaved by intimate partner suicide, but different recruitment strategies were unsuccessful in obtaining a diverse sample. Men are often less comfortable in confiding about intimate issues and this gender difference may have hindered men from volunteering. The use of the English language and the role of stigma could also explain why men and other survivors from different cultural and diverse backgrounds could not be recruited.

The focus of this study did not include risk factors (alcohol use and violence) or

attempt to understand the family life cycle (family structure, dependent children, living arrangements, ages of both partners) and socio-economic status prior to or at the time of the suicide. Despite the impact of suicide on finances and employment, recruiting according to a diverse socio-economic range may have given greater insight into coping experiences of survivors following intimate partner suicide.

Participants were interviewed once, with the duration of bereavement varying across participants. The inclusion requirement of being bereaved for at least one month may have resulted in some survivors not participating. As such, the findings from this study did not capture a full understanding of coping from the outset, and the coping strategies adopted by survivors at certain time points in their bereavement period.

It could be possible that other survivors of suicide share similar suicide-related grief experiences to the participants in this study and the proposed model of coping might reflect their lived experience of coping. However, comparisons of different grief and coping experiences of all survivors that experienced suicide bereavement was not the focus of this study.

Finally, this study was limited to the subjective lived experiences of survivors provided by self-reported accounts. The findings of the study do not imply that all survivors share similar coping experiences therefore generalised conclusions cannot be drawn. There was however, a sense of coherence across participants' experiences and identified themes aimed to reflect a shared journey of coping.

6.9 Conclusion

This chapter discussed the super-ordinate themes generated from the study. The results of this study have contributed to the development of a model of coping following intimate partner suicide. While elements of existing coping and grief models were evident, this qualitative study shed new light on the experiences of survivors and builds on some existing qualitative research as it provides more depth in understanding the coping experiences of survivors following intimate partner suicide. Participants in this study provided greater insight into their varied coping behaviours and the different support they encountered (manageability) in their lifeworld: at home with or without the responsibility of children and in their

occupational and social environments. These lived experiences were underpinned by meaning-making (meaning) of the suicide, their motivation to live, understanding the changes in their friendships, a strong need to be supported with a 'humanistic approach', identifying with other survivors and developing compassion for others. Finally, in this study, nearly all participants reported posttraumatic growth as they changed (transformation) as they considered new possibilities and appreciated life with new priorities with a focus on living in the 'here and now'.

The next and final chapter of this thesis will discuss the major conclusions from this study. This discussion will provide recommendations for future practice and research in this specialist field.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

There are seven major conclusions from this study: a proposed model of coping following intimate partner suicide bereavement, the notion that coping following intimate partner suicide is complex in nature, duration and outcome, resilience is rarely considered in suicide literature, support is essential, survivors benefit from psychological interventions, the workplace plays an important role in support and recovery and coping can be compromised as suicide is still stigmatised. These conclusions will be discussed and recommendations for future health care practice and research provided. This chapter will conclude with some brief remarks.

7.2 Conclusions and recommendations

7.2.1 The Intimate Partner Suicide Bereavement Coping Model potentially provides a framework for practice

The IPSBCM proposed three coping processes: manageability, meaning and transformation following the findings of this research study. The coping model identifies that survivors cope differently, have positive and negative experiences and adopt both helpful and unhelpful coping strategies. There was some evidence of personal growth as part of the coping experience but this was not always the case.

The model aims to reflect the survivor's coping experience and provide a generic frame with a focus on the lived oscillated experiences within the three coping processes. The model is applicable to health care professional practice, however further testing and development over time is warranted. Health care professionals and associated professionals receive limited education and training in suicide bereavement and this model in the future, following further validation, may provide insight for professionals to better support those bereaved by intimate partner suicide.

Future research should test and validate the IPSBCM to demonstrate validity for use in practice. The validated model could give greater insight into the coping

experiences of survivors and influence timely support and interventions.

7.2.2 Coping following intimate partner suicide is complex in nature, duration and outcome

When supporting survivors in their suicide-related grief a full understanding of their coping experiences and their adopted coping strategies is essential. A holistic approach to assessment is required to identify survivors' needs from their perspective which includes an understanding of their past and present mental health, coping strategies, available support, and the nature of their relationship with the deceased.

The complexities associated with suicide-related grief indicates potential risk factors for survivors. These include increased risk of suicide (Stroebe, et al., 2005), harmful use of alcohol and drugs (Velleman, 2011), reduced capability to support dependents (which can put others at risk) (Diaz-Caneja et al., 2004), increased financial debt or loss of employment, mental health problems, physical health problems, changed environmental factors and social isolation (Young, et al., 2012).

Healthcare services predominantly are reliant on survivors to initiate and engage in seeking help. Health care professionals need to consider that a survivor is likely to be unsupported or cautious in self-disclosing. Survivors might fear repercussions such as stigma and blame, hospital admission, removal of children from their care, and loss of wages due to time off work. Consequently, survivors may go to great lengths to appear to be coping. A trusting relationship needs to be established (Rogers, 1980) that encourages disclosure and integrates ongoing assessment of psychosocial risk during their suicide-related bereavement. Survivors that have children could benefit from a family liaison service that specialise in families bereaved by suicide so they whole family can be supported (PHE, 2016b).

Providers of support have to consider that suicide-related grief may be complicated by pre-existing, current, or developing mental health problems and become a barrier to accessing support. Offering health information, practical advice and support particularly in the home environment is part of the wider national agenda for providing care in the community (DH, 2016; PHE, 2016b).

Furthermore, the quality of care provided needs to be monitored through supervision and consumer feedback (PHE, 2016a).

Health care professionals should be cautious about generalising suicide bereavement. GPs, in particular, as key primary health care providers, should avoid making assumptions about bereavement and grief, and adopting a 'factory' approach to treatment options. GPs would benefit from education and training (Nic an Fhaili, et al., 2016; General Medical Council, 2017). Training programmes such as Postvention: Assisting those bereaved by suicide training (PABBS) which is aimed at health care professionals but specifically GPs to build confidence and skills in caring for those bereaved by suicide (Foggin, et al., 2016; PHE, 2016a) and support from a multidisciplinary team (Thistlethwaite, 2012) including mental health nurses, social workers and psychologists in this area.

A comprehensive approach to assessment needs to give consideration to gender differences (Leone, 2012), the influences of culture, health beliefs, coping styles, attitudes (Holland and Hogg, 2010) and meaning-making towards suicide (Gall, et al., 2014). This would identify survivors' rumination styles and assist professionals in their postvention interventions. Exploring if survivors are experiencing disenfranchised grief will inform professionals of the nature of their complexities in coping, implications for complicated grief and associated risk factors such as suicide. Understanding the nature of disenfranchised grief from survivors' lifeworld will enhance the support they receive (Corr, 1999). Furthermore, exploring the emotional attachment (Bowlby, 1969) rather than making assumption or judgements on survivors' social or legal relationship status and the continuing bond (Bell, et al., 2015a) to the deceased would be extremely informative. This insight as part of the assessment process will contribute to better support and provision of postvention activities and resources.

Women are highly likely to be the predominant survivor group (ONS, 2017b), assume some blame for the suicide and could have the stress of being a single parent. In particular, understanding the survivor's experience in relation to the suicide (circumstances or finding the body) should be identified as part of the assessment. Cultural factors need to be included in a health assessment as they may influence views of death and suicide and contribute to stigmatisation and social isolation (Honkasalo and Tuominen, 2014).

Health care professionals should adopt a facilitative and reassuring approach within the therapeutic relationship to enable survivors to feel confident and safe in seeking and engaging support (Rogers, 1980; Pompili, et al., 2008). Health care professionals might use a variety of assessment tools and models to inform their counselling approach. The principles of the recovery model are recommended based on the findings of the current study and recognised treatment guidelines (NIMHE, 2005; DH, 2016; PHE, 2016b).

Further research exploring survivors' coping experiences and adopted coping strategies is required. Topics in need of investigation include the coping of men and survivors from non-western cultures. Mixed methods approaches are more likely to provide a fuller understanding of coping following intimate partner suicide bereavement and enable the generalisations of findings. Further research could also provide an understanding of associations between risk factors, the nature of the family life cycle and socio-economic status to better inform assessment and management of survivors' needs.

7.2.3 Resilience is rarely considered in suicide literature and yet underpinned many of the coping strategies identified by participants

Resilience is an ability to engage in positive behaviours following life stresses (R. Smith and Ascough, 2016). Predicting resilience in individuals is multi-factorial. Resilience has been conceived as both a process and an outcome (Lepore and Revenson, 2014). Resilience has been linked with certain personality traits (such as optimism and hardiness) (Kim, Lee and Lee, 2013) and the interplay between available support in the person's social world (Lepore and Revenson, 2014). The notion of resilience underpinned the experiences of survivors as they attempted to manage and adapt over time. Resilience varies amongst individuals and some may require additional support (Campbell-Sills, Cohan and Stein, 2006). Resilience can be enhanced through health promotion strategies targeting psychological and physical wellbeing and social inclusiveness (Lepore and Revenson, 2014). Resilience-building strategies will require active participation from different service providers such as public health, primary care and the voluntary sector to work together and provide safe and trusting interactions that facilitate self-disclosure. Furthermore, health promotion activities may be required to develop skills in: mindfulness, stress management, problem solving

and conflict resolution techniques in their social (communities) as well as the creation of physical environments such as healing gardens (Lepore and Revenson, 2014).

Future research could conduct randomised controlled trials to test the effects of 'resilience-promoting' interventions and services with suicide survivors and explore factors that enhance resilience following adversity through in-depth interviews.

7.2.4 Support is essential

In line with the work of Znoj (2014), support was an essential requirement of all participants to assist coping. Various forms of support (practical, emotional, financial, interpersonal) need to be accessible, flexible and responsive to the needs of suicide survivors (DH, 2012b; 2016; PHE, 2016b; WHO, 2017b). Every participant described difficulties accessing community-based services or receiving services from professionals who may have been prejudiced against same-sex relationships, made assumptions about the intimate relationship, or propagated a religious view.

Immediate support received by survivors was often given by the public sector: police, coroner's department, funeral and/or religious services possibly before the involvement of health care professionals. A referral by immediate support professionals to a liaison service which includes psychoeducation group support provides one to one support up to and including the coroner's inquest (PHE, 2016a) or suicide outreach service often referred by the police with seventy-two hours (PHE, 2016b) would be a great support especially as survivors are in the initial stages of grief and likely to be in shock or denial. Proactive support is vital as it is often viewed as more positive and improves the grieving process (McKinnon and Chonody, 2014). This network of immediate support providers could also be extended to schools and other educational institutions for survivors with children such as offering mindfulness (PHE, 2016a).

All agencies dealing with members of the public should be aware of useful resources such as the 'Help is at Hand' full resource or the pocket size version, or online resource (Support After Suicide, 2017). This resource was published in 2015 and provides a revised version of the resource pack called 'Help is at Hand'

(NHS Direct, 2008) which was available and distributed to participants (and offered to those who made initial inquiries) in this study.

Quite often survivors are in shock and sensitive communication should be clear, honest and non-judgemental. Survivors of the current and previous studies have consistently reported experiencing a lack of sensitivity, poor communication, and a lack of information (Freeman, Olesen and Hjortdahl, 2003). This suggests a lack of competence and confidence by frontline service personnel in supporting survivors. Services could be improved through training and education, including cultural sensitivity awareness such as a training programme called 'Connect 5' to understand mental health, mental illness, mental wellbeing with awareness of qualities and attitudes and develop professionals to improve their skills and confidence (PHE, 2016a).

Line managers need to ensure that staff receive regular clinical supervision (Care Quality Commission, 2013; Nic an Fhaili, et al., 2016), have well developed case management skills, and can liaise across sectors (legal, health, education, housing, social security) (Kathol, Perez and Cohen, 2010; DH, 2016). Support was often compromised due to the lack of continuity and case management. Continuity of care can be enhanced through a review of communication and handover processes within the multi-disciplinary team and the inclusion of external agencies in case management discussions (Freeman, et al., 2003; PHE, 2016a).

Difficulties were encountered by some survivors in regards to their legal relationship to the deceased. As identified in the current study, some partners were not recognised as next-of-kin. This created additional challenges and stress as these individuals were excluded, received less information, and were unable to deal with formal processes such as bank accounts, mortgages and insurance companies. Social work and legal advice may be able to assist individuals in such circumstances. Furthermore, professionals should ensure that some survivors are not disadvantaged and have full access to postvention activities such as those not recognised legally or within other collective cultures such as the armed forces (Aronson, et al., 2017).

7.2.5 Survivors benefit from psychological interventions

The review of the literature and interviews with participants revealed that survivors benefit from psychological interventions. Participants spoke positively of counselling elements characteristic of a humanistic approach that included unconditional positive regard, empathic understanding, and genuineness which promoted rapport, trust, and positive engagement with services (Simonsen and Cooper, 2015). A humanistic approach also provides the survivor with control because it is client led (Simonsen and Cooper, 2015). Survivors have reported control over emotions (Begley and Quayle, 2007) and are best positioned to manage their support by being supported by a facilitative approach.

Professionals providing psychological based interventions could consider integrated therapy that is inclusive of developing coping skills for survivors. This might include Mindfulness-Based Cognitive Therapy (MBCT) with a focus on psychoeducation related to common symptoms of depression and anxiety (Coelho, Canter and Ernst, 2013). MBCT addresses ruminative thought patterns, emotional regulation, and the relationship between mood, thoughts and behaviour with mindfulness techniques. Acceptance and Commitment Therapy (ACT) is also appropriate with strategies such as mindfulness, defusion, acceptance, values, and committed action (Hayes, et al., 2012).

These therapies, as well as the popularised Mindfulness-Based Stress Reduction (MBSR) programmes, could provide a shift in survivor thinking from brooding to reflective rumination by reframing appraisals of events and increase posttraumatic growth (Tedeschi and Blevins, 2015). These approaches fit with the notion of the coping experience being interchangeable, complicated, and lengthy but amenable to intervention.

Survivors might find groups more beneficial through a shared identification with other survivors (Begley and Quayle, 2007; A. Smith, et al., 2011). Survivors could attend closed therapeutic for adults bereaved by suicide or self-help groups such as SOBS (PHE, 2016b). Group work can provide protected time for survivors outside of work and children commitments (Wertheimer, 2014). Professionals considering running small groups based on cognitive behavioural therapy (CBT) would find the 'Living Life to The Full' course useful so they can train survivors in key tools and techniques to enable them to cope (PHE, 2016a).

Survivors would benefit from psycho-education on suicide and coping. Understanding the causes and associated factors could reduce complications related to their suicide-related grief. Survivors often want to know why the suicide happened in addition to factual evidence or reports provided by the coroner. Being well informed about the concept of suicide could reduce feelings of guilt, anger, self-blame, abandonment and rejection.

7.2.6 The workplace plays an important role in support and recovery

Support in the workplace can be provided by formal (polices, human resources and line management) and informal processes (collegial) (Ferguson, et al., 2015). Employment for survivors played an important role in coping. Employers have the responsibility to support survivors by providing flexible-working options to help them return to work and encourage access to workplace programs and external supportive agencies (HSE 2016a; 2016b). Employers should consider Mental Wellbeing Impact Assessment (MWIA) training (PHE, 2016a). This programme focuses on promoting and protecting mental health and wellbeing which can be used as a tool to support and develop to promote mental wellbeing in the workplace.

The role of occupational health departments in the workplace can be a useful resource in supporting survivors and play a mediation role between the survivor and employer as advocates (Zomorodi and Foley, 2009). Furthermore, occupational health staff can support line managers and other colleagues through raising awareness and encouraging a non-discriminative working environment. This can be done by providing training such as Adult Mental Health First Aid which gives all employees a greater understanding of mental health issues and learn techniques to respond on a first aid basis (PHE, 2016a).

A wide professional group including community agencies, spiritual and religious leaders have a responsibility to work together and initiate support for survivors following intimate partner suicide at both a micro and macro level to address this public health issue (DH, 2012b; 2016; PHE, 2016b). This includes training and education for both providers and survivors to achieve their caring/healing goals. Future research on professionals' attitudes and beliefs about supporting survivors of intimate partner suicide would be beneficial to inform evidence-based

interventions and decision making.

7.2.7 Coping can be compromised as suicide is stigmatised

Survivors of intimate partner suicide experience stigma and discrimination (Peters, et al., 2016). Many survivors reported feeling isolated, ashamed and worthless. They reported a loss of friendships and feeling unsupported in their communities.

Education and training can reduce stigma (Pitman, et al., 2016) and raising awareness and understanding amongst the public and health professionals. In particular the public need to understand the impact of suicide and the link to suicidal ideation (DH, 2016; PHE, 2016a; 2016b; HM Government, 2017). Raising suicide alertness through training programmes such as 'safeTALK' provides this and is underpinned by stigma-based barriers which will help address suicide-related stigma (PHE, 2016a).

In general, survivors' experiences following intimate partner suicide are not well understood. Raising awareness requires a revision of well-being, mental health and suicide prevention national and regional policies (DH, 2012a; 2012b; 2016; HM Government, 2012; 2017). The implementation of anti-discrimination practices through the public health agenda and by adopting a health promotion approach. A collective collaborative community approach needs to be adopted with the filtration at an individual level.

Stigma related research such as surveys would be useful to identify the current factors that lead to stigmatised and discriminatory views. Research focussing on the public's attitudes towards survivors will give insight into their unique views to enable the public health sector to target their related health promotion strategies.

7.3 Concluding remarks

This study has contributed to suicide bereavement research through an in-depth investigation of intimate partner suicide survivor coping. There is still a lack of understanding in this field. Qualitative and quantitative research approaches such as mixed methods are needed to build on the emerging qualitative findings.

The findings of this study contributed to the development of the IPSBCM to help

shape supportive practices and models of care for survivors. More needs to be done to effectively support survivors at a very difficult time in their lives and contribute to better personal, social, economic, psychological and physical outcomes.

REFERENCES

- Affleck, G. and Tennen, H., 1996. Construing Benefits from Adversity: Adaptational Significance and Dispositional Underpinnings. *Journal of Personality*, 64(4), pp.899-922.
- Ali, F., 2015. Exploring the Complexities of Suicide Bereavement Research. *Procedia - Social and Behavioral Sciences*, 165, pp.30-39.
- Alvarez, A., 1974. *The Savage God: A Study of Suicide*. Harmondsworth: Penguin.
- American Psychiatric Association., 2013. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association.
- Aronson, K.R., Kyler, S.J., Morgan, N.R., Perkins, D.F. and Love, L., 2017. Spouse and Family Functioning Before and After a Marine's Suicide: Comparisons to Deaths by Accident and in Combat. *Military Psychology*, 29(4) pp.294-306.
- Aveyard, H., 2010. *Doing A Literature Review in Health and Social Care: A Practical Guide*. 2nd ed. Maidenhead: McGraw-Hill/Open University Press.
- Ballester, S., Sastre, M.T.M. and Mullet, E., 2009. Forgivingness and Lay Conceptualizations of Forgiveness. *Personality and Individual Differences*, 47(6), pp.605-609.
- Bandura, A., 1977. Self-efficacy: Toward a Unifying Theory of Behavioral Change. *Psychological Review*, 84(2), pp.191-215.
- Barlow, C.A. and Phelan, A.M., 2007. Peer Collaboration: A Model to Support Counsellor Self-Care. *Canadian Journal of Counselling*, 41(1), pp.3-15.
- Barrett, T.W. and Scott, T.B., 1990. Suicide Bereavement and Recovery Patterns Compared with Nonsuicide Bereavement Patterns. *Suicide and Life-Threatening Behavior*, 20(1), pp.1-15.
- Bartik, W., Maple, M., Edwards, H. and Kiernan, M., 2013. The Psychological Impact of Losing a Friend to Suicide. *Australasian Psychiatry*, 21(6), pp.545-549.

- Beautrais, A.L., 2006a. Suicide in Asia. *Crisis*, 27(2), pp.55-57.
- Beautrais, A.L., 2006b. Women and Suicidal Behavior. *Crisis*, 27(4), pp.153-156.
- Begley, M. and Quayle, E., 2007. The Lived Experience of Adults Bereaved by Suicide: A Phenomenological Study. *Crisis*, 28(1), pp.26-34.
- Bell, J., Bailey, L. and Kennedy, D., 2015a. 'We Do It to Keep Him Alive': Bereaved Individuals' Experiences of Online Suicide Memorials and Continuing Bonds. *Mortality*, 20(4), pp.375-389.
- Bell, J., Stanley, N., Mallon, S. and Manthorpe, J., 2015b. Insights into The Processes of Suicide Contagion: Narratives from Young People Bereaved by Suicide. *Suicidology Online*, 6(1), pp.43-52.
- Biddle, L., 2003. Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroners' Procedures on Those Bereaved by Suicide. *Social Science and Medicine*, 56(5), pp.1033-1045.
- Biddle, L., Donovan, J., Owen-Smith, A., Potokar, J., Longson, D., Hawton, K., Kapur, N. and Gunnell, D., 2010. Factors Influencing the Decision to Use Hanging as A Method of Suicide: Qualitative Study. *The British Journal of Psychiatry*, 197(4), pp.320-325.
- Biggerstaff, D. and Thompson, A.R., 2008. Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research. *Qualitative Research in Psychology*, 5(3), pp.214-224.
- Biggs, H., 2009. *Healthcare Research Ethics and Law*. New York: Routledge-Cavendish.
- Birks, M., Chapman, Y. and Francis, K., 2008. Memoing in Qualitative Research: Probing Data and Processes. *Journal of Research in Nursing*, 13(1), pp.68-75.
- Bleakley, A., 1999. From Reflective Practice to Holistic Reflexivity. *Studies in Higher Education*, 24(3), pp.315-330.
- Boerner K., Stroebe M., Schut H. and Wortman C.B., 2015. Grief and Bereavement: Theoretical Perspectives. In: N., Pachan, ed. *Encyclopedia of Geropsychology*. Singapore: Springer. pp.6-19.

- Bogenschneider, K., 2014. *Family Policy Matters: How Policymaking Affects Families and What Professionals Can Do*. 3rd ed. New York: Routledge.
- Bolton, G., 2014. *Reflective Practice: Writing and Professional Development*. 4th ed. Los Angeles: Sage Publications.
- Bowlby, J., 1969. *Attachment and loss. Vol. 1, Attachment*. London: Penguin Books.
- Bowlby, J., 1973. *Attachment and loss. Vol. 2, Separation, Anxiety and Anger*. London: Penguin Books.
- Bowlby, J., 1980. *Attachment and Loss. Vol. 3, Loss, Sadness and Depression*. London: Penguin Books.
- Brown, C., 2014. *Understanding Person-centred Counselling*. Los Angeles: Sage Publications.
- Brülde, B., 2007. Happiness and the Good Life. Introduction and Conceptual Framework. *Journal of Happiness Studies*, 8(1), pp.1-14.
- Buglass, E., 2010. Grief and Bereavement Theories. *Nursing Standard*, 24(41), pp.44-47.
- Burke, P.J. and Stets, J.E., 2009. *Identity Theory*. Oxford: Oxford University Press.
- Calhoun, L.G., Cann, A., Tedeschi, R.G. and McMillan, J., 2000. A Correlational Test of the Relationship Between Posttraumatic Growth, Religion, and cognitive processing. *Journal of Traumatic Stress*, 13(3), pp.521-527.
- Calhoun, L.G. and Tedeschi, R.G., 2014. The Foundations of Posttraumatic Growth: An Expanded Framework. In: L. G. Calhoun and R. G. Tedeschi, eds. *The Handbook of Posttraumatic Growth: Research and Practice*. 2nd ed. New York: Psychology Press. pp.176-196.
- Calhoun, L.G., Tedeschi, R.G., Cann, A. and Hanks, E.A., 2010. Positive outcomes Following Bereavement: Paths to Posttraumatic Growth. *Psychologica Belgica*, 50(1-2), pp.125-143.

Campbell-Sills, L., Cohan, S.L. and Stein, M.B., 2006. Relationship of Resilience to Personality, Coping, And Psychiatric Symptoms in Young Adults. *Behaviour Research and Therapy*, 44(4), pp.585-599.

Care Quality Commission, 2013. *Supporting Information and Guidance: Supporting Effective Clinical Supervision*. [online]. Available at: <http://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf> [Accessed 12 December 2017].

Carmichael, M., 2005. Bereavement Assessment in Palliative Care – Identifying Those ‘at risk’. *Scottish Journal of Healthcare Chaplaincy*, 8(2), pp.21-25.

Casemore, R. and Tudway, J., 2012. *Person-centred Therapy and CBT*. London: Sage Publications.

Cerel, J., Jordan, J.R. and Duberstein, P.R., 2008. The Impact of Suicide on the Family. *Crisis*, 29(1), pp.38-44.

Chandler, D., 2002. *Semiotics: The Basics*. London: Routledge.

Chang, S., Stuckler, D., Yip, P. and Gunnell, D., 2013. Impact of 2008 Global Economic Crisis on Suicide: Time Trend Study in 54 countries. *British Medical Journal*, 347, p.13.

Charmaz, K., 2006. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage Publications.

Chiaramello, S., Sastre, M.T.M. and Mullet, E., 2008. Seeking Forgiveness: Factor structure, and Relationships with Personality and Forgiveness. *Personality and Individual Differences*, 45(5), pp.383-388.

Clarke, A., 2010. *The Sociology of Healthcare*. 2nd ed. Harlow: Longman.

Cleiren, M.P.H.D., Grad, O., Zavasnik, A. and Diekstra, R.F.W., 1996. Psychosocial Impact of Bereavement After Suicide and Fatal Traffic Accident: A Comparative Two-Country Study. *Acta Psychiatrica Scandinavica*, 94(1), pp.37-44.

- Clements, P.T., DeRanieri, J.T., Vigil, G.J. and Benasutti, K.M., 2004. Life after Death: Grief Therapy after the Sudden Traumatic Death of a Family Member. *Perspectives in Psychiatric Care*, 40(4), pp.149-154.
- Coelho, H.F., Canter, P.H. and Ernst, E., 2013. Mindfulness-based Cognitive Therapy: Evaluating Current Evidence and Informing Future Research. *Psychology of Consciousness: Theory, Research, and Practice*, 1, pp.97-107.
- Coleman, D., Kaplan, M.S. and Casey, J.T., 2011. The Social Nature of Male Suicide: A New Analytic Model. *International Journal of Men's Health*, 10(3), pp.240-252.
- Coleman, R.A. and Neimeyer, R.A., 2010. Measuring Meaning: Searching for and Making Sense of Spousal Loss in Late-Life. *Death Studies*, 34(9), pp.804-834.
- Colucci, E. and Martin, G., 2008. Religion and Spirituality along the Suicidal Path. *Suicide and Life-Threatening Behavior*, 38(2), pp.229-244.
- Constantino, R.E. and Bricker, P.L., 1996. Nursing Postvention for Spousal Survivors of Suicide. *Issues in Mental Health Nursing*, 17(2), pp.131-152.
- Constantino, R.E., Sekula, L.K., Lebish, J. and Buehner, E., 2002. Depression and Behavioral Manifestations of Depression in Female Survivors of the Suicide of Their Significant Other and Female Survivors of Abuse. *Journal of the American Psychiatric Nurses Association*, 8(1), pp.27-32.
- Constantino, R.E., Sekula, L.K. and Rubinstein, E.N., 2001. Group Intervention for Widowed Survivors of Suicide. *Suicide and Life-Threatening Behavior*, 31(4), pp.428-441.
- Constantino, R.E., Sutton, L.B. and Rohay, J., 1997. Assessing Abuse in Female Suicide Survivors. *Holistic Nursing Practice*, 11(2), pp.60-68.
- Cooper, C., 2012. Kinship Families: Grandparents and Other Relatives as Primary Caregivers for Children. *International Journal of Childbirth Education*, 27(4), pp.27-31.
- Corbin, J.M. and Strauss, A.L., 2015. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. 4th ed. Los Angeles: Sage Publications.

- Corr, C.A., 1999. Enhancing the Concept of Disenfranchised Grief. *Journal of Death and Dying*, 38(1), pp.1-20.
- Costello, J., 1999. Anticipatory Grief: Coping with The Impending Death of a Partner. *International Journal of Palliative Nursing*, 5(5), pp.223-231.
- Creswell, J.W., 1998. *Qualitative Inquiry and Research Design: Choosing among Five Traditions*. Thousand Oaks, California: Sage Publications.
- Creswell, J.W., 2009. *Research Design: Qualitative, Quantitative, and Mixed Method Approaches*. 3rd ed. London: Sage Publications.
- Creswell, J.W., 2013. *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. 3rd ed. London: Sage Publications.
- Crunk, A.E., Burke, L.A. and Robinson, E.H.M., 2017. Complicated Grief: An Evolving Theoretical Landscape. *Journal of Counseling & Development*, 95(2), pp.226-233.
- Currier, J.M., Neimeyer, R.A. and Berman, J.S., 2008. The Effectiveness of Psychotherapeutic Interventions for Bereaved Persons: A Comprehensive Quantitative Review. *Psychological Bulletin*, 134(5), pp.648-661.
- Curtis, E.A. and Drennan, J., 2013. *Quantitative Health Research*. Berkshire: Open University Press.
- Cvinar, J.G., 2005. Do Suicide Survivors Suffer Social Stigma: A Review of the Literature. *Perspectives in Psychiatric Care*, 41(1), pp.14-21.
- Dahlberg, K., Dahlberg, H. and Nyström, M., 2008. *Reflective Lifeworld Research*. 2nd ed. Sweden: Studentlitteratur.
- Davies, R., 2004. New Understandings of Parental Grief: Literature Review. *Journal of Advanced Nursing*, 46(5), pp.506-513.
- De Groot, M.H., De Keijser, J. and Neeleman, J., 2006. Grief Shortly After Suicide and Natural Death: A Comparative Study Among Spouses and First-Degree Relatives. *Suicide and Life-Threatening Behavior*, 36(4), pp.418-431.

De Leo, D., 2002. Struggling Against Suicide: The need for an Integrative Approach. *Crisis*, 23(1), pp.23-31.

De Leo, D., Burgis, S., Bertolote, J.M., Kerkhof, A.J.F.M. and Bille-Brahe, U., 2006. Definitions of Suicidal Behavior: Lessons Learned from the WHO/EURO Multicentre Study. *Crisis*, 27(1), pp.4-15.

De Leo, D., Milner, A., Fleischmann, A., Bertolote, J., Collings, S., Amadeo, S., Chan, S., Yip, P.S.F., Huang, Y., Saniel, B., Lilo, F., Lilo, C., David, A.M., Benavente, B., Nadera, D., Pompili, M., Kolves, K.E., Kolves, K. and Wang, X., 2013. The WHO START Study: Suicidal Behaviors across Different Areas of the World. *Crisis*, 34(3), pp.156-163.

Demi, A.S., 1984. Social Adjustment of Widows After a Sudden Death: Suicide and Non-Suicide Survivors Compared. *Death Education*, 8, pp.91-111.

Department of Health, 2012a. *No Health without Mental Health: Implementation Framework*. London: DH.

Department of Health, 2012b. *Suicide Prevention Strategy for England*. London: DH.

Department of Health, 2016. *The Five Year Forward View for Mental Health*. London: DH.

De Vogli, R., Marmot, M. and Stuckler, D., 2013. Strong Evidence that the Economic Crisis Caused a Rise in Suicides in Europe: The Need for Social Protection. *Journal of Epidemiology and Community Health*, 67(4), p.298.

Diaz-Caneja, A. and Johnson, S., 2004. The Views and Experiences of Severely Mentally Ill Mothers - A Qualitative Study. *Social Psychiatry and Psychiatric Epidemiology*, 39(6), pp.472-482.

Doka, K.J., 1989. *Disenfranchised Grief: Recognizing Hidden Sorrow*. Lexington, MA: Lexington Books.

Doka, K.J., 2002. *Disenfranchised Grief: New directions, Challenges, and Strategies for Practice*. Champaign, IL: Research Press.

- Doka, K.J., 2008. Disenfranchised Grief in Historical and Cultural Perspective. In: M.S. Stroebe, R.O. Hansson, H. Schut and W. Stroebe, eds. *The Handbook of Bereavement Research and Practice: Advances in Theory and Intervention*. Washington, DC, USA: American Psychological Association. pp.223-240.
- Dunne, K., 2004. Grief and its Manifestations. *Nursing Standard*, 18(45), pp.45-53.
- Dyregrov, K., 2002. Assistance from Local Authorities versus Survivors' Needs for Support after Suicide. *Death Studies*, 26(8), pp.647-668.
- Egan, G., 2014. *The Skilled Helper: A Client-centred Approach*. Andover: Cengage Learning.
- Elliott, R., Fischer, C.T. and Rennie, D.L., 1999. Evolving Guidelines for Publication of Qualitative Research Studies in Psychology and Related Fields. *British Journal of Clinical Psychology*, 38(3), pp.215-229.
- Farberow, N.L., Gallagher, D.E., Gilewski, M.J. and Thompson, L.W., 1987. An Examination of the Early Impact of Bereavement on Psychological Distress in Survivors of Suicide. *The Gerontologist*, 27(5), pp.592-598.
- Farberow, N.L., Gallagher-Thompson, D., Gilewski, M. and Thompson, L., 1992a. Changes in Grief and Mental Health of Bereaved Spouses of Older Suicides. *Journal of Gerontology: Psychological Sciences*, 47(6), pp.357-366.
- Farberow, N.L., Gallagher-Thompson, D., Gilewski, M. and Thompson, L., 1992b. The Role of Social Supports in The Bereavement Process of Surviving Spouses of Suicide and Natural Deaths. *Suicide and Life-Threatening Behavior*, 22(1), pp.107-124.
- Fehr, B. and Sprecher, S., 2013. Compassionate Love: What We Know So Far. In: M. Hojjat and D. Cramer, eds. *Positive Psychology of Love*. New York: Oxford University Press.
- Ferguson, M., Carlson, D. and Kacmar, K.M., 2015. Flexing Work Boundaries: The Spillover and Crossover of Workplace support. *Personnel Psychology*, 68(3), pp.581-614.

Finlay, L., 2003. The Reflexive Journey: Mapping Multiple Routes. In: L. Finlay and B. Gough, eds. *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*. Oxford: Blackwell Science. pp.3-20.

Finlay, L., 2014. Engaging Phenomenological Analysis. *Qualitative Research in Psychology*, 11(2), pp.121-141.

Fischer, P.C., 2014. The Link Between Posttraumatic Growth and Forgiveness: An Intuitive Truth. In: L.G. Calhoun. and R.G. Tedeschi, eds. 2014. *The Handbook of Posttraumatic Growth: Research and Practice*. Mahwah, New Jersey: Lawrence Erlbaum Associates Publishers. pp.311-333.

Fit for Work, 2017. *Benefits of a Healthy Workforce*. [online] Available at: <<http://fitforwork.org/employer/benefits-of-a-healthy-workforce/>> [Accessed 12 December 2017].

Flick, U., 2014. *An Introduction to Qualitative Research*. 5th ed. Los Angeles: Sage Publications.

Foggin, E., McDonnell, S., Cordingley, L., Kapur, N., Shaw, J. and Chew-Graham, C., 2016. GPs' Experiences of Dealing with Parents Bereaved by Suicide: A Qualitative Study. *The British Journal of General Practice*, 66(651), pp.737-746.

Freeman, G.K., Olesen, F. and Hjortdahl, P., 2003. Continuity of Care: An Essential Element of Modern General Practice? *Family Practice*, 20(6), pp.623-627.

Freud, S., 1961. Mourning and Melancholia. In: J. Strachey, J, ed. *The Standard Edition of The Complete Psychological Works of Sigmund Freud*. London: Hogarth Press. pp. 152-170.

Frey, L.M., Hans, J.D. and Cerel, J., 2016. Perceptions of Suicide Stigma: How Do Social Networks and Treatment Providers Compare? *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 37(2), pp.95-103.

Gadamer, H.G., 1975. *Truth and Method*. London: Sheed & Ward.

Gall, T.L., Henneberry, J. and Eyre, M., 2014. Two Perspectives on the Needs of Individuals Bereaved by Suicide. *Death Studies*, 38(7), pp.430-437.

Gee, J.P., 2005. *An Introduction to Discourse Analysis: Theory and Method*. 2nd ed. London: Routledge.

General Medical Council, 2017. *Good Medical Practice (2013)*. [online]. Available at: <http://www.gmc-uk.org/guidance/good_medical_practice.asp> [Accessed 12 December 2017].

Genevro, J.L., Marshall, T., Miller, T. and Center for Advancement of Health., 2004. Report on bereavement and grief research. *Death Studies*, 28(6), pp.491-491.

Ghezeljeh, T.N. and Emami, A., 2009. Grounded Theory: Methodology and Philosophical Perspective. *Nurse Researcher*, 17(1), pp.15-23.

Gilewski, M.J., Farberow, N.L., Gallagher, D.E. and Thompson, L.W., 1991. Interaction of Depression and Bereavement on Mental Health in The Elderly. *Psychology and Aging*, 6(1), pp.67-75.

Girardin, M. and Widmer, E.D., 2015. Lay Definitions of Family and Social Capital in Later Life. *Personal Relationships*, 22(4), pp.712-737.

Glaser, B.G, Strauss. A., 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.

Gloria, C.T. and Steinhardt, M.A., 2016. Relationships Among Positive Emotions, Coping, Resilience and Mental Health. *Stress and Health*, 32(2), pp.145-156.

GOV.UK, 2017. *Marriages and Civil Partnerships in the UK*. [online] Available at: <<http://www.gov.uk/marriages-civil-partnerships/overview>> [Accessed 12 December 2017].

Graham, S. and Weiner, B., 1996. Theories and Principles of Motivation. In: D. C. Berliner and R. C. Calfee, eds. *Handbook of Educational Psychology*. New York: Macmillian. pp.63-84.

Granek, L., 2010. Grief as Pathology: The Evolution of Grief Theory in Psychology from Freud to the Present. *History of Psychology*, 13(1), pp.46-73.

Green, J., 2010. *Creating the Therapeutic Relationship in Counselling and Psychotherapy*. Exeter: Learning Matters.

Green, J. and Thorogood, N., 2004. *Qualitative Methods for Health Research*. London: Sage Publications.

Greenstreet, W., 2004. Why Nurses Need to Understand the Principles of Bereavement Theory. *British Journal of Nursing*, 13(10), pp.590-593.

Gregory, M.J., 2013. Dying Together: Suicide Pacts and Other Episodes of Paired Suicides in Yorkshire and the Humber. *British Journal of Social Work*, 43(2), pp.298-316.

Griffiths, F., 2009. *Research Methods for Health Care Practice*. London: Sage Publications.

Guba, E.G. and Lincoln, Y.S., 1994. Competing Paradigms in Qualitative Research. In: N. K. Denzin and Y. S. Lincoln, eds. *Handbook of Qualitative Research*. London: Sage Publications. pp.105-117.

Guest, G., Bunce, A. and Johnson, L., 2006. How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. *Field Methods*, 18(1), pp.59-82.

Hall, C., 2011. Beyond Kübler-Ross: Recent Developments in Our Understanding of Grief and Bereavement. *InPsych*, 33(6), pp.8-11.

Hall, C., 2014. Bereavement Theory: Recent Developments in Our Understanding of Grief and Bereavement. *Bereavement Care*, 33(1), pp.7-12.

Hall, H., Griffiths, D. and McKenna, L., 2013. *From Darwin to Constructivism: The Evolution of Grounded Theory*. *Nurse Researcher*, 20(3), pp.17-21.

Hammersley, M. and Atkinson, P., 1995. *Ethnography: Principles in Practice*. 2nd ed. London: Routledge.

Hammond, M. and Wellington, J.J., 2013. *Research Methods*. New York: Routledge.

Harris, Z., 1952. Discourse Analysis. *Language*, (28), pp.1-30.

- Hawton, K. and Haw, C., 2013. Economic Recession and Suicide. *British Medical Journal*, 347, p.13.
- Hayes, S.C., Luoma, J.B., Bond, F.W., Masuda, A. and Lillis, J., 2006. Acceptance and Commitment Therapy: Model, processes and Outcomes. *Behaviour Research and Therapy*, 44(1), pp.1-25.
- Hayes, S.C., Pistorello, J. and Levin, M.E., 2012. Acceptance and Commitment Therapy as a Unified Model of Behavior Change. *The Counseling Psychologist*, 40(7), pp.976-1002.
- Health and Safety Executive, 2017a. *Health and Safety Legislation - Laws in the Workplace*. [online] Available at: <<http://www.hse.gov.uk/legislation/>> [Accessed 12 December 2017].
- Health and Safety Executive, 2017b. *Stress and Mental Health at Work: Guidance for Managers*. [online] Available at: <<http://www.hse.gov.uk/stress/furtheradvice/guidance.htm>> [Accessed 12 December 2017].
- Heathwood, C., 2006. Desire Satisfactionism and Hedonism. *Philosophical Studies*, 128(3), pp.539-563.
- Hefferon, K. and Gil-Rodriguez, E., 2011. Interpretative Phenomenological Analysis. *The Psychologist*, 24(10), pp.756-759.
- Heidegger, M., 1927. *Being and Time*. Reprint 1962. Oxford: Blackwell.
- Heikkinen, M., Aro, H. and Lönnqvist, J., 1992. Recent Life Events and Their Role in Suicide as Seen by The Spouses. *Acta Psychiatrica Scandinavica*, 86(6), pp.489-494.
- Henley, S.H.A., 1984. Bereavement Following Suicide: A Review of The Literature. *Current Psychological Research and Reviews*, 3(2), pp.53-61.
- Henriksson, M.M., Aro, H.M., Marttunen M.J., Heikkinen, M.E., Isometsä, E.T., Kuoppasalmi, K.I. and Lönnqvist, J.K., 1993. Mental Disorders and Comorbidity in Suicide. *American Journal of Psychiatry*, 150, pp.935–940.

Hill, K.M., Twiddy, M., Hewison, J. and House, A.O., 2014. Measuring Patient-Perceived Continuity of Care for Patients with Long-Term Conditions in Primary Care. *BMC Family Practice*, 15, pp.191-191.

Hjelmeland, H., Osafo, J., Akotia, C.S. and Knizek, B.L., 2014. The Law Criminalizing Attempted Suicide in Ghana: The Views of Clinical Psychologists, Emergency Ward Nurses, and Police Officers. *Crisis*, 35(2), pp.132-136.

HM Government, 2011. *Consultation on Preventing Suicide in England*. London: DH.

HM Government, 2012. *Preventing Suicide in England: A Cross-government Outcomes Strategy to Save Lives*. London: DH.

HM Government, 2017. *Preventing Suicide in England: Third Progress Report of the Cross-government Outcomes Strategy to Save Lives*. London: DH.

Hodgetts, R.M., 1991. *Organizational Behavior: Theory and Practice*. New York: Macmillian.

Hoffer, T.A., Shelton, J., Behnke, S. and Erdberg, P., 2010. Exploring the Impact of Child Sex Offender Suicide. *Journal of Family Violence*, 25(8), pp.777-786.

Holland, K. and Hogg, C., 2010. *Cultural Awareness in Nursing and Health Care*. 2nd. London: Hodder Arnold.

Holloway, I. and Wheeler, S., 2010. *Qualitative Research in Nursing and Healthcare*. 2nd ed. Chichester: Wiley-Blackwell.

Holmes, R.M. and Holmes, S.T., 2005. *Suicide: Theory, Practice and Investigation*. Thousand Oaks, California: Sage Publications.

Honkasalo, M. and Tuominen, M. eds., 2014. *Culture, Suicide, and The Human Condition*. New York: Berghahn Books.

Hopmeyer, E. and Werk, A., 1994. A Comparative Study of Family Bereavement Groups. *Death studies*, 18(3), pp.243-256.

Hough, M., 2014. *Counselling Skills and Theory*. 4th ed. London: Hodder Education.

- Hunt, Q.A. and Hertlein, K.M., 2015. Conceptualizing Suicide Bereavement from an Attachment Lens. *American Journal of Family Therapy*, 43(1), pp.16-27.
- Husserl, E., 1931. *Ideas: General Introduction to Pure Phenomenology*. London: Allen & Unwin.
- Hyams, M., 2004. Hearing girls' Silences: Thoughts on The Politics and Practices of a Feminist Method of Group Discussion. *Gender, Place and Culture*, 11(1), pp.105-119.
- Infurna, F.J. and Mayer, A., 2015. The Effects of Constraints and Mastery on Mental and Physical Health: Conceptual and Methodological Considerations. *Psychology and Aging*, 30(2), pp.432-448.
- Iso-Ahola, S., 1980. *The Social Psychology of Leisure and Recreation*. Iowa: William C. Brown.
- Jaques, J.D., 2000. Surviving Suicide: The Impact on the Family. *The Family Journal*, 8(4), pp.376-379.
- Johns, C., 2010. *Guided Reflection*. 2nd ed. Chichester: Wiley-Blackwell.
- Jordan, J. R., 2001. Is Suicide Bereavement Different? A Reassessment of the Literature. *Suicide and Life-Threatening Behavior*, 31, pp.91–102.
- Jordan, R. and McIntosh, J.L., 2011. Is Suicide Bereavement Different? Perspectives from Research and Practice. In: R.A. Neimeyer, D.L. Harris, H.R. Winokue and G. F. Thornton, eds. *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*. London: Routledge. pp. 223-234.
- Judd, F., Jackson, H., Komiti, A., Bell, R. and Fraser, C., 2012. The Profile of Suicide: Changing or changeable? *Social Psychiatry and Psychiatric Epidemiology*, 47(1), pp.1-9.
- Jukkala, T. and Mäkinen, I.H., 2011. Acceptance of Suicide in Moscow. *Social Psychiatry and Psychiatric Epidemiology*, 46(8), pp.753-765.
- Kabat-Zinn, J., 2005. *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*. New York: Hyperion.

- Kalekin-Fishman, D. and Denis, A.B., 2012. *The Shape of Sociology for the 21st Century*. Los Angeles: Sage Publications.
- Kathol, R.G., Perez, R. and Cohen, J.S., 2010. *The Integrated Case Management Manual: Assisting Complex Patients Regain Physical and Mental Health*. New York: Springer.
- Khan, M.M., 2002. Suicide on the Indian Subcontinent. *Crisis*, 23(3), pp.104-107.
- Kim, J.W., Lee, H. and Lee, K., 2013. Influence of Temperament and Character on Resilience. *Comprehensive Psychiatry*, 54(7), pp.1105-1110.
- Klass, D., Silverman, P.R. and Nickman, S.L., 1996. *Continuing Bonds: New Understandings of Grief*. Philadelphia: Taylor and Francis.
- Kübler-Ross, E., 1969. *On Death and Dying*. New York: The Macmillan Company.
- Langdridge, D., 2007. *Phenomenological Psychology*. Harlow: Prentice Hall.
- Larkin, M., Watts, S. and Clifton, E., 2006. Giving Voice and Making Sense in Interpretative Phenomenological Analysis. *Qualitative Research in Psychology*, 3(2), pp.102-120.
- Latham, A.E. and Prigerson, H.G., 2004. Suicidality and Bereavement: Complicated Grief as Psychiatric Disorder Presenting Greatest Risk for Suicidality. *Suicide and Life-Threatening Behavior*, 34(4), pp.350-362.
- Laverty, S.M., 2003. Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods*, 2(3), pp.21-35.
- Lawler, S., 2014. *Identity: Sociological Perspectives*. 2nd ed. Cambridge: Polity.
- Lazarus, R. S., 1966. *Psychological Stress and the Coping Process*. New York: McGraw-Hill.
- Lazarus, R. S. and Folkman, S., 1984. *Stress, Appraisal, and Coping*. New York: Springer.
- Leone, J.E., 2012. *Concepts in Male Health*. San Francisco: Jossey-Bass.

Leonetti, D.L., 2008. Cultural Dimensions of Kin Investment: An Introduction. *Human Nature*, 19(3), pp.227-230.

Lepore, S.J. and Revenson, T.A., 2014. Resilience and Posttraumatic Growth: Recovery, Resistance and Reconfiguration. In: L. G. Calhoun and R. G. Tedeschi, eds. *The Handbook of Posttraumatic Growth: Research and Practice*. 2nd ed. New York: Psychology Press. pp.176-196.

Levin, I., 1999. What Phenomenon is Family? *Marriage and Family Review*, 28, pp.93-104.

Li, J., Stroebe, M., Chan, C.L.W. and Chow, A.Y.M., 2014. Guilt in Bereavement: A Review and Conceptual Framework. *Death Studies*, 38(3), pp.165-171.

Lincoln, Y.S. and Guba, E.G., 1985. *Naturalistic Inquiry*. California: Sage Publications.

Lindemann, E., 1944. Symptomatology and Management of Acute Grief. *The American Journal of Psychiatry*, 151(6), pp.155-160.

Lindqvist, P., Johansson, L. and Karlsson, U., 2008. In the Aftermath of Teenage Suicide: A Qualitative Study of the Psychosocial Consequences for the Surviving Family Members. *BMC Psychiatry*, 8(1), pp.26-33.

Lyon, B.L., 2012. Stress, Coping, and Health: A Conceptual Overview. In: V. Hill Rice, ed, *Handbook of Stress, Coping, And Health: Implications for Nursing Research, Theory, And Practice*. 2nd ed. California: Sage Publications. pp.2-20.

Maddi, S.R., 2006. Hardiness: The Courage to Grow from Stresses. *Journal of Positive Psychology*, 1(3), pp.160-168.

Magyar-Moe, J.L. and Lopez, S.J., 2015. Strategies for Accentuating Hope. In: S. Joseph, ed. *Positive Psychology in Practice*. 2nd ed. Hoboken: John Wiley and Sons. pp.483-502.

Manning, W. and Brown, S.L., 2011. The Demography of Unions Among Older Americans, 1980-Present: A Family Change Approach. In: R.A. Settersten and J.L. Angel, eds. *Handbook of Sociology of Aging*. New York: Springer. pp.193–210.

Martin, T.L. and Doka, K.J., 2011. The Influence of Gender and Socialization on Grieving Styles. In: R.A. Neimeyer, D.L. Harris, H.R. Winokuer and G. F. Thornton, eds. *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*. London: Routledge. pp. 69-78.

Martin, L. L. and Tesser, A., 1989. Toward a Motivational and Structural Theory of Ruminative Thought. In: J. S. Uleman and J.A. Bargh, eds. *Unintended Thought*. New York: Guilford. pp.306-326.

Martin, L.L. and Tesser, A., 1996. Some Ruminative Thoughts. In: R.S. Weyer, ed. *Advances in Social Cognition*. Mahwah, New Jersey: Lawrence Erlbaum. pp.1-47.

Maslow, A. H., 1987. *Motivation and Personality*. 3rd ed. New York: Harper & Row.

Mead, S. and MacNeil C., 2006. Peer Support: What Makes It Unique? *International Journal of Psychosocial Rehabilitation*, 10(2), pp.29-37.

Merleau-Ponty, M., 1962. *Phenomenology of Perception*. London: Routledge.

McKinnon, J.M. and Chonody, J., 2014. Exploring the Formal Supports Used by People Bereaved Through Suicide: A Qualitative Study. *Social Work in Mental Health*, 12(3), pp.231-248.

McLeod, J., 2007. *Counselling Skill*. Maidenhead: McGraw-Hill Open University Press.

McNiel, D.E., Hatcher, C. and Reubin, R., 1988. Family Survivors of Suicide and Accidental Death: Consequences for Widows. *Suicide and Life-Threatening Behavior*, 18(2), pp.137-148.

Mind, 2017. *Home Page*. [online] Available at: <<http://www.mindhey.co.uk/>> [Accessed 12 December 2017].

Mitchell, A.M., Crane, P.A. and Kim, Y., 2008. Perceived Stress in Survivors of Suicide: Psychometric Properties of the Perceived Stress Scale. *Research in Nursing and Health*, 31(6), pp.576-585.

- Mitchell, A.M., Sakraida, T.J., Kim, Y., Bullian, L. and Chiappetta, L., 2009. Depression, Anxiety and Quality of Life in Suicide Survivors: A Comparison of Close and Distant Relationships. *Archives of Psychiatric Nursing*, 23(1), pp.2-10.
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G. and The PRISMA Group., 2009. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA statement. *British Medical Journal*, 339, pp.332-336.
- Morse, J. M., 1994. Designing funded Qualitative Research. In N. K. Denzin and Y. S. Lincoln, eds. *Handbook of Qualitative Research*. 2nd ed. Thousand Oaks, California: Sage Publications. pp.220-235.
- Moule, P. and Goodman, M., 2014. *Nursing Research*. 2nd ed. Los Angeles: Sage Publications.
- Munhall, P., 2012. *Nursing Research a Qualitative Perspective*. 5th ed. Canada: Jones & Bartlett Learning.
- Myers, P.L. and Isralowitz, R., 2011. *Alcohol*. Santa Barbara, California: Greenwood.
- National Institute for Mental Health in England, 2005. *NIMHE Guiding Statement on Recovery*. London: NIMHE.
- Neimeyer, R.A., 2001. The Language of Loss: Grief Therapy as A Process of Meaning Reconstruction. In: R.A. Neimeyer, ed. *Meaning Construction & The Experience of Loss*. Washington, DC, USA: American Psychological Association. pp.261-292.
- Neimeyer, R.A., Baldwin, S.A. and Gillies, J., 2006. Continuing Bonds and Reconstructing Meaning: Mitigating Complications in Bereavement. *Death Studies*, 30(8), pp.715-738.
- Neimeyer, R.A. and Sands, D.C., 2011. Meaning Reconstruction in Bereavement from Principles to Practice. In: R.A. Neimeyer, D.L. Harris, H.R. Winokuer and G. F. Thornton, eds. *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*. London: Routledge. pp. 9-23.

Neto, F., 2007. Forgiveness, Personality and Gratitude. *Personality and Individual Differences*, 43(8), pp.2313-2323.

Neulinger, J., 1981. *To Leisure: An Introduction*. Boston: Allyn and Bacon.

NHS Choices, 2015. *About the NHS: NHS Principles*. [online] Available at: <<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx>> [Accessed 12 December 2017].

NHS Direct, 2008. *Help is at Hand: A Resource for People Bereaved by Suicide and Other Sudden, Traumatic Death*. DH: London.

Nic an Fhaili, M., Flynn, N. and Dowling, S., 2016. Experiences of Suicide Bereavement: A Qualitative Study Exploring the Role of the GP. *The British Journal of General Practice*, 66(643), pp.92-98.

Nicolson, P., 2003. Reflexivity, 'Bias' and the In-Depth Interview: Developing Shared Meanings. In: L. Finlay and B. Gough, eds. *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*. Oxford: Blackwell Science. pp.133-145.

Noy, C., 2008. Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research. *International Journal of Social Research Methodology*, 11(4), pp.327-344.

Office for National Statistics, 2013. *Statistical Bulletin: Suicides in the United Kingdom: 2011 Registrations*. London: ONS.

Office for National Statistics, 2016. *Statistical Bulletin: Suicides in the United Kingdom: 2014 Registrations*. London: ONS.

Office for National Statistics, 2017a. *Statistical Bulletin: Suicides in Great Britain: 2016 Registrations*. London: ONS.

Office for National Statistics, 2017b. *Statistical Bulletin: Suicides in the United Kingdom: 2016 Registrations*. London: ONS.

Owens, C. and Lambert, H., 2012. Mad, Bad or Heroic? Gender, Identity and Accountability in Lay Portrayals of Suicide in Late Twentieth-Century England. *Culture, Medicine and Psychiatry*, 36(2), pp.348-371.

- Paltridge, B., 2012. *Discourse Analysis*. 2nd ed. London: Bloomsbury Publishing.
- Park, C. L. and Blumberg, C. J., 2002. Disclosing Trauma through Writing: Testing the Meaning-making Hypothesis. *Cognitive Therapy and Research*, 26, pp.597-616.
- Parkes, C.M., 1998. Coping with Loss: The Dying Adult. *British Medical Journal*, 316 (7140), pp.1313-1315.
- Patton, M. Q., 2002. *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks, California: Sage Publications.
- Pearlin, L.I. and Schooler, C., 1978. The Structure of Coping. *Journal of Health and Social Behavior*, 19(1) pp.2-21.
- Pennebaker, J.W. and O'Heeron, R.C., 1984. Confiding in Others and Illness Rate Among Spouses of Suicide and Accidental-Death Victims. *Journal of Abnormal Psychology*, 93(4), pp.473-476.
- Perugini, M. and Bagozzi, R.P., 2001. The Role of Desires and Anticipated Emotions in Goal-Directed Behaviours: Broadening and Deepening the Theory of Planned Behaviour. *British Journal of Social Psychology*, 40(1), pp.79-98.
- Petch, J., Halford W.K., Creedy, D.K. and Gamble, J., 2012. A Randomised Controlled Trial of a Couple Relationship and Co-Parenting Program (Couple CARE for Parents) For High and Low-Risk New Parents. *Journal of Consulting and Clinical Psychology*, 80(4), pp.662-73.
- Peters, K., Cunningham, C., Murphy, G. and Jackson, D., 2016. 'People Look Down on You When You Tell Them How He Died': Qualitative Insights into Stigma as Experienced by Suicide Survivors. *International Journal of Mental Health Nursing*, 25(3), pp.251-257.
- Peters, K., Murphy, G. and Jackson, D., 2013. Events Prior to Completed Suicide: Perspectives of Family Survivors. *Issues in Mental Health Nursing*, 34(5), pp.309-316.
- Petty, M.S., 2000. SOS and the Retelling of Suicide. *Health*, 4(3), pp.288-308.

- Pietilä, M., 2002. Support groups: A psychological or Social Device for Suicide Bereavement? *British Journal of Guidance and Counselling*, 30(4), pp.401-414.
- Pitman, A.L., Osborn, D.P.J., Rantell, K. and King, M.B., 2016. The stigma perceived by people bereaved by suicide and other sudden deaths: A cross-sectional UK study of 3432 bereaved adults. *Journal of Psychosomatic Research*, 87, pp.22-29.
- Pompili, M., Lester, D., De Pisa, E., Del Casale, A., Tatarelli, R. and Girardi, P., 2008. Surviving the Suicides of Significant Others: A Case Study. *Crisis*, 29(1), pp.45-48.
- Ponterotto, J.G., 2005. Qualitative Research in Counseling Psychology: A Primer on Research Paradigms and Philosophy of Science. *Journal of Counseling Psychology*, 52(2), pp.126-136.
- Praeger, S.G. and Bernhardt, G.R., 1985. Survivors of Suicide: A Community in Need. *Family and Community Health*, 8(3), pp.62-72.
- Prigerson, H.G., Frank, E., Kasl, S.V., Reynolds, C.F., Anderson, B., Zubenko, G.S., Houck, P.R., George, C.J. and Kupfer, D.J., 1995. Complicated Grief and Bereavement-Related Depression as Distinct Disorders: Preliminary Empirical Validation in Elderly Bereaved Spouses. *The American Journal of Psychiatry*, 152 (1), pp.22-30.
- Prigerson, H.G., Horowitz, M.J., Jacobs, S.C., Parkes, C.M., Aslan, M., Goodkin, K., Raphael, B., Marwit, S.J., Wortman, C., Neimeyer, R.A., Bonanno, G., Block, S.D., Kissane, D., Boelen, P., Maercker, A., Litz, B.T., Johnson, J.G., First, M.B. and Maciejewski, P.K., 2009. Prolonged Grief Disorder: Psychometric Validation of Criteria Proposed for DSM-V and ICD-11. *PLoS Medicine*, 6(8), pp.1-12.
- Provini, C. and Everett, J.R., 2000. Adults Mourning Suicide: Self-Reported Concerns About Bereavement, Needs for Assistance, And Help-Seeking Behaviour. *Death Studies*, 24(1), pp.1-19.

Prymachuk, S., 2011. Theoretical Perspectives in Mental Health Nursing. In: S. Prymachuk, ed. *Mental Health Nursing: An Evidence-Based Introduction*. Los Angeles: Sage Publications. pp.3-41.

Public Health England, 2016a. *Mental Health Promotion and Prevention Training Programmes: Emerging Practice Examples*. London: PHE.

Public Health England, 2016b. *Support After a Suicide: A Guide to Providing Local Services. A Practice Resource*. London: PHE.

Rando, T., 1988. *Grieving: How to Go on Living When Someone You Loves Dies*. Massachusetts: Lexington Books.

Rawlinson, D., Schiff, J.W. and Barlow, C.A., 2009. A Review of Peer Support for Suicide Bereavement as a Postvention Alternative. *Currents: New Scholarship in the Human Services*, 8(2). pp.1-20.

Reiners, G.M., 2012. Understanding the Differences between Husserl's (Descriptive) and Heidegger's (Interpretive) Phenomenological Research. *Journal of Nursing Care*, 1(5), pp.1-3.

Reuther, B.T., 2014. On Our Everyday Being: Heidegger and Attachment Theory. *Journal of Theoretical and Philosophical Psychology*, 34(2), pp.101-115.

Rodger, M.L., Sherwood, P., O'Connor, M. and Leslie, G., 2006. Living Beyond the Unanticipated Sudden Death of a Partner: A Phenomenological Study. *Omega*, 54(2), pp.107-133.

Rogers, C.R., 1980. *A Way of Being*. Boston: Houghton Mifflin.

Root, B.L. and Exline, J.J., 2014. The Role of Continuing Bonds in Coping with Grief: Overview and Future Directions. *Death Studies*, 38(1), pp.1-8.

Rosenblatt, P.C., 2017. Researching Grief: Cultural, Relational, and Individual Possibilities. *Journal of Loss & Trauma*, 22(8), pp.617-630.

Russo, M., Shteigman, A. and Carmeli, A., 2016. Workplace and Family Support and Work-life Balance: Implications for Individual Psychological Availability and Energy at Work. *Journal of Positive Psychology*, 11(2), pp.173-188.

- Salmond, S., 2011. Steps in The Systematic Review Process. In: M.K. Saimbert, ed. *Comprehensive Systematic Review for Advanced Nursing Practice*. New York: Springer Publishing. Co. pp.13-32.
- Sarte, J.P., 1943. *Being and Nothingness*. Reprint 1956. New York: Washington Square Press.
- Schleiermacher, F. and Bowie, A. ed., 1998. *Hermeneutics and Criticism and Other Writings*. Cambridge: Cambridge University Press.
- Schneider, B., Grebner, K., Schnabel, A. and Georgi, K., 2011. Is the Emotional Response of Survivors' Dependent on the Consequences of the Suicide and The Support Received? *Crisis*, 32(4), pp186-193.
- Segerstrom, S.C., Tsao, J.C.I., Alden, L.E. and Craske, M.G., 2000. Worry and Rumination: Repetitive Thought as a Concomitant and Predictor of Negative Mood. *Cognitive Therapy and Research*, 24(6), pp.671-688.
- Shaver, P.R., Collins, N. and Clark, C.L., 1996. Attachment Styles and Internal Working Models of Self and Relationship Patterns. In: G.J.O. Fletcher and J. Fitness, eds. *Knowledge Structures in Close Relationships: A Social Psychological Approach*. New Jersey: Lawrence Erlbaum Associates. pp. 25-53.
- Shaw, R., 2010. Embedding Reflexivity within Experiential Qualitative Psychology. *Qualitative Research in Psychology*, 7(3), pp.233-243.
- Shear, M.K., 2012. Getting Straight About Grief. *Depression and Anxiety*, 29(6), pp.461-464.
- Shneidman, E.S., 1965. Some Reflections on Death and Suicide. *Psychiatry and Clinical Neurosciences*, 19(4), pp.317-325.
- Simonsen, G. and Cooper, M., 2015. Helpful Aspects of Bereavement Counselling: An Interpretative Phenomenological Analysis. *Counselling & Psychotherapy Research*, 15(2), pp.119-127.
- Silverman, D., 2009. *Doing Qualitative Research*. 3rd ed. London: Sage Publications.

Smit, C., 2015. Theories and Models of Grief: Applications to Professional Practice. *Whitireia Nursing & Health Journal*, (22), pp.33-37.

Smith, J.A., 2004. Reflecting on the Development of Interpretative Phenomenological Analysis and its Contribution to Qualitative Research in Psychology. *Qualitative Research in Psychology*, (1), pp.39-54.

Smith, J.A., 2011a. Evaluating the Contribution of Interpretative Phenomenological Analysis. *Health Psychology Review*, 5(1), pp.9-27.

Smith, J.A., 2011b. Evaluating the Contribution of Interpretative Phenomenological Analysis: A Reply to the Commentaries and Further Development of Criteria. *Health Psychology Review*, 5(1), pp.55-61.

Smith, J.A., 2011c. "We Could Be Diving for Pearls": The Value of the Gem in Experiential Qualitative Psychology. *Qualitative Methods in Psychology Bulletin*, (12), pp.6-15.

Smith, R.E. and Ascough, J.C., 2016. *Promoting Emotional Resilience*. Guilford Publications.

Smith, A., Joseph, S. and Das Nair, R., 2011. An Interpretative Phenomenological Analysis of Posttraumatic Growth in Adults Bereaved by Suicide. *Journal of Loss & Trauma*, 16(5), pp.413-430.

Smith, J.A., Larkin, M. and Flowers, P., 2009. *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.

Smith, J.A. and Osborn, M., 2008. Interpretative Phenomenological Analysis. In: J.A. Smith, ed. *Qualitative Psychology: A Practical Guide to Research Methods*. 2nd ed. London: Sage Publications. pp.53-80.

Snyder, C.R., 2000. Hypothesis: There is Hope. In: C.R., Snyder, ed. *Handbook of Hope*. San Diego: Academic Press. pp.3-21.

Starks, H. and Trinidad, S.B., 2007. Choose Your Method: A Comparison of Phenomenology, Discourse Analysis and Grounded Theory. *Qualitative Health Research*, 17(10), pp.1372-1380.

Streubert, H.J. and Carpenter, D.R., 2011. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. 5th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Stroebe, M. and Schut, H., 1999. The Dual Process Model of Coping with Bereavement: Rationale and Description. *Death Studies*, 23(3), pp.197-224.

Stroebe, M.S. and Schut, H., 2001. Meaning-making in The Dual Process Model of Coping with Bereavement. In: R.A. Neimeyer, ed. *Meaning Construction & The Experience of Loss*. Washington, DC, USA: American Psychological Association. pp.55-73.

Stroebe, M., Schut, H. and Boerner, K., 2017. Cautioning Health-Care Professionals: Bereaved Persons Are Misguided Through the Stages of Grief. *Journal of Death and Dying*, 74(4), pp.455-473.

Stroebe, M., Schut, H. and Stroebe, W., 2007. Health Outcomes of Bereavement. *The Lancet*, 370, pp.1960-1973.

Stroebe, M., Stroebe, W. and Abakoumkin, G., 2005. The Broken Heart: Suicidal Ideation in Bereavement. *The American Journal of Psychiatry*, 162(11), pp.2178-2180.

Suicide Act 1961. (9&10 Eliz. 2, c.60). London: HMSO.

Support After Suicide, 2017. *Help is at Hand: Support After Someone May Have Died by Suicide*. [online]. Available at: <<http://www.supportaftersuicide.org.uk/help-is-at-hand>> [Accessed 12 December 2017].

Survivors of Bereavement by Suicide, 2017. *Home Page*. [online] Available at: <<http://uk-sobs.org.uk/>> [Accessed 12 December 2017].

Taylor, B.J., 2010. *Reflective Practice for Healthcare Professionals: A Practical Guide*. 3rd ed. New York: Open University Press.

Taylor, B.J., 2013. Revising the Process of Developing a Research Project. In: B.J. Taylor and K. Francis, eds. *Qualitative Research in the Health Sciences*. London: Routledge. pp.181-204.

- Tedeschi, R.G. and Blevins, C.L., 2015. From Mindfulness to Meaning: Implications for the Theory of Posttraumatic Growth. *Psychological Inquiry*, 26 (4), pp.373-376.
- Tedeschi, R.G and Blevins, C.L., 2016. Posttraumatic Growth: A Pathway to Resilience. In: U. Kumar, ed. *The Routledge International Handbook of Psychosocial Resilience*. Milton: Taylor and Francis.
- Tedeschi, R.G. and Calhoun, L.G., 1995. *Trauma & Transformation: Growing in the Aftermath of Suffering*. Thousand Oaks, California: Sage Publications.
- Tedeschi, R.G. and Calhoun, L.G., 1996. The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma. *Journal of Traumatic Stress*, 9(3), pp.455-472.
- Tedeschi, R.G. and Calhoun, L.G., 2004. Target Article: 'Posttraumatic Growth: Conceptual Foundations and Empirical Evidence'. *Psychological Inquiry*, 15(1), pp.1-18.
- Tee, S., Brown, J. and Carpenter, D., 2012. *Handbook of Mental Health Nursing*. London: Hodder Education.
- Thistlethwaite, J., 2012. *Values-based Interprofessional Collaborative Practice: Working Together in Health Care*. Cambridge: Cambridge University Press.
- Tolan, J., 2012. *Skills in Person-centred Counselling & Psychotherapy*. Los Angeles: Sage Publications.
- Trachtenberg, F., Dugan, E. and Hall, M.A., 2005. How Patients' Trust Relates to Their Involvement in Medical Care. *Family Practice*, 54(4), pp.344-352.
- Tracy, S.J., 2013. *Qualitative Research Methods*. Chichester: Wiley-Blackwell.
- Triplett, K. N., Tedeschi, R. G., Cann, A., Calhoun, L. G. and Reeve, C. L., 2012. Posttraumatic Growth, Meaning in Life, And Life Satisfaction in Response to Trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(4), 400– 410.

- Underwood, L. G., 2009. Compassionate Love: A Framework for Research. In B. Fehr, S. Sprecher, and L. G. Underwood, eds. *The science of Compassionate Love: Theory, Research, and Applications*. Malden, MA: Wiley-Blackwell. pp.3–25.
- Van Dongen, C.J., 1990. Agonizing Questioning: Experiences of Survivors of Suicide Victims. *Nursing Research*, 39(4), pp.224-229.
- Van Dongen, C.J., 1991. Experiences of Family Members After a Suicide. *Journal of Family Practice*, 33(4), pp.375-381.
- Velleman, R.D.B., 2011. *Counselling for Alcohol Problems*. London: Sage Publications.
- Vitae, 2009. *The Researcher Development Framework*. Cambridge: Vitae.
- Voracek, M., 2005. Suicide Risk After Spousal Suicide or Psychiatric Admission: Effects of Assortative Mating on Heritable Traits Compared with Environmental Explanations. *Journal of Epidemiology and Community Health*, 59(5), pp.347-348.
- Vroom, V., 1964. *Work and Motivation*. New York: Wiley.
- Weigel, D.J., 2008. The Concept of Family: An Analysis of Laypeople's Views of Family. *Journal of Family Issues*, 29(11), pp.1426-1447.
- Werdel, M.B. and Wicks, R.J., 2012. *Primer on posttraumatic Growth*. Hoboken, New Jersey: John Wiley & Sons.
- Wertheimer, A., 2014. *A Special Scar: The Experiences of People Bereaved by Suicide*. 3rd ed. Oxfordshire: Routledge.
- Wicks, R., 2012. *The Inner Life of the Counselor*. Hoboken, New Jersey: Wiley.
- Wiles, R., 2013. *What are Qualitative Research Ethics?* London: Bloomsbury Academic.
- Windsor, T.D., Ryan, L.H. and Smith, J.E, 2009. Individual Well-being in Middle and Older Adulthood: Do Spousal Beliefs Matter? *Journal of Gerontology: Psychological Sciences*, 64B (5), pp.586-596.

- Woolgar, S., 1988. *Knowledge and Reflexivity: New Frontiers in the Sociology of Knowledge*. London: Sage Publications.
- Wortman, C.B. and Silver, R.C., 1989. The Myths of Coping with Loss. *Journal of Consulting and Clinical Psychology*, 57(3), pp.349-357.
- Yardley, L., 2000. Dilemmas in Qualitative Health Research. *Psychology and Health*, 15(2), pp.215-228.
- World Health Organization, 2017a. *Health Topics: Suicide*. [online] Available at: <<http://www.who.int/topics/suicide/en/>> [Accessed 12 December 2017].
- World Health Organization, 2017b. *Media Centre: Suicide (Fact sheet N°398)*. [online] Available at: <<http://www.who.int/mediacentre/factsheets/fs398/en/>> [Accessed 12 December 2017].
- World Health Organization, 2017c. *Mental Health: Suicide Data*. [online] Available at: <http://www.who.int/mental_health/prevention/suicide/suicide_prevent/en/> [Accessed 12 December 2017].
- Yalom, I.D., 1985. *The Theory and Practice of Group Psychotherapy*. 3rd ed. New York: Basic Books.
- Yip, P.S.F. and Liu, K.Y., 2006. The Ecological Fallacy and the Gender Ratio of Suicide in China. *The British Journal of Psychiatry*, 189(5), pp.465-466.
- Young, I., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M. and Zisook, S., 2012. Suicide Bereavement and Complicated Grief. *Dialogues in Clinical Neuroscience*, 14(2), pp.177-186.
- Zeifman, D. and Hazan, C., 2000. A Process Model of Adult Attachment Formation. In: W. Ickes and S. Duck, eds. *The Social Psychology of Personal Relationships*. Chichester: John Wiley & Sons Ltd. pp.37-54.
- Znoj, H.J., 2014. Bereavement and Posttraumatic Growth. In: L. G. Calhoun and R. G. Tedeschi, eds. *The Handbook of Posttraumatic Growth: Research and Practice*. 2nd ed. New York: Psychology Press. pp.176-196.

Zoellner, T. and Maercker, A., 2006. *Posttraumatic growth in Clinical Psychology - A Critical Review and Introduction of a Two Component Model*. Clinical Psychology Review, 26(5), pp.626-653.

Zomorodi, M. and Foley, B.J., 2009. The Nature of Advocacy Vs. Paternalism in Nursing: Clarifying The 'Thin Line'. *Journal of Advanced Nursing*, 65(8), pp.1746-1752.

APPENDICES

Appendix A: Table 1: Summary of included studies

Author, Year, Country	Focus of Study	Design and Methods	Sample (size, recruitment, setting)	Findings related to Suicide Survivors' coping	Limitations/Critique
Demi (1984) USA	<p>Comparison of social adjustment of widows following a sudden death by suicide, natural or accidental causes.</p> <p>Hypotheses: suicide spouses will report less social adjustment; more guilt and resentment; and</p>	<p>Comparative ex-post facto design</p> <p>Methods: Survey interview.</p> <p>Measures used: SAS.</p>	<p>Convenience sample (n=40) of widows between ages 18-58 years.</p> <p>Suicide sample (n=20).</p> <p>Natural and accidental death sample (n=20).</p> <p>Recruitment: Names collected from coroner's records in three urban Californian counties.</p>	<p>Suicide sample reported good levels of social adjustment and social leisure. No significant differences between groups. (SAS for suicide survivors (item M=1.94 out of 5) similar for non-suicide survivors (item M=1.89 out of 5).</p> <p>Suicide sample experienced more guilt and resentment (item</p>	<p>Small sample size to achieve generalizable conclusions to other bereaved widows.</p> <p>All participants were Caucasian.</p> <p>Study investigated at one-time period only.</p> <p>Social adjustment is only one measurement of overall adjustment.</p>

	poorer role adjustment in social leisure than non-suicide spouses.		Length of widowhood range: 12 to 21 months Setting: General population. Survey in homes of bereaved.	M=2.49) compared to spouses of other death events (Item M=1.95) (p<0.05) on Family Unity Scale.	
Pennebaker and O'Heeron (1984) USA	Comparison of bereaved spouses of suicide and accidental motor vehicle deaths in confiding in others and illness rates. Hypothesis: suicide survivors less likely to discuss death of the spouse due to stigma and have higher illness rates.	Comparative survey study Methods: Mailed questionnaire. Measures used: Coping questionnaire developed by the authors.	Convenience sample (n=19) bereaved spouses (12 women, 7 men). Spouse married and living with spouse prior to the death, mean age: 37.5 yrs. Recruitment: Names collected from coroner's files during 1982. Length of widowhood range: 12 months. Setting: General population in a large metropolitan county in Southwest America.	Participants discussed the death a great deal with friends (M=2.52 out of 3). Those who talked about the death to counsellors had a mean of 1.58 illness events. Number of health in the year following the death increased (from M = .84 to M=2.53 problems).	Small non-random sample size to achieve generalizable conclusions to other bereaved spouses. Psychometric properties of measures not reported. Group and gender representation not reported. All participants were Caucasian. Nature of confiding not

					reported.
Farberow, Gallagher, Gilewski and Thompson (1987) USA	<p>Early impact of bereavement. A comparison of suicide and natural death amongst elderly survivors.</p> <p>Hypothesis: suicide sample will experience greater psychological distress compared to natural death group.</p>	<p>Comparative survey study (part of a longitudinal research project)</p> <p>Methods: Self-report questionnaires.</p> <p>Measures used: TIG Past and Present, BDI, BSI, MHSR.</p>	<p>Convenience sample (n=358) participants over 55 yrs. living in California. Recruitment from Coroner's records.</p> <p>Suicide sample (n=89): 70 women, 19 men, mean age: 62.4 yrs.</p> <p>Natural death sample (n=157): 91 women, 66 men, mean age: 68 yrs.</p> <p>Non-bereaved control sample (n=112): 50 women and 62 men, mean age: 70 yrs.</p> <p>Comparative controls from senior centres, aged care residential facilities and a volunteer group from a local university.</p>	<p>Grief reactions amongst both suicide survivors and natural death survivors were not significantly different.</p> <p>Suicide survivors (both women and men) reported more anxiety on the BSI anxiety subscale than natural death survivors ($p<0.003$).</p>	<p>Good sample size to achieve generalizable conclusions to other bereaved spouses. Both genders represented.</p> <p>Self-report measures likely to be influenced by acute grief reactions (2 months after death) introducing bias.</p> <p>Most participants were Caucasian (88%).</p>

McNiel, Hatcher and Reubin (1988) USA	A comparison of bereaved widows of suicide and accidental death and its consequences.	Comparative study Methods: Structured clinical interviews and self-report questionnaires. Measures used: FES, Family APGAR, LEQ, GHQ.	Convenience sample of bereaved widows (n=26) in California. Suicide sample (n=13), mean age: 44.3 yrs. Accident sample (n=13), mean age: 50.1 yrs. Length of widowhood range: 4-24 months (M= 18). Recruitment: Public records of death and next-of-kin details from coroner's office.	Suicide survivors reported a mild elevation on FES cohesion subscale (mean score = 60.33) but not significantly different from accidental death survivors. Structured interview data suggested more guilt and blame amongst suicide survivors.	Small sample limits generalizability. Most participants were Caucasian; widows only; from urban upper to middle class. Family functioning based on widow's subjective views.
Barrett and Scott (1990) USA	Comparison of bereavement experiences of spousal suicide survivors with survivors of natural and accidental	Case-control study Methods: Structured interview and self-report questionnaires. Measures: GEQ,	Convenience sample (n=57) of bereaved spouses between ages 24-48 years. Suicide sample (n=14): 11 women and 3 men. Recruitment: Names collected	Suicide survivors scored significantly higher than all others on the rejection and unique grief reactions subscales ($p<0.05$). Grief recovery measures revealed no significant	A non-standardised measure used. Reliability not reported. Small sample limits generalizability. Death of marital

	deaths.	PIL.	from obituaries. Setting: General population of North Dakota and Minnesota.	differences between groups.	partner occurred 24-48 months prior, results may be affected by recall bias.
Van Dongen (1990) USA	<p>Exploration of perceived life experiences 3 to 9 months after the suicide death of a family member.</p> <p>Research question:</p> <p>What do adult survivors report regarding their perceived life experiences 3 to 9 months after the suicide death of a family member?</p>	<p>Grounded theory methodology</p> <p>Method: In-depth interview lasting 90 minutes approximately</p> <p>conducted 5.8 months post suicide.</p>	<p>Purposive and snowballing sample (n=35): of suicide survivors (parents n=17, siblings n=8, children n=5 and spouses n=5) between ages 25-68 years (m=41.7).</p> <p>Gender: 25 women and 10 men.</p> <p>Notification of the suicide: found the body (n=10) and informed by family or public official (n=25).</p> <p>Religion: Protestant (54.3%), Catholic (37.1%) and Jewish (8.6%).</p>	<p>Themes: perception of the death, emotional turmoil, cognitive dissonance, physical disturbances, altered socialization, survival strategies and life experiences over time.</p> <p>Survivors experience a severe form of bereavement.</p> <p>Cognitive dissonance was an indicator of the grief response.</p> <p>Survivors that perceived the victim to be at risk of suicide and the death was</p>	<p>All participants were Caucasian with a majority (n=30) from the middle socio-economic class.</p> <p>Less than half of participants (48.6%) had no post high school education.</p> <p>Kinship and relation to findings were not reported.</p> <p>Quality and emotional attachment in kinship not reported.</p>

			<p>Length of bereavement: 3-9 months.</p> <p>Recruitment: names and addresses were sought from death certificates at county records office and a regional survivors of suicide organisation mailing list.</p> <p>Setting: General population. Face to face interviews at participants' homes or researcher's office.</p>	<p>unpreventable reported less or reduced grief symptoms.</p> <p>Survivors that experienced intensive cognitive dissonance had no expectation that a suicide would occur.</p>	<p>Bereavement period short and in the first year of bereavement.</p> <p>Participants were recruited from metropolitan and rural areas but findings and sample size were not reported.</p> <p>Self-report likely to be influenced by acute grief reactions and affect accuracy.</p> <p>More than one family member could participant in the study therefore one participant does not necessarily represent one victim.</p>
--	--	--	--	---	--

Van Dongen (1991) USA	<p>Exploration of perceived life experiences 3 to 9 months after the suicide death of a family member (part of qualitative study previously reported (Van Dongen, 1990).</p> <p>Research question:</p> <p>This part of the study focuses on the role of the GP as part of postvention.</p>	<p>Grounded theory methodology</p> <p>Method: in-depth interview lasting 90 minutes approximately conducted 5.8 months post suicide.</p>	<p>Purposive and snowballing sample (n=35): of suicide survivors (parents n=17, siblings n=8, children n=5 and spouses n=5) between ages 25-68 years (m=41.7).</p> <p>Gender: 25 women and 10 men.</p> <p>Notification of the suicide: found the body (n=10) and informed by family or public official (n=25).</p> <p>Religion: Protestant (54.3%), Catholic (37.1%) and Jewish (8.6%).</p> <p>Length of bereavement: 3-9 months: case study participants: mother (6 months), sibling (5 months)</p>	<p>Survivors of suicide experience a severe and varied bereavement.</p> <p>The GP is the main health professional to provide initial and follow up care to survivors.</p> <p>Survivors had different experiences with their GP: supportive (mother), avoided discussing it (sibling) and never sought consultation (spouse).</p>	<p>All participants were Caucasian with a majority (n=30) from the middle socio-economic class.</p> <p>Less than half of participants (48.6%) had no post high school education.</p> <p>Kinship and relation to findings were not reported.</p> <p>Quality and emotional attachment in kinship not reported.</p> <p>Bereavement period short and in the first year of bereavement.</p> <p>Participants were</p>
-----------------------	--	--	--	--	---

			<p>and spouse (4 months).</p> <p>Recruitment: names and addresses were sought from death certificates at county records office and a regional survivors of suicide organisation mailing list.</p> <p>Setting: General population. Face to face interviews at participants' homes or researcher's office.</p>		<p>recruited from metropolitan and rural areas but findings and sample size were not reported.</p> <p>More than one family member could participant in the study therefore one participant does not necessarily represent one victim.</p> <p>Case study social demographic information not all is provided.</p>
Gilewski, Farberow, Gallagher and Thompson	Effects of depression on bereavement status in the	Comparative study (part of original longitudinal study) Methods: Structured	<p>Sample (n=393) participants over 55 yrs. (M=67.5).</p> <p>Suicide random sample</p>	Suicide survivors reported more moderate-severe levels of depressive symptoms in first month,	<p>Small sample limits generalizability.</p> <p>Self-report likely to be influenced by acute</p>

(1991) USA	elderly following spousal suicide, natural death and a non-bereaved group.	interviews and self-reporting questionnaires. Measures used: BDI, BSI (measured post bereavement at 2, 6, 12 and 30 months).	(n=77). Natural death random sample (n=188). Non-bereaved control sample (n= 128). Recruitment: Bereaved: Coroner's records. Non-bereaved: community volunteers. Setting: General population in California.	and 30 months ($p<0.05$). Suicide survivors generally scored higher on phobic anxiety symptoms ($p<0.05$) than other participants. At 30 months manifested more hostility, phobic anxiety and paranoid ideation relative to other groups.	grief reactions and affect accuracy. All participants were Caucasian, from a low-middle income.
Farberow, Gallagher-Thompson, Gilewski and Thompson (1992a) USA	Comparison of grief and mental health changes in older spouses amongst suicide surviving, natural death and a non-bereaved group.	Longitudinal comparative study Methods: Structured interviews and self-report questionnaires. Measures: TIG, BDI,	Sample (n=230) participants. Suicide random sample (n=71): 57 women and 13 men. Natural death random sample (n=147): 93 women and 54	Mean scores on all measures decreased indicating improvement over time for all participants: TIG Present ($p=0.001$), BDI ($p=0.001$), BSI severity index ($p=0.01$) and MHLTH	Self-report measures at 12 months may not be timely as coincides with anniversary of death. Natural death and non-bereaved groups were all Caucasian and 88%

		BSI, MHLTH.	<p>men.</p> <p>Non-bereaved control sample (n=123):61 women and 62 men.</p> <p>Recruitment: Bereaved: Coroner's and health department records.</p> <p>Non-bereaved: Senior centres, elderly residential facilities and a local university.</p> <p>Setting: General population from an urban area.</p>	<p>(p=0.001).</p> <p>Suicide survivors had high grief, sustained for 12 months but reduced significantly by 30 months on TIG Present (p=0.001).</p>	in the suicide group.
Farberow, Gallagher-Thompson, Gilewski and Thompson (1992b) USA	Changing role of social supports in the bereavement process of surviving spouses of elderly suicide and natural	<p>Comparative survey study (part of an original longitudinal research study)</p> <p>Methods: Structured interviews and self-report</p>	<p>Convenience sample (n=472) participants.</p> <p>Suicide sample (n=110): 88 women and 22 men.</p> <p>Natural death sample (n=199): 104 women and 95</p>	Women received more practical help than men (p<0.001), had more people in their current network (p<0.03) and felt more positive about people in their network	<p>Unable to generalize findings as participants from middle-class socioeconomic background.</p> <p>Type of support in social network and the</p>

	deaths.	questionnaires. Measures: TIG, BDI, BSI, MHSR.	men. Non-bereaved control sample (n=163): 78 women and 85 men. Recruitment: Bereaved: Coroner's and health department records. Non-bereaved: Senior centres, elderly residential facilities and a local university. Setting: General population from an urban area.	(p<0.02). Men in natural death and suicide groups received more emotional help (p<0.002) than women but less than non-bereaved controls. Natural death and control groups received more emotional help than suicide survivors (p<0.001). Suicide survivors received significantly less emotional support for depression and grief than natural death survivors (p<0.05).	role of the family in offering this support was not reported.
Cleiren, Grad, Zavasnik and	Examination of psychosocial problems of	Cohort, comparative survey	Convenience sample of bereaved spouses (n=85): 67	Slovenian sample reported more depression symptoms compared to	General bereaved population.

Diekstra (1996) Slovenia and The Netherlands	spouses bereaved as a consequence of unnatural causes of death (suicide and traffic fatality) in two countries.	Methods: Structured interviews using a standardised questionnaire. Measures used: BDI (Measured post bereavement 2 months in Slovenia and 3 to 4 months in The Netherlands).	women and 18 men. Suicide sample (SS) (n=44): Slovenian (n=30) and Dutch (n=14). Traffic fatality (TF) (n=41): Slovenian (n=23) and Dutch (n=18). Slovenia Recruitment: SS: National Register for Suicides and Suicide Attempts. TF: Names collected from the Police. Dutch Recruitment: SS: Names collected from the Police in several regions TF: Identified through health services and news reports/	Dutch sample ($p<0.05$) but symptom patterns almost identical. Slovenian participants reported more sadness, pessimism, loss of appetite, indecisiveness, and disinterest in others. Dutch participants reported more avoidance by others ($p<0.01$); increased alcohol consumption ($p<0.05$); more abandoned by society ($p<0.05$); and more likely to be blamed by society for the death ($p<0.10$) than Slovenian group.	Criteria for cause of death and reports may differ between countries. Cultural significance and context not embedded in the study. Socio demographic background differences: cultural reporting of certain symptoms or situations such as alcohol consumption. Variation of time bereaved periods in the different countries.
---	---	---	--	--	--

			<p>newspapers.</p> <p>Setting: General population in bereaved homes.</p>		
Constantino and Bricker (1996) USA	Comparison of two theoretically derived nursing interventions: amongst widows bereaved by spousal suicide.	<p>Comparative intervention study</p> <p>Methods: Initial interview and self-report questionnaires prior and after group intervention.</p> <p>Groups 1.5 hours per week for 8 weeks.</p> <p>Measures: BDI, BSI, SAS, GEI.</p>	<p>Convenience sample of bereaved spouses (n=32).</p> <p>Recruitment: Advertisements on television/radio and newspapers.</p> <p>Community Referrals: mental health professionals/clergy/funeral home directors</p> <p>Setting: General population.</p>	<p>BGP participants experienced significantly reduced anger/hostility and guilt but these increased for SGP group.</p> <p>GP participants had better social adjustment but less adjustment in their parental roles.</p> <p>Both groups reported less depression, distress, feelings of despair, rumination and depersonalization.</p>	<p>Small sample may limit generalizable conclusions to other bereaved spouses of suicide.</p> <p>Group function and dynamics differed and may have influenced results.</p> <p>Improvements could be due to natural grief recovery time.</p> <p>Gender representation unknown.</p> <p>Loss of spouse timeframe unknown.</p>

Constantino, Sutton and Rohay (1997) USA	Perceptions of rejection levels of surviving spouse toward suicide victim (spouse) and possible verbal, physical or sexual abuse incurred before the suicide.	Comparative postvention study Methods: Self-report questionnaires. Measures: VRS.	Convenience sample of bereaved widows (n=49), mean age: 43 yrs. Length of widowhood range: 1 to 28 months (M=10). Recruitment: Newspaper advertisements and referrals from religious, social and community agencies. Setting: General population.	Verbal abuse adversely affected happiness ($p<0.001$); enjoyment of being with the person ($p<0.001$); and importance of victim in person's life ($p<0.001$). Female suicide survivors reported experiencing verbal abuse (65.3%), physical abuse (42.9%) and sexual abuse (32.7%).	Small sample may limit generalizability. Not known why there is more abuse amongst this population.
Provini and Everett (2000) USA	Exploring adults mourning suicide perceptions of their functioning, needs for help, reasons for help-seeking behaviour, not desiring help and	Quantitative study Method: Information gathered from family charts using a survey form.	Cluster Sample: 227 adult next-of-kin aged over 18 years who lost relatives to suicide in New York City in 1997. Gender: 144 women and 83 men. Findings reported represented	The most reported received help (n=34): formal (n=16) 47% and desired (n=25): formal (n=18) 72% help was from professional services. Those who reported concerns reported an	No information provided on culture, diversity, education of survivors. Rationale of researching adults bereaved by suicide in

	barriers to receiving desired help.		<p>n=144 of next-of-kin (unknown n=40, siblings n=27, mother n=21, wife n=21, in-law/stepchild n=12, child n=10, nephew/niece/cousin n=4, aunt/uncle n=3, father n=3, husband n=2, grandchild n=1) parents n=17, siblings n=8, children n=5 and spouses n=5).</p> <p>Length of bereavement: 3-6 months.</p> <p>Recruitment: Names identified through a list provided by New York City medical examiner's office. Next-of-kin were informed of a larger project aimed at children and this study sought adult suicide bereavement experiences.</p>	<p>average of two concerns (M = 2.19, SD = .52).</p> <p>Those who reported concerns reported an average of two needs (M = 1.6, SD = 1.1).</p> <p>Families including children reported an average of two or more non-specific concerns (p=.005).</p>	<p>1997 is not provided.</p> <p>No research question provided.</p> <p>Kinship and relation to findings were not reported.</p> <p>Quality and emotional attachment in kinship not reported.</p> <p>Self-report likely to be influenced by acute grief reactions and affect accuracy.</p> <p>The highest relationship group is unknown (n= 40) 28% to the deceased.</p> <p>It is not explicit to why</p>
--	-------------------------------------	--	---	---	--

			<p>Setting: Information spontaneously volunteered by next-of kin during telephone conversations were charted, retrieved and statistically analysed.</p>		<p>the next-of-kin sample size reduced to n=144 and the gender representation is not also provided.</p> <p>Spontaneous information volunteered could have resulted in not capturing a full understanding of the bereaved experiences.</p> <p>Findings are not representative of total next-of-kin sample (n=144).</p> <p>Small sample limits generalizability.</p> <p>Significate rate of</p>
--	--	--	---	--	---

					participants did not volunteer their experiences.
Constantino, Sekula and Rubinstein (2001) USA	<p>An evaluation of the effects of two theoretically derived nursing postventions.</p> <p>Two groups (BGP) and (SGP) amongst the widowed bereaved by spousal suicide.</p>	<p>Comparative postvention study</p> <p>Methods: Initial interview and self-report questionnaires prior to group intervention.</p> <p>Post intervention: Repeated self-report questionnaires.</p> <p>Measures: BDI, BSI, SAS, GEI.</p>	<p>Convenience sample: Analysis of 47 spouses who completed the intervention: 37 women and 10 men.</p> <p>Length of widowhood range: 1 to 27 months (M=10.91).</p> <p>Recruitment: Advertisements on television/radio and newspapers.</p> <p>Community Referrals: mental health professionals/ clergy/ funeral home directors.</p> <p>Setting: General population.</p>	<p>Regardless of group allocation all participants had better psychological adjustment.</p> <p>Significant reduction in phobic anxiety and paranoid ideation symptoms (post-test and 6 months) and decline in psychoticism symptoms between 6 months and a year.</p>	<p>Improvements could be due to natural grief recovery time.</p> <p>Gender representation unknown in the groups.</p>
Constantino, Sekula, Lebish and Buehner	To compare depression and behavioural	<p>Descriptive Cross-sectional cohort</p> <p>Methods: Abuse</p>	Convenience sample of female survivors (n=78) in south west Pennsylvania.	The two groups of women did not differ in overall level of depression with	Suicide data collected 2 years before abuse survivors.

(2002) USA	manifestations of depression between female abuse survivors and female survivors of suicide of their significant other.	<p>survivors: Data collected during protection from abuse.</p> <p>Suicide survivors: Prior to a group intervention.</p> <p>Measure: BDI.</p>	<p>Abuse survivors (n=39): mean age: 38 yrs. Length of abuse: 6 to 12 months.</p> <p>Suicide survivors (n=39): mean age: 44 yrs. Length of widowhood range: 1 to 18 months.</p> <p>Recruitment: Abuse survivors: during process of filing for protection from abuse in court.</p> <p>Suicide survivors: Participated in an 8-week group intervention program.</p>	<p>both groups being moderately to severely depressed.</p> <p>Suicide survivors experienced higher sadness (p=0.05); whereas abuse survivors experienced higher irritability (p=0.04) and social withdrawal (p=0.04).</p>	<p>Conflict of interest noted for abuse survivors.</p> <p>Principal Investigator was also a court representative for this group.</p>
De Groot, De Keijser and Neeleman (2006)	A comparison of suicide and natural death amongst spouses and first-degree relatives.	<p>Cross sectional design</p> <p>Method: Self-report questionnaires.</p> <p>Measures: EPQ-</p>	Convenience sample of bereaved spouses and first-degree relatives (n=229): 179 women, 50 men, mean age: 42 yrs.	Suicide survivors (6.5%) has attempted suicide which is significantly higher than general adult population (2.9%) of The	<p>Small sample may limit generalizability.</p> <p>GP had overall control on: whether to cooperate with</p>

The Netherlands	<p>Hypothesis: suicide bereaved relatives and spouses constitute a vulnerable group of mourners</p>	<p>RSS, PMS, RSES, RAND-36, CES-D, single-item suicidality assessment, ITG.</p> <p>Open ended questions: on suicide method and unmet need for professional help.</p>	<p>Relation to the deceased: spouse (n=37), parent (n=36), child (n=37), sibling (n=30), in-laws/other (n=13).</p> <p>Suicide sample (n=159) representing 74 families.</p> <p>Natural death sample (n=70) representing 39 families.</p> <p>Length of bereavement: 3 months.</p> <p>Recruitment: Suicide sample: Coroners provided the deceased's GP details.</p> <p>Natural death sample: The Morbidity Registration Network Groningen (RNG) provides access to data from general practice.</p>	<p>Netherlands that have attempted (p<0.05).</p> <p>Suicide survivors reported higher levels of neuroticism (M=5.7, (p<0.05), depression (M=20.6, p<0.01), complicated grief (M=75.9, p<0.01) and loneliness (M=3.9, (p<0.01) with lower levels of functioning (general health concerns) (M=65.7, (p<0.05) and a need for professional help (p<0.001).</p> <p>Across groups female gender depression scores were higher (p<0.001) but not complicated grief (p<0.268).</p>	<p>research team and if/how they selected participants.</p> <p>GP relationship and mediation could have influenced the survivors' responses.</p> <p>No research question provided. Hypothesis was provided but did not provide a definition of vulnerability.</p> <p>A rationale for specifically studying in the north of The Netherlands region was not provided.</p> <p>Interchange use of terms related to</p>
-----------------	---	--	---	---	--

			<p>Recruitment process for both groups was a letter sent to the GP whom contacted survivors inviting them to participate in the study.</p> <p>Setting: General population located in three northern provinces of The Netherlands. Questionnaires sent and returned to research team.</p>		<p>kinship used but not clear and decided upon the definition of kinship in the study.</p> <p>Self-report likely to be influenced by acute grief reactions and affect accuracy.</p> <p>Kinship and relation to findings were not reported.</p> <p>Gender and age representation within the kinship groups were not reported.</p> <p>The distribution of kinship types differed considerably.</p> <p>Quality and emotional</p>
--	--	--	--	--	---

					<p>attachment in kinship not reported.</p> <p>Context of relationship and events prior or around the suicide not reported.</p> <p>Recruitment of relatives of elderly deaths (natural death sample) was stopped to encourage more younger death relatives to participate though age and the relationship to coping was not measure.</p> <p>Questionnaires could have been completed together with other family members which</p>
--	--	--	--	--	--

					<p>could have influenced the results.</p> <p>Some measures might not be reliable. Such as adding a question to the scale.</p> <p>Measurements translated to another language can lose cultural and/or contextual meaning.</p> <p>Establishing death types did not result in any causal factors in grief.</p>
Mitchell, Sakraida, Kim, Bullian and Chiappetta (2009) USA	Comparison of depression, anxiety and quality of life between closely related and	Comparative study (part of a family focused crisis intervention study) Methods: Self-report	Convenience sample (n=60): 43 women and 17 men between 18-78 years (M=43.3). Close relations (n=27): 9	Close relations differed on BDI (M=21.11, p<0.001) and BSI anxiety subscale (M=1.75, p<0.001) compared to distant	<p>Small sample.</p> <p>All participants were Caucasian.</p> <p>No subjective</p>

	distantly related suicide survivors.	questionnaires. Measures: BDI, BSI, MOS-SF36.	spouses, 6 parents, 5 children, 7 siblings. Distant relations (n= 33): 18 in-laws, 14 friends/co-workers, 1 niece/nephew. Length of bereavement: 1 month. Recruitment: Family focused crisis intervention study. Setting: Psychiatric outpatients' population in south-west Pennsylvania.	relations. Distant relations scored higher (M=42.89) on the MOS-SF36 mental health scale than close relations (M=33.76, p<0.001). No significant statistical group differences in regards to physical health.	measurement of closeness to suicide victim. Characteristics reflect groups but not actual kinship. Self-report measure with no validation of symptoms.
Schneider, Grebner, Schnabel and Georgi (2011) Germany	An exploration of emotional reactions of those bereaved by suicide according to gender and relationship to the	Auto-psychological study Methods: A modified and translated semi-structured interview from the National Suicide Prevention	Convenience sample (n=167) bereaved adults: spouses (n=57), adult children (n=34), parents (n=33) - 22 mothers and 11 fathers, other relatives and friends (n=43) -16 siblings.	Suicide survivors experienced strong, frequent, disturbing emotions (89%). Frequently reported depressed mood and guilt. More likely to seek	Small sample. Reliability of measure not reported. Interviewer reworded questions in interview and may have

	deceased.	<p>Project in Finland.</p> <p>Measures: SCID-I and SCID-II.</p> <p>Interviews took place between 1999-2000.</p>	<p>Length of bereaved range: 8.5 months.</p> <p>Recruitment: people noted in police reports and those authorised to regulate formalities of the deceased.</p> <p>Setting: General population in Frankfurt.</p>	<p>professional support.</p> <p>Positive consequences of suicide, associated with less depressed mood and guilt.</p> <p>Being female, a parent or spouse had higher risk for lack of energy.</p> <p>Spouses at highest risk.</p> <p>Spouses and parents more affected by the loss than adult children.</p> <p>75% had sufficient or almost enough support from family and friends 17% had insufficient and 8% had no support.</p> <p>If professional support</p>	<p>influenced results.</p> <p>Some participants were interviewed together and may have been influenced by each other.</p> <p>Gender in all kinship not reported.</p> <p>Quality and emotional attachment in kinship not reported.</p> <p>Type of support not reported.</p>
--	-----------	---	--	--	--

				insufficient, participants reported more emotions of sorrow, lack of energy and abandonment.	
A. Smith, Joseph and Das Nair (2011) United Kingdom	<p>To explore post traumatic growth in adult bereaved by suicide by examining their lived experience of growth since their bereavement.</p> <p>Research questions:</p> <p>Tell me about your experiences of losing someone to suicide?</p> <p>How has life been</p>	<p>Interpretive phenomenological analysis</p> <p>Method: semi - structured interview lasting 50 to 150 minutes.</p>	<p>Purposive and snowballing self-selected sample (n=6): of suicide survivors (husband n=1, close friend n=1, father n=1, mother n=1, brother n=1, mother and sister n=1) between ages 40-72 years (3 women, 3 men).</p> <p>Length of bereavement: 2-33 years.</p> <p>Recruitment: Study advertised by charity organisations (Samaritans and Survivors of Bereavement by Suicide).</p> <p>Setting: General population. Face to face interviews at</p>	<p>Two super-ordinate themes emerged with three ordinate themes within each:</p> <p>Positive growth: life view, knowledge of self, relation to others.</p> <p>Social context: gaze of others, public guise, solace of other survivors.</p> <p>Post traumatic growth is evident whilst social context is distinctive to suicide survivors.</p>	<p>Kinship and relation to findings were not reported.</p> <p>Quality and emotional attachment in kinship not reported.</p> <p>Variation of bereavement periods.</p> <p>Lead researcher was the interviewer and has been personally bereaved by suicide. This can reduce objectivity in the analysis stage.</p>

	<p>since your loss?</p> <p>What does that change mean for you? /what does it mean to you that it remained the same?</p> <p>What else might you want to tell me about that we have not included?</p>		<p>participants' homes.</p>		<p>Interview criteria of 2 years post bereavement with no justification for this minimum period.</p>
<p>Mc Kinnon and Chonody (2014) Australia</p>	<p>To explore formal supports utilised by those bereaved by suicide.</p> <p>Of these supports which were helpful?</p> <p>What were their</p>	<p>Interpretive phenomenological methodology</p> <p>Method: semi - structured interview lasting 90 minutes approximately.</p>	<p>Purposive sample (n=15) of suicide survivors (brothers n=5, sons n=5, grandfather, husband, father, sister and wife n=5) between ages 26-75 years (12 women, 2 men).</p> <p>Rural sample (n=6).</p> <p>Metropolitan sample (n=8).</p>	<p>Two dominant themes emerged:</p> <p>Supports in the immediate aftermath and ongoing supports.</p> <p>Immediate support provided by first responders were mostly</p>	<p>Most participants were women (86%).</p> <p>One participant responded by email capturing meaning is compromised.</p> <p>Participants' social demographic status</p>

	<p>unmet needs?</p> <p>How have the supports used affected their bereavement journey?</p>		<p>Length of bereavement: 1-24 years (m=5.93).</p> <p>Recruitment: Social services organizations, peer support groups and advertising on related support group websites.</p> <p>Setting: General population. Face to face interviews and one response via email.</p>	<p>negative with the GP being the exception.</p> <p>Ongoing support such as peer support groups were helpful as it provided normalisation, a sense of feeling validated and hope.</p> <p>Equally these groups were unhelpful as they lacked: focus, professional facilitation, coping strategies and created more trauma through retelling of suicide stories.</p> <p>Ongoing support from other professionals were unhelpful with GP being the exception.</p>	<p>was not disclosed despite researchers reporting a lack of diversity.</p> <p>Majority of the participants engaged in one type of support.</p> <p>Kinship and relation to findings were not reported.</p> <p>Quality and emotional attachment in kinship not reported.</p> <p>Variation of bereavement periods.</p> <p>Study reports participants (n=14) but kinship description</p>
--	---	--	--	--	---

				The supports received influenced the bereavement of suicide survivors.	data totals (n=15). Sample size was increased to reflect a metropolitan and rural sample but findings reported were not explicit from these perspectives.
Aronson, Kyler, Morgan and Perkins (2017) USA	Comparison of marine spousal suicide survivors and family functioning before and after a suicide compared with other marine survivors of accidental deaths and combat.	Mixed methods study Method: Structured interviews and self-report questionnaires. Measures: SRFI, SOS, AWS, MSPSS, GEQ, IAAF, SDQ, ICGR, PTGI.	Convenience sample of bereaved widows (n=70). Mean age: 52.9 yrs. Suicide sample (n=17). Accident sample (n=19). Combat sample (n=34). Length of bereavement: Marines died 4 years prior to study.	Spouses and families of marines who died by suicide reported exhibited significantly poorer pre- and post-mortem functioning. There were no differences in current spouse or family functioning. There was weak evidence for posttraumatic growth amongst suicide survivors.	No research question was provided. All participants were female. Most participants were Caucasian (74%). Small sample may limit generalizability. Accidental death types by not reported.

		<p>Open-ended questions.</p>	<p>Recruitment: Names provided by the U.S Marine Corps and a letter was sent informing and inviting survivors to participate in the study.</p> <p>Setting: Marine general population: interviewed by telephone (n=33) and online version (n=37).</p>		<p>Representation of participants from the different groups by interview type is not reported.</p> <p>It is not explicit to why the suicide survivor (self-inflicted) descriptive statistics sample size reduced to n=15 from n=17.</p> <p>Length of bereavement is not reported. Deaths occurred over a three-year span and year of study conducted not known.</p> <p>More participants (53%) chose to be</p>
--	--	------------------------------	--	--	--

					<p>interviewed by the online version.</p> <p>A rationale for spousal survivors specifically from a marine community over other military communities was not provided.</p> <p>Qualitative open-ended questions were not provided. It is not clear what guided the questions and at what part of the study they were used.</p> <p>Common themes emerged qualitatively but analysis methods used were not</p>
--	--	--	--	--	--

					<p>reported.</p> <p>Army measures have not been used with marine families.</p> <p>Kinship and relation to findings were not reported.</p> <p>Quality and emotional attachment in kinship not reported.</p>
--	--	--	--	--	--

Appendix B: Reflexive notes

Reflexive entry: 30th January 2016

I'm in the process of clustering the first case's emergent themes. I can see evidence of posttraumatic growth and models of coping. There is a journey that reflects the changing 'self' as part of the lived experience. I continue to cluster and relabel the themes as the parts come together to make a new whole.

Reflexive entry: 1st February 2016

This case's clustering of themes continues to naturally pull together to make meaning. It is evident that distress and depression is necessary and inevitable as part of working through the loss.

Reflexive entry: 4th February 2016

I reread the transcript again something is standing out to me. Is this what they mean about themes 'showing themselves' or is this me seeing what I want to see? It's at these moments I need to remind myself of my position, my research question and lens. I need to keep checking and rechecking and bracket my thoughts.

Reflexive entry: 6th February 2016

During the initial coding, it made me realise that all survivors are so different through their shared experiences. Grief is so different for this participant and she is so positive about most of it.

Reflexive entry: 9th February 2016

As I analyse the emergent themes, it is clear that friendships are important in coping. Could there be so much positivity and benefits as a consequence? Obviously, it is for this participant and that is what matters. Appearing to be okay to others emerges again. Being 'normal' is important for different reasons.

Reflexive entry: 11th February 2016

The 'self' then and now is shared and a lot of sameness. There are changes and being busy is a main motivator to keep going. It comes across as choosing rather than having to be is the drive underpinning the motivation.

Reflexive entry: 12th February 2016

Currently clustering themes at a case level and not much has changed in what seems a relative short bereavement period compared to other participants. I stop and reflect on my wondering thoughts. I bracket them and refocus. I have no judgement or opinion at this stage. The data will reveal the participant's meaning of their coping experience.

Reflexive entry: 14th February 2016

It is amazing how immersion during analysis can occur relatively quite quickly. I think this is a good thing. My approach with being grounded and focused in each case and at each stage is doing justice to each participant. I see some sameness but see difference too. I ask myself questions about their experience. Does it mean the same? What does this mean for the participant in this context? After completing all the analysis, if there is some sameness, well it is what it is. However, two participants may share a similar experience but it is never exactly the same.

Reflexive entry: 15th February 2016

Personality traits seem to be linked to motivation and positivity. It seems to be more natural for me to stay with the participant and not think about previous cases especially at this stage of individual cased analysis. However, I am cautious of being complacent. I still ground myself in what I am doing and why. I have put some prompts on the wall so I continue to keep focused regardless.

Reflexive entry: 16th February 2016

I have started the process of analysing the emergent themes. It continues to be evident that motivation and personality contributes to coping.

Reflexive entry: 18th February 2016

It is interesting how the 'self' before and after has not changed indicating that personality play a big part in this. The participant has gone from strength to strength. Posttraumatic growth? Bereavement is different, some have grieved, some still grieving and some yet to grieve regardless of their bereavement periods. I stopped working today as a started to feel really tired. This is not just a task and it needs to be done. The consequence is smeared lens. Where is the justice in that? The participant is trying to be kind to herself so I take note. Learning in the research project is much wider than I expected it to be.

Reflexive entry: 26th February 2016

This case has been quite challenging. It is quite dark and completely stands out from the other cases. Every participant's experience is unique and contextual to them. This participant's experiences have been dark and just got darker as time went on. I get the impression it might get even darker and I would have thought the suicide would have been a relief in some way. I think this is the nurse in me coming out. That is not what I am doing here. Time to bracket again. The data will speak for itself.

Reflexive entry: 4th March 2016

This case continues to be challenging hence why it is taking longer. I have to take more breaks and needing more days off. I am aware the constant darkness in this case has been very impactful and leaving me quite drained and tired. Analysis is not just a step or stage in research that needs to be done and ticked off the list. Immersion in the data requires a lot of energy both mentally and physically and when you connect with the lived experiences of the participants that are very dark and explicit it is hard. I think there is more in the concept of two people making sense of one's lived experience. In some ways its two peoples' lived experience. It requires a lot from the analyst and it is not just a 'look in'. I need to look after myself so rest and relaxation is important with regular breaks is the way forward.

Reflexive entry: 7th March 2016

What is clear to me is that depression is the participant. After so many years' depression is still there and even worse. It makes me think of the literature and the consistent evidence of complicated grief following suicide. I did not expect that but that is her lived experience.

Reflexive entry: 4th April 2016

I am constantly aware of my lens and questioning how I see things. Language that has appeared in others tasks outside of this the case has surfaced in the analysis. As result I have stopped and thought hard.

Is this me seeing and projecting or is it coincidence that the concept is the same or similar? Stopping, thinking and reviewing is a constant approach in my analysis. It stems back to the truth and justice in what I am doing which is to interpret participants' stories.

Reflexive entry: 11th April 2016

I commenced doing the emergent themes. It's evident that Sharon talks in great detail about the partner's mood and behaviour. It seems its always on her mind as she tries to remember clear accounts to make sense of it all. She appears to have trouble recalling memory or why she talked about something. She is conflicted by events such as the partner being depressed, getting better and then dying. She questions that he was always depressed and she never really saw it or that he appeared be appeared okay when they met. She moves through intellectually by rationalising what happened and she did what she could have done. At the same time, she feels she's let him down, is to blame and holds some guilt. Some element of denial but thought it would all come out in the wash eventually. She blames herself because she got it so wrong. The recalling could be attributed to some anxiety or uncomfortableness talking about her experience?

Reflexive entry: 13th April 2016

Clustering has commenced. I can see that the emergent themes can be seen from different angles. This can be hard as there is always the need to get it right. For example, a need can be a support. I think I need to stop trying too hard and go with the flow. I will need to review them again at a later stage.

Reflexive entry: 14th April 2016

I'm feeling tired and got a headache. It's time to stop in the best interest of the analysis. There is a need to keep going but then there is no quality so what's the point. I have an ethical responsibility to my research. Less is more which is rather fitting with IPA.

Reflexive entry: 15th April 2016

This case has made me think about the themes and clustering. The immediate 'self' and now 'self' can be similar or very different. I need to make sure that Sharon's shared experience is captured clearly and reflects her making sense of her experience.

Reflexive entry: 22nd April 2016

It's been quite draining doing the coding on this case. On the whole it's quite negative for Christine despite her motivation and desire to get through her experience. I think it angers me knowing that at every corner she has turned has always led to some disappointment or lack of help. I guess that's the nurse coming out and fundamentally it's about helping others in some way, no matter how big or small. Having this awareness helps me accept her experience and remind myself of my lens and what I am doing in the analysis. I will start the emergent themes with this in mind.

Reflexive entry: 29th April 2016

Finished the emergent themes. It's consistent that Christine felt unsupported generally and excluded. If support was available, it was limited, difficult to access or no longer available for different reasons. Her sister, a stranger and Samaritans have been available and there for her. Frustration and disappointment led to reduced self-worth. However, the desire to survive has been motivated by the 'self'. Evidence personal growth: because of the suicide, the treatment afterwards and limitations to get help.

Reflexive entry: 30th April 2016

I question if Christine's personal growth was significant because of the lack of support. Her motivation was driven for the 'self' to survive and fear of what life could look like. She only had that choice to recover and she took it. It's

interesting because Christine is a nurse and what support was available she even found great difficulty in finding and accessing the limited support. There is no surprise that she really needed to be free in expression, free to grieve and be heard. She is now offering this to others.

Reflexive entry: 3rd May 2016

This case is quite challenging and very draining. The minute description which is extremely graphic contributes to this. I've approached this case with smaller chunks and breaks as well as mixing up work and recreation. Talking with my supervisors has helped me process it and I feel quite supported.

Reflexive entry: 12th May 2016

I noticed my initial coding has slightly changed in how I am presenting my interpretation of what Tracey has interpreted. It's more to do with language but in fact it makes me think that it really captures my immersion in the data. To a lay person it probably would be interpreted as judgement. This does not mean that the other cases don't reflect a deeper immersion. What it does mean that with time, my confidence which is still developing, shapes the style but not compromise truth. In this journey like the participants over times things are changing for and developing for me too.

Reflexive entry: 20th May 2016

The process of going through the cases has evolved in how the themes are pulling together. It is now becoming clearer that posttraumatic growth is evident. Once I finish the last case I will be reviewing the themes and their clusters. Naturally seeing how they come together to create the whole.

Reflexive entry: 26th May 2016

Growth can run parallel to stress and who says one happens one after the other? Could it also be possible that the interpreter sees growth but the participant doesn't? If so, what does that mean? Regardless, there is for sure some change and unlike most models suggestion of return to normality or restoration, that for sure is not evident. After experiencing something like that (a bereavement by suicide) one can never be the same. In fact, I feel confident that all eight participants would agree with me!

Reflexive entry: 2nd June 2016

For Diane it's more evident that she experienced stigma and had to face conversations with people telling her their views. Diane is not explicit about what she does now but this depends on the level of sharing and what matters to her. Though my understanding is essential I can't assume either.

Reflexive entry: 3rd June 2016

The themes seem to stand out, as I've gone through the transcript and started the initial coding. I'm conscious that my lens is blurred from previous cases so I keep checking to be sure. This enables me to be 'true' to the participant. Checking meaning and context for each case is vital. On one hand as I am 'doing' I am developing my skills in analysing. What is shown, some is shared with others. There are shared experiences but their experiences are individual.

Reflexive entry: 6th June 2016

The process of reviewing, renaming and highlighting the most important for each case happens all the time and though I write things down, I'm not sure everything is captured! The thinking processes seems to happen when I'm not actually 'doing' it, well most of the time. Shared connections are about identifying with other survivors bereaved by suicide. Receiving empathy is about

being understood. I question if both is about understanding. Will review cases. It could be about abnormality, positive comparison?

Reflexive entry: 8th June 2016

Being organised and being flexible with all this data is extremely overwhelming. The process of more renaming and clustering is still going on. However, it's an iterative process. Some themes are fading and some are looming. How much is enough? I guess this is the novice IPA researcher's anxiety.

Reflexive entry: 10th June 2016

After posting on the IPA forum and speaking to my supervisor. There is not right or wrong really as long as it is justified. My main ethical duty to the participants is to tell their story and capture the meaning and its importance in their lived experience.

Reflexive entry: 21st June 2016

As I prepare my write up of the findings it is evident that themes require further revision. Depression has been renamed reactions to suicide-related grief. This grief and the cases demonstrate: depression, PTSD, reactions and grief. Personal strength has been renamed to motivation to survive. Also moved to attach meaning cluster. The motivation is the drive not a personal strength as a consequence to suicide. Need for empathy renamed to need for humanistic conditions. It's not just about empathy but also trust, non-judgemental and accepting.

Reflexive entry: 13th July 2016

The write up seems to be flowing and I think the narrative is supported well by the evidence from the transcripts. I will have supervision tomorrow for some

feedback. I think the findings are interwoven but I need to check connectivity and language. I am concerned about that this as my discussion chapter is separate so I need to stick to presenting the findings. I think this is a challenge as it needs to be digestible for the reader and have a logical flow. As part of the process some themes have been removed to another super-ordinate theme and one has collapsed after checking the transcript for clarification and meaning.

Reflexive entry: 14th July 2016

I received positive feedback regarding the results chapter and the narrative style. This is very encouraging. I have decided to merge the two rumination themes to one as it seems more fluid and connective to do.

Appendix C: Recruitment advert

Coping After Suicide

Who?
Adults Over 18
Years Old

What?
Conversational
Interview

Why?
To Understand and
it Could Develop
Services

Where?
Negotiated at Your
Convenience

**WANTED
RESEARCH
VOLUNTEERS**

Have you been bereaved by intimate partner suicide?
Would you like to make a difference? **Telling your story about your coping experiences following the suicide of your intimate partner could be valuable.** It could develop and reshape support services for survivors like you.

**CONTACT ME FOR
MORE INFORMATION**

Samantha Torres

Tel: 07902 970335

Email:
S.Torres@2013.hull.ac.uk

Appendix D: Participant information sheet

RESEARCH STUDY TITLE: LIFE AFTER DEATH: THE COPING EXPERIENCES OF THE SURVIVING PARTNER FOLLOWING SUICIDE

Invitation

I would like to invite you to take part in a conversational interview as part of my research study. Before you decide I would like you to understand what the research is about and what it would involve from you. The following information should give you all the information you need about the study so you can make an informed decision whether to participate or not. Ask me if there is anything that is not clear or if you need any further clarification. My contact details are provided at the bottom of this information sheet.

What is this study about?

I will explore the coping experiences and the factors that influence these following the suicide of an intimate partner. The impact of suicide on the surviving partner is complex and complicated. The impact might affect all areas of the survivor's life even many years after the loss of their partner. It is anticipated that the results of this study could inform health and social services to develop and improve future practices at a local, national and international level.

Who is doing the research?

The study is being conducted as part of my PhD qualification under the supervision of two Professors at the University of Hull and Griffith University. I am also a Registered Mental Health Nurse. I have the necessary experience and training to enable me to conduct the interviews. Though I am a nurse I am not able to provide you with any advice or care. I am able to direct you to relevant support services if this becomes apparent during or after the interview.

Why have I been invited?

You have had this experience so you know what it's like to cope following a suicide of an intimate partner. Your experiences no matter what they are or were, or even how long ago you were bereaved are valuable. Understanding your unique experience could make a difference in developing and/or reviewing support and resources for survivors like you. To participate in this study, you must be bereaved no less than one month. It is anticipated that I will interview approximately ten survivors.

Do I have to take part?

Simply, no. Participating in this study is completely voluntary and if you decide to take part you can at any time withdraw from the study up to the point of the analysis of your interview with no explanation. If you decide to participate, alongside this information sheet I will discuss the study with you and answer any questions you might have. You will be then asked to sign a consent form before you can participate.

What will I have to do?

You will be interviewed by me in a friendly and informal manner. The interview will be predominantly led by you, with you sharing your experiences. To give you some idea, I will ask you some questions about what was happening at the time of the suicide, your coping experiences, your relationship and about life after the suicide. It will be more a conversation and there is no right or wrong answers. The interview will be audio recorded to enable me to analyse the information you have shared after the interview.

What will happen to me if I take part?

You will be interviewed which might take up to one and half hours and the interview will take place once. The interview will be held at a time and place that is convenient and comfortable for you. It is important that the interviewed is held in a place where there is no interruption. The information you provide will be confidential and private. To ensure your confidentiality and privacy is maintained you will be completely anonymized. This means that any identifying particulars will be removed and will be replaced with a number and/or a false name. The information you have shared will be kept in a locked filing cabinet in a locked office at the University of Hull. My supervisors and I will only have access to the files in this secure filing system. This is in accordance to the university's regulatory requirements to protect your confidentiality and privacy. The information given by you may be used in future reports, articles or presentations by the research team (myself or my supervisors). All information at all times will remain completely confidential. The audio recording will be securely destroyed once the interview has been transcribed.

Your confidentiality is important and will be protected, however in some circumstances confidentiality has to be broken. Your confidentiality will only be broken if you disclose that you will commit a crime or express harming yourself and/or others. If this becomes apparent I am required in the first instance to report this to my supervisor(s) and other authorities where appropriate.

What are the possible advantages if I take part?

Not all participants will benefit personally. Some participants might find talking about their experiences will help them. Your participation could help other survivors that share or had similar experiences to you. The study might benefit society to know and understand more so it could develop and improve support services for survivors like you.

What are the possible disadvantages if I take part?

Talking about your coping experiences following the suicide of an intimate partner can be very distressing and this might happen for you. I will advise you at the beginning of the interview that if you become distressed at any time during the interview you can stop the interview at any time. Remember you are a volunteer and can withdraw from the study at any time up to the point of the analysis of your interview with no explanation.

After the interview you might also feel distressed or feel you need some support. In either situation you can call: Survivors of Bereavement by Suicide on 0300 111 5065 or The Samaritans on 08457 90 90 90 or refer to the NHS comprehensive resource pack called 'Help is at Hand' which you will be given at the beginning of the interview if you decide to participate. If you chose not to participate, the resource pack will still be accessible to you if you wish.

What happens after the study?

As previously mentioned the study is part of an educational qualification and will be written up in a thesis but it is also anticipated that the results of the study will be published. If you would like a copy of the results, please let me know. Please remember that you will not be identified and will be completely anonymised.

How do I get involved?

If you would like to take part in the study please contact me by telephone or email, whichever is most convenient or suitable for you.

Name of Researcher: Samantha Torres

Email: S.Torres@2013.hull.ac.uk

Telephone Number: 0790297

Participant Number:
Date:

Appendix E: Participant consent form

RESEARCH STUDY TITLE: LIFE AFTER DEATH: THE COPING EXPERIENCES OF
THE SURVIVING PARTNER FOLLOWING SUICIDE

Name of Researcher: Samantha Torres

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, the purpose of this study, ask any questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, up to the point of the analysis of my interview without giving any reason or explanation.

☐

3. I understand that any information collected as part of this study may be viewed by other individuals other than the researcher relevant to the study at the University of Hull. This information given by me may be used in future reports, articles or presentations by the research team. All information will be anonymized and my identity will remain completely confidential.

☐

4. I understand that the information I share will be audio recorded and will be anonymized and my identity will remain completely confidential.

☐

5. I understand that my confidentiality will only be breached if I disclose that I will commit a crime or express harming myself and/or others.

☐

6. I understand that this consent form will be securely stored in the researcher's site files and I have a copy for my own records.

☐

7. I have received a hard copy of a NHS comprehensive resource pack called 'Help is at Hand' which is mine to keep even if I decide to withdraw from the study.

☐

Participant Number:
Date:

8. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

Researcher

Date

Signature

Appendix F: Interview guide

RESEARCH STUDY TITLE: LIFE AFTER DEATH: THE COPING EXPERIENCES OF THE SURVIVING PARTNER FOLLOWING SUICIDE

Opening Question

1. I would like to hear about what life has been like for you after you lost your partner to suicide. Where would you like to start?

Events surrounding the suicide

1. Can you tell me what was happening in your life at the time of the suicide?

Possible prompts if required:

- What was going on in other areas of your life at the time of the suicide?
- Has that influenced how you cope?

Relationship

2. What was your relationship like before the suicide?

Possible prompts if required:

- Had your relationship changed in anyway?
- Has that influenced how you cope?

Coping

3. Can you tell me what life is like for you now, following the suicide of your partner?

Possible prompts if required:

- Can you describe a good day?
- Can you tell me what a bad day looks like?
- Has it changed over time?

Support

Participant Number:
Date:

4. What has been important in helping you cope following the suicide?

Possible prompts if required:

- What support have you received?
- What types of support have you received?
- What has been helpful?
- What hasn't been helpful?

Individual

5. Can you tell me, how other people think you cope?

Possible prompts if required:

- How do your family think you coped?
- How do your friends think you coped?

6. Has the suicide affected you as person?

Possible prompt if required:

- Has the suicide changed you?

7. How do you see the future?

Possible prompt if required:

- How do you see yourself in the future?

Closing Question

8. Is there anything else you would like to add?

Participant Number:

Date:

Appendix G: Social demographic form

RESEARCH STUDY TITLE: LIFE AFTER DEATH: THE COPING EXPERIENCES OF THE SURVIVING PARTNER FOLLOWING SUICIDE

Name	
Address	
Contact Details	
Age	
Gender	
Nationality	
Ethnicity	
Religion	
Dependents (If Any)	
Occupation	
Education <i>What is the highest degree or level of school you have completed?</i>	
Average Household Income	
Current Relationship Status	
Relationship to the Deceased	
Relationship to the Deceased at the Time of the Suicide	
Length of Time Bereaved	

Appendix H: A case transcript example

PARTICIPANT: Christine

EMERGENT THEMES		EXPLORATORY COMMENTS
	1 I: So Christine , erm, I would like you to tell me a little bit about how life has 2 been like for you since you lost your partner to suicide. Where would you like 3 to start?	
	4 P: Erm, I don't know really. It's all been a bit of a disaster to be fair.	Life is a disaster.
	5 I: Okay.	
Life changed for the worse L4	6 P: It's kind of had a knock on effect on everything. So I don't know. I don't 7 know where is a good place to start really.	Knock on effect – influenced other areas life as a consequence. Impact on all areas of her life, not for the better.
	8 I: Okay.	
Life changed dramatically L6	9 P: is there any particular question you're looking to for me to answer or...?	
	10 I: You mentioned it's had a knock on certain things. Is that a good place to 11 start? What are those things? What knock on...?	
Overwhelming L13	12 P: Erm, well, it's a little bit heavy. Can we just go to the story as it helps me 13 better at finding it chronologically?	Heavy – overwhelming
	14 I: Sure, okay.	Starting from the beginning to recollect thoughts.
Short secret relationship L17	15 P: So, and I'm just going to bring up things and just...	
	16 I: Roll.	
Long history as friends L19	17 P: Whatever's in my head. So my boyfriend of almost two years is somebody 18 I'd known for twenty-five years and we kind of got together, kept it all a little 19 secret for a little while so that was fun. And we'd been together for this 20 number of years and he was fun, serious and he had a job in the Government,	Free thinking about the experience, too much to recollect? Two years together but known each other a very long time. A secret relationship and fun. They know each other well. He worked in government.

PARTICIPANT: Christine

Difficulty in recalling events L22	21 shall we say and that is a kind of job, I'm just talking at you. I'm sorry if it	Talking at you – difficult recalling
Partner's job was at a secure level L23	22 doesn't make any sense. It's a kind of job where you're not allowed to have	Partner's job – high in government/security level. Does she
Suspect partner had mental health problems L26	23 any weaknesses because you might be affected by outside agencies that	suspect some secrets? affected by outside agencies that would
	24 would take advantage of these weaknesses. I'm trying not to say it out loud.	take advantage of these weaknesses – was she one of those
	25 So, he never gave me or had recorded any evidence of mental illness, at all,	secrets? No one really knew about them. She didn't like this?
	26 none. Perfectly fine. The only clues I ever got was when he needed to talk	
	27 about when his mum died in her fifties and he looked after her that it gets to	No evidence of partner having mental illness. The only clues I
	28 there and it never gets any further and she was in a jar in his loft which was	got – she suspected partner had mental health problems. he
	29 odd. But no, you know, he was gregarious. He was funny. He was about the	looked after her that it gets to there- the explanation for his
	30 sanest person I'd ever met and then we started rowing and he started doing	mental health problems? Doesn't elaborate. Why? Partner's
	31 that, he did that testing thing where they just behave really badly and see if	behaviour at times were odd. Partner was social able and
	32 you'll deal with it. And then at our friend's wedding, we'd been practi- we'd	funny – she liked him as a person. He was sane – contraction?
	33 been learning to dance and we were going to do a big reveal at this wedding	
Relationship had its ups and downs L31	34 and my friend, who was a lady, danced with me and he just went absolutely	Some arguments and felt he was testing how far he could go.
Scared of partner L35	35 ape shit. Went completely mental. I ran away and said, 'Right we need a two	
	36 weeks' break,' because I had just started my first nursing job. I was three	Went completely mental – partner was jealous/angry/caused
	37 weeks in so after the two weeks I went round to see him and just wasn't	a scene. Shocked/scared her so she proposed a break from
	38 communicative at all. It was like nothing had happened and he said please	each other. Didn't want it to affect her new nursing job. Did
Relationship could affect work L36	39 excuse my language. I have language, just so you don't get offended. He said	she know it was going to interfere with her ability to perform
	40 I know I've been a complete cunt to you but, and then he started ironing his	at work? Swears – informing the interviewer.
Feelings dismissed L41	41 shirts. So I got angry and left.as is my way. And I had this wild text message,	
	42 and then I got one text message saying, 'Please stop texting me. I've got	then he started ironing- Feelings were dismissed this angered
	43 something to do,' which I didn't think anything of and then half past six in	her so she left. Wild text message – out of the ordinary. Please
	44 the morning I got one and I can't remember what it said and I've lost it off	stop texting me. I've got something to do,- recognises this as
Fearing the consequences L46	45 my phone. So that's weird. But it was basically the idea of he was right,	the sign that he was planning suicide but didn't see at the
	46 goodbye and that's it and I've left you a note. I jumped out of bed, put on the	time. She's taken back by the suicide.
	47 clothes I'd been wearing yesterday and ran, literally. It's about two miles to	
	48 his house, all the time ringing his friends, ringing his, ringing our friends,	She kept the last text the partner sent her. Lost it – weird. She
	49 ringing his brother. We'll go into that later. And it ended up with me having	didn't want the text removed. His last contact to her? She
	50 to, I rang nine, nine, nine and they sent two Police people which I think is	reacted immediately to his last text of goodbye and note. She
		knew what this meant. Her sudden response to go his house
		was based on she knew he would do it.

PARTICIPANT: Christine

Shock L54	51 weird. Why wouldn't you send an ambulance first? But the Police lady and 52 gentleman broke into his house. They ran upstairs and I can't remember 53 whether I peeled back the duvet cover or they peeled back the duvet cover. 54 He was laying there, on his side. I didn't see it at the time but I remembered it 55 recently, a few months ago. So he was laying there, on his side, knees curled 56 up in this foetal position with a black plastic bin bag taped around his head. 57 And I don't know, I'm sure as you know being a nurse, you've heard	Tried calling everybody to alert them. Called emergency services. Surprised the police responded and not an ambulance. Can't remember exact sequence of events when they found the found the body. Shocked/ upsetting/painful. Months later recalled more accurately. She saw the body.
Realisation of suicide L58	58 somebody, when somebody they love dies, when you actually scream that 59 scream, you'll never forget it and my world was whizzing round and they 60 dragged me out of the house and forcibly dragged me downstairs. So I'm	I'm sure as you know being a nurse-seeking an understanding of her response. This to provide insight to the actual emotion she felt at the time.
Rage L61	61 hitting the Police woman, got bruises all down my arms and this was Sunday 62 morning so all the curtains were twitching. A quiet suburb of city X close at	She will always remember finding him. Screamed- shock. Hysterical. Aggressive towards the police and was removed forcibly. The local community witnessed it. Humiliated possibly felt she was guilty?
Humiliation L62	63 half past seven and they shut me in the Police van with the Police woman and 64 I had to wait in there with her until CID came and basically decided that I 65 hadn't killed him, which took hours. And then the ambulance came.	Kept in the police van until they ruled out any involvement. She was a suspect at that point, which took hours - felt like it because of the shock. How he managed to do it on his own but anyway. So that was very odd - denial? Can't accept that he took his own life.
Judged by other L65	66 Apparently they tried to resuscitate him. How he managed to do it on his own 67 but anyway. So that was very odd. Then the nice CID man came in his 68 polyester suit and said, 'Oh it's alright, we don't think there's any foul play. 69 Off you go.' And so I, at this point, had rung my sister who lives down in	the nice CID man came in his polyester suit and said, 'Oh it's alright, we don't think there's any foul play. Off you go - angry. She felt dismissed, what she'd had seen and experienced. That was the man she loved. Not regarded at all. Contacted her sister who lives in another area. She lives in that area now. Good relationship with the sister? Poor relationship with parents whom she lived with, they didn't know about him either. She could rely on the sister. Blur - overwhelming, shock. Went off sick from work. I don't know how that started- disconnected from what was going on around her. Numb? Others did they calling, doing etc.
Denial L67	70 City Y, where I am now because this was happening in city X, and I said, 71 'Please come and get me. I can't,' because I was living with my mum and 72 dad, 'I can't face them,' because we don't have good relationship. It's okay 73 but it's not close, you know, they didn't even know about him. So she's	Stayed with friends upon her return to the area. Couldn't be back at home with parents? Relationship issues is rooted, she's an adult, he was a secret and lives with them.
Poor relations with parents L72	74 whisked me back to city Y and then it's all a bit of a blur. So obviously I 75 wasn't working. Somebody had rung work and said this had happened. I 76 don't know how that started. And then I came back and stayed with some	Partner's brother blames her. Completely - everything. She was shut out of the funeral arrangements. His brother gave false information so she wouldn't be at the funeral. Dismissed again, excluded.
Being blamed L77	77 friends and basically his bro- his brother blames me completely for the whole 78 thing and I wasn't allowed any input into the funeral, into the order of 79 service, into anything. And he even told me a lie about when the funeral was 80 going to be and what time it was. Fortunately, the lovely funeral director in	

PARTICIPANT: Christine

Being excluded L79	81 town X peered over my shoulder and nudged me some details that she	Received information secretly from the funeral director so she could attend. She's shut out from it all. She shouldn't have done – not entitled to know.
Singled out L84	82 shouldn't have done so I knew where to be at what time. We sent flowers but	so he got my flowers – some relief that something she gave to him was there, these people from all these different walks of life there – so no reason why she couldn't be there. Brother didn't want her there – why? Relationship or blame? He was vile – brother was really nasty to her. She was really hurt by it. he
A victim L89	83 they had flowers so he got my flowers so it's, and he was cremated and there	walked in and kissed me on the top of the head and I just muttered to him ignorant cunt – hypocrite. It was personal and no one would know how mean was to her.
	84 were all these people from all these different walks of life there. But he	Brother horrible to her at the inquest too. Every opportunity, her suffering is impacted further. Brother was aggressive towards her and lied about her. Feels brother projecting his own guilt on her. that was awful so I've had none of the – opportunity to be involved, to grieve as she needed.
	85 basically didn't want me to go to the funeral. He was vile. And then when I	She's a palliative care nurse – she deals with death. She needed to go through the process to grieve but was denied the opportunity, hundred times worse because I've had none of the rituals – she couldn't be involved. No help, no self-preparation. It hit her harder because she was working with death but couldn't process the death of her partner. Returned to work after 4 months. Work – were badgering me – bothering persistent. She did feel they were insensitive to her grief? She requested counselling but it was inflexible with set times. Work were not accommodating. They also requested she didn't tell anyone about the suicide. Struggle with job: speciality, no counselling and keep it a secret. She wasn't able to process, she was restricted. Awful – no support or relief. Everyone and everything was against her in some way? Everything had to be a secret.
	86 was there he walked in and kissed me on the top of the head and I just	
	87 muttered to him ignorant cunt and my Salvation Army friend said oh, what?	
	88 But that was just for everybody else's because he's been absolutely vile to	
	89 me. I mean his was absolutely vile to me at the inquest.	
	90 I: When, when you say 'vile' can you tell me a little bit what that's about?	
	91 P: Erm, aggressive, rude, naming. He told one of our closest friends that I	
	92 hadn't even sent Mark a birthday card and I had. He just was, you know, he	
Disadvantaged L94	93 just was trying to make me look as bad as he could, probably because he, I	
	94 don't know, felt guilty himself but. So that was awful so I've had none of the,	
	95 because my background is in palliative care nursing so that makes it a	
	96 hundred times worse because I've had none of the rituals and none of the help	
Powerless L96	97 and none of the build-up and I was working, I'd just started my first nursing	
	98 job at a hospice in town Y and they were badgering me to come back to	
	99 work. I did have four months out but when I went back to work I said I need	
Harassed L98	100 to find some counselling or some bereavement counselling or something. And	
	101 everybody does it, it's a set day, it's a set time, that's how counselling works.	
	102 And I said to them please can I have X day off every week? No. By the by	
Unaccommodated at work L102	103 please don't tell anybody what happened. So I was trying to struggle on in	
	104 this job, not discussing what had happened to me, keeping it a secret, not	
	105 having any counselling of any kind. So it was all just a little bit awful to be	
Repression L104	106 frank.	

PARTICIPANT: Christine

Being saved L115	<p>107 I: So you, you, you've mentioned obviously some barriers and some supports 108 that you weren't able to access. Thinking about resources or supports, 109 whether they are formal or informal, what do you think had he- what was 110 important in helping you cope at that time following the suicide?</p> <p>111 P: I think it was my sister.</p> <p>112 I: Sorry?</p> <p>113 P: My sister, I would say.</p> <p>114 I: Okay.</p> <p>115 P: So she just kind of scooped me up and looked after me because her 116 husband had died two years previously.</p> <p>117 I: When you mentioned she scooped you up and looked after you, what did 118 that actually look like?</p>	<p>Sister was a great support</p> <p>Scooped me up – took over and looked after her. Can identify with sister, her partner died too.</p>
Unconditional love L119 To be cared for L121	<p>119 P: She actually, literally drove up from city Y, got a speeding ticket, put me 120 in the car, got some clothes and underwear for me and took me home. Took 121 me to the doctor's and got me Temazepam and Mirtazapine* which I took 122 and didn't have any effect on me. None at all.</p> <p>123 I: Okay.</p>	<p>Sister cared for her and was there for her. Sister took control because she couldn't. got a speeding ticket - knows the sister loves her. Sister was a helping hand: took her home with her, took her to the doctor. She was prescribed medication for sleep and depression. She couldn't function so sister stepped in. The medications didn't work at all. Expectations of the medication?</p>
Hysterical L127	<p>124 P: That distressed, I was on, what did they give me? I think she gave me two 125 point five milligrams by mistake. It's a lot isn't it? So I was taking a couple of 126 those and ten milligrams of Temazepam and still running round the house 127 screaming like a loony. It didn't help me at all.</p>	<p>Distressed. Rationalises medication doses being high and ineffective. She's highlight how bad this experienced was for her, still running round the house screaming like a loony – hysterical, in pain.</p>

PARTICIPANT: Christine

	128	I: Other than your sisters was there any other supports or resources that you	
	129	found quite helpful?	
Resisting pleasing others L131	130	P: Erm, friends, no. They were just please, be okay. Well actually no, I'm not	Friends unhelpful – please be okay. Needing
	131	okay, deal with it. I did try Survivors of Bereavement by Suicide but found	understanding or practical help? I'm not okay, deal with
Fear of no progress L133	132	it hideous. I was horrified. People getting up and saying I've been here for	it – didn't live up to their expectations.
	133	twenty years, oh my God. Am I going to be like this in twenty years' time?	
Not responsible L139	134	They do little split off groups, don't they? So we were all sat there and all I	Attended group – unpleasant and horrible. Fear being
	135	heard was this huge long history of mental illness and it's not his fault, it's	like others in the group many years later. Fear the future
	136	the carer's fault, the Government's fault, the hospital's fault, the doctor's	won't be better. Didn't accept the rationale of mental
	137	fault, the, forgive me, mental health service's fault. It's their fault, it's not his	illness and all the factors of fault and not the fault of the
	138	fault. Whereas I'm sitting there and this one poor other lady, saying it is his	person who died by suicide. She only blames him, it was
Rationalising L140	139	fault. He decided to do it. I've got nobody else to blame and I've got no	his fault, he chose. I've got no history to draw on – she
	140	history to draw on. So I didn't go back there again because I think it's	had no idea. Another secret? A contradiction? Didn't go
	141	terrible. Erm, actually the Hospice Deputy Chaplain, she was good, not that	again.
Freedom of expression L143	142	I'm religious but Bernadette , bless her, if she was there and I needed ten	Hospice Deputy Chaplain- good, she was available to talk,
	143	minutes out to talk, she would always stop and help. But the full time	she needed talk to someone, the full time Chaplain and
Disappointed L144	144	Chaplain said she would try and look out some help for me, didn't bother.	Hospice Social Worker – didn't follow through with
	145	Nor did the Hospice Social Worker. And I think being at work fourteen hours	getting some help. Let down.
	146	a day and not being able to recognise it or share it or acknowledge it was just	
Being suppressed L146	147	a wrong thing really. So while all that was happening my mum was diagnosed	Working long shifts around death and being restricted in
	148	with breast cancer. So I left that job and went to a bank job and I just, yes, I,	grieving. No control. At the same time mother diagnosed with
	149	yes, and I have lost another job since then and I think it's all interweaved.	cancer. Some impact on her despite their relationship, fear of
	150	And I think what I should have done is take advice and go and work in an old	losing her.
Combined events L149	151	ladies' ward or something rather than trying to go back to palliative care,	Employment – left, did bank job then lost a job. Work team,
	152	where you know all the deaths are done properly and my significant death	speciality and hours were too much. Bank work can be more
	153	which never had or never will be done properly has had quite a negative	flexible – needed to pick and choose based on how she felt? I
Wanting to grieve her way L152	154	effect on me I think.	think it's all interweaved – Many factors play apart in
	155	I: When you mean a negative effect, what, what do you mean by that?	employment and ability to nurse. Was advice to work outside of
			palliative. Recognises it was the best environment for her. It
			was a conflict and painful. Feels his death wasn't done
			properly? Why, she was part of it?

PARTICIPANT: Christine

Jealousy L157	156	P: I don't know. It's difficult to, I don't know. I did, and I still do, I don't	jealous of sister being able to grieve. Nurse sister's husband.
	157	know what I would call it, grief envy. My sister's husband died of cancer in	
	158	the Hospice I worked at for a wee while and I'm thinking well she was	She wasn't supported like her sister. Type of death also
	159	prepared, I mean it was only a year from diagnosis to death, but she was	prevented the opportunity to prepare.
	160	prepared. She had pre-bereavement, she had after bereavement, she had	
Discriminated against L161	161	recognised pathways and I had to fight and struggle and relocate and beg just	Discriminated support. Lack of support. She had to really
	162	to get some basic occupational health counselling. It was a real fight. There is	work hard to get support and when she found some had to
	163	nothing. There is nothing at all. The Police gave me a victim support leaflet	work hard to receive it. Frustration. No support- generally or
Unsupported L163	164	but there isn't anything. It's like boom! They're dead. Deal with it yourself.	just for her? Got a leaflet from police. Insult. Felt alone.
	165	Nothing at all. Nothing, nothing. There was nothing. My journey, who can	Aggressive expectation to cope.
	166	help me? That bloody leaflet you sent me, completely useless to me. Yes, I	
Denied opportunities L167	167	would love to ring the bank, yes I would absolutely love to go the registry	That bloody leaflet you sent me-referring to resource pack
	168	office and get ten copies of the death certificate. That would be lovely. I'd	sent by interviewer prior to interview. The advice would
	169	love to organise the funeral. Love to tell the benefits office. I'd love to tell	have been helpful but she wasn't in a position to do any of
	170	work but I wasn't permitted to do that. And that's just, oh it's, I will get over	those things. Powerless of herself and their relationship.
	171	it but it's just so sad. There's no, I mean there is no closure when somebody	Doing relevant things would have helped her grieve?
Unfinished business L171	172	dies, they die. But it's just. So I don't know even if I have coped to be frank.	
	173	I: So, if you were to look at what you've just been saying about coping, how	Feeling insignificant, feelings dismissed. Expected to get over
	174	would you, how would you have described a good day?	it. Hasn't got over it because of her lack of involvement and
	175	P: What? when? Now or then?	ability to grieve.
	176	I: Then.	
	177	P: Then. Erm, Well, I don't think there were any.	No good days. It was all bad. Affected her badly.
Mostly negative L177	178	I: Thinking about everyday life, what, what did, what did your day look like?	

PARTICIPANT: Christine

Work as a distraction L182	179 P: Er, well while I was working full time over in town Y I would be up at five 180 to get there at half past seven and work till ten o'clock and come home. So 181 no, I didn't get chance to think about it really because I was looking after 182 other people which I think is probably an escape mechanism really.	Was working full time after suicide. Long shifts, looking after other people. Didn't look after herself? Helped to distract herself from thinking. Thinking was painful.
Being nurtured L186 Fear of being alone L189	183 I: Because you mentioned about your sister coming, and obviously coming to 184 look after you. Thinking about that, how, what is it your sister had to do, did 185 to help you with that you weren't doing necessarily yourself for example? 186 P: She would make sure I was eating, for a start. Made sure I was going to the 187 doctor's. That kind of thing. Just holding my hand or a couple of nights 188 would be with her for about a week and I just couldn't be on my own. I had to 189 sleep in the bed with her. I just couldn't be alone. It was just too bad. 190 I: So it sounds like, with your sister helping you those things probably would 191 have been the opposite then. You weren't eating so she kind of helped you get 192 you into a routine of eating. And it sounds like work, you, you called it a bit 193 of an escape really because you had to kind of help others really kind of kept 194 you in a bit of a routine.	Sister was a carer, she prompted her in her routine. Poor appetite. Avoided being alone-thinking, upset. Avoided being alone so much she didn't sleep alone. Did she fear being alone? Did she not trust her feelings and thoughts?
Poor self-worth L195	195 P: Yes. It's just easier to think of somebody else, isn't it? But not yourself 196 unfortunately.	Looking after others helped in some way.
Avoiding thinking L201	197 I: What about days when you weren't working? 198 P: Erm, do you know, I can't think of anything I was doing other than 199 working. I really can't. I would have been sleeping because we used to do 200 long days so we do three long days and a day off. So I would have been 201 basically asleep. So sleep and work really.	Sleep and work. Slept on days off. Working was hard anyway but she was exhausted physically and mentally.
	202 I: Sleep and work.	

PARTICIPANT: Christine

<p>Workplace a constant reminder L208</p> <p>Financial debt L212</p> <p>Changing profession to help heal L215</p> <p>Putting the self-first L216</p> <p>Life was unbalanced L224</p>	203 P: Which, when you look back on it, it's not really very healthy, is it? No.	<p>Reflects on how she didn't look after herself much. Was he punishing herself? Did she think others around her were punishing her too? Low self-esteem.</p> <p>Her grief affected her employment in nursing but also another reason too?</p> <p>Changed occupation completely. Call centre. She can leave work there – nursing did the opposite. She had no relief from it at work or at home. Tormented by the experience.</p> <p>Planned to train as a counsellor. She wanted someone to listen to her so she could talk. This is important to her, to off load and help grieve. Took a year out but needed to work before due to debts. This was for her. Looked for work that wasn't emotionally challenging as long as she wasn't tormented by the thoughts. Needed work-life balance too.</p> <p>Enjoys dancing. Putting the self-first deliberately. Required mental and physical effort to look after the self. Realised it had to come from her. Nothing else was helping much. Motivated to get through it.</p> <p>It was just work and her relationship.</p>
	204 I: And in comparison to now, is life much different for you with regards to 205 coping?	
	206 P: Erm, yes. I'm not working there anymore but that's a completely long 207 different story but probably related to the grief, but you know. So I work in a 208 call centre so I can go to work and leave work there. I've just decided now, 209 because I was going to do, I did an introductory counselling course and I was 210 going to go and train to be a counsellor but I decided I'm going to take a year 211 off trying to do stuff like that, and, you know, because I was in so much debt 212 after Mark had died it was just crazy. I was still trying to work my way out 213 of that so I decided a year out. Take whatever job comes along as long as I 214 can go in there, leave it there and come home again and work to live rather 215 than live to work which is what I was doing before. So just trying to look 216 after myself really. I've taken up dancing. I do jiving and lindy hopping 217 which is interesting. And yes, yes, just trying to get myself, trying to look 218 after myself. Actually it's the first time I've made a conscious effort to look 219 actually look at how I am and try and look after me. But it's actually taken 220 quite a lot of effort to do that.	
	221 I: To do it. Was that very much thinking about, you know, you mentioned at 222 the time life, at the time of the suicide you had just started a new job. Was 223 there anything else going on in your life?	
	224 P: Erm, no, not really. It was just job and, yes, Mark basically. That was my 225 life at that moment really.	
	226 I: So a lot of these things that you're doing now, they weren't things you were 227 necessarily doing before when you and your partner were together? Sorry.	

PARTICIPANT: Christine

Moving forward L229	228 P: That's all new, all the dancing. I decided I've got to go out and get a life because I'd just been sitting in this house being black widows basically and	Trying something new. Her choice to take control of her life. I'd just been sitting in this house being black
Being stuck L232	230 not socialising and not getting out and not seeing anybody else and just sitting	widows- idiom usually means A disingenuous woman
	231 there thinking shall we go out? It was easier just to stay in. So I had to make a	who exploits her position in a relationship to the
	232 conscious effort to get out, even into work again. I kind of shut down and shut	detriment of her partner. However, I think she means she
	233 everything out really.	was in mourning (black) and like his widow (his partner)
Strength L232	234 I: You mentioned about, erm, at the, you started the story talking about giving	Life had to go one and she had to break the cycle. She was
	235 me a kind of how, how it came about. Thinking about your relationship, was	socially isolative, avoiding people. It was too much hard
	236 your relationship, what was it like before the suicide? Had it changed very	work to move on but she did it, to get a life, got to work.
	237 much?	She needed to survive, I kind of shut down and shut
Relationship because volatile L238	238 P: It had, yes. Yes. I remember just doing, you know, I remember one day,	everything out really - she stopped functioning and
	239 we'd come back from somewhere, I think it was my boss's anniversary party.	everything around her stopped. It was really impactful.
	240 Got on the bus, had a little bit to drink as we do, a nurse and a Government	Relationship changed a lot before the suicide.
	241 employee, there's always booze involved which probably has something to do	Recalls a night out with partner. He left her alone to go
	242 with it as well. We were on the bus in town Z and we got off the bus at my	home at night when they both had been drinking. Felt
	243 stop and I thought it was oh right we're going to walk home together and he	abandoned by him?
Felt abandoned L244	244 got back on the bus and dropped off home. I went you bastard. No	That was kind of an odd thing. Really odd- not what you would
	245 explanation. That was kind of an odd thing. Really odd. Kind of pushing. I'm	expect from someone who supposed to love and care about you.
	246 trying my best to upset you as much as I can kind of thing. And looking back	Did she question their relationship? He hurt her and thinks he
Questioning relationship L245	247 on it I wonder whether he was trying to push me away because his brother	did that often to see how far he could go. His brother was
	248 had said he wasn't surprised, which I thought was quite odd. And also said	surprised - acknowledges this though she doesn't like him.
	249 that perhaps I'd kept him alive for another three or four years which I thought	Thinks there is something about the partner. Feels the brother
Uninformed L250	250 was odd but he never went into why. And Mark always used to say this thing	is also not surprised at the suicide. I'd kept him alive for another
	251 like he loved me so much and he'd wished it to be simpler and I just thought	three or four years - brother's comment is positive one? Was
	252 it was a phase but clearly it was a fact. Looking back, looking back, now I	she always the last to know and have secrets around her?
Deceived L253	253 know, they were little clues that all was not well but I mean, other than that,	He loved her, he told her. The suicide doesn't make sense to her.
	254 we used to just laugh all the time. Used to be just hilariousness. Used to just	On reflection thinks they were all clues. She didn't see it then.
	255 giggle and laugh and we used to both like words and just make up words or	They had fun together and laughed most of the time. It was a
		shock.

PARTICIPANT: Christine

<p>Experimenting L258</p> <p>Coming to terms L261</p>	<p>256 use really long words inappropriately and just spend all the time laughing.</p> <p>257 And dancing. We did the dancing. We did to a ten week dancing course with</p> <p>258 him so I actually started a similar course this year. I thought I was quite brave</p> <p>259 but I haven't cried yet. I did once, last week. I did cry because I danced to Jail</p> <p>260 House Rock with a man and that was a thing I'd wanted to do and so I had a</p> <p>261 little weep then but. That was odd. So no, it just, we just used to have fun</p> <p>262 really.</p>	<p>They danced together. She dances now.</p> <p>Recognised she is being assertive and pushing herself. She wished she was dancing with him so cried a little. It was a sad moment, she misses him. That was odd – surprised at her emotional response?</p>
<p>Could have prevented L267</p>	<p>263 I: But it, it sounds like, from you're saying, looking back it had changed but</p> <p>264 didn't necessarily quite have an explanation or an understanding of it.</p> <p>265 Whereas maybe now you feel there were some potential signs.</p>	<p>Conflict on self-blame. He took his own life but feels it was her fault. She didn't see?</p>
<p>Looking for an explanation L271</p>	<p>266 P: Yes, I wonder whether, I don't know. I mean completely, I know it's not</p> <p>267 my fault but I feel like it's my fault. I know it's not the fact but, and I know</p> <p>268 I'm not to blame. I know people don't want to blame me but I know deep</p> <p>269 down at a low level it is my fault and I do. Though because of me but I don't</p> <p>270 really think it was. I think there was something else going on which then</p> <p>271 blends into the conspiracy theory. Was there something going on at work that</p> <p>272 I didn't know about? So I don't know that. And also, rather horribly, his dad</p> <p>273 used to work for a television channel and used to take the two boys to Top of</p> <p>274 the Pops a lot in the seventies. Half of them have been arrested and taken to a</p> <p>275 television studio so the brain is thinking is there something around that? Is</p> <p>276 there something there that he would never, ever tell anyone something</p> <p>277 happened? You've frozen. Are you still there?</p>	<p>Others don't blame her. Deep down she felt she should have known and could have done something? Also thinks it had nothing to do with her. the conspiracy theory- believes something else is to blame? His work, the secrets? Questions if she really did know him after all? Considers the others areas of his life that she knew nothing of despite knowing him for 25 years. She is pulling at straws from him work to he was younger, something must have happened. She can't accept that he took his life without a reason. A reason she knows nothing about.</p>
<p>Impaired memory L279</p>	<p>278 I: I am, I am still here.</p> <p>279 P: Now, where were we at. I really can't remember. I'm good at that. It's</p> <p>280 gone. I really can't remember where I was. Ask me another question, you</p> <p>281 might get me going again.</p>	<p>You've frozen. Are you still there? – pause in the interview. Technical blip.</p> <p>Train of thought and memory is challenging at times.</p>

PARTICIPANT: Christine

<p>A possible explanation L296</p> <p>Deceived L302</p>	<p>282 I: Get you going again. [Laughter] Going back, erm, and, well you were</p> <p>283 talking about how your relationship had changed, what it was and kind of it</p> <p>284 had moved forward a bit and looking back it looked like potentially there</p> <p>285 were signs there and that was reinforced by other people as well and then</p> <p>286 bringing us up to the time of, the time of the suicide, erm, you started a new</p> <p>287 job. Was there anything else going on in your particular life at the time of the</p> <p>288 suicide?</p>	<p>The went to a friend's wedding together.</p> <p>It was an emotional wedding.</p> <p>I don't know whether that flipped something – unbalanced him emotionally a possible explanation.</p> <p>She can't explain the death. The bothers her not knowing.</p> <p>She was employed, he was a bit restless which thought she could sort. She was determined to get on and be stable at 40 yrs. Now 10 years later life is a mess again. Thought life was looking promising, it went and it's not now. Feels life has been unfair to her. Bang-sudden.</p>
	<p>289 P: No, not really, no.</p>	
	<p>290 I: Just work, okay.</p>	
	<p>291 P: It was our friend's wedding because they'd been together years, he was</p> <p>292 having a really tricky, difficult divorce and they are very devout Christians.</p> <p>293 She's Salvation Army, [Pause] practising God person, and he even looks like</p> <p>294 Jesus when he used to shake his head. And the wedding, we went to the</p> <p>295 wedding and everybody was crying. We were all crying, everybody was just,</p> <p>296 it was just so emotional and I don't know whether that flipped something or</p> <p>297 not or. Well that was, that was about the only other thing I would say. There</p> <p>298 was nothing of any great significance happening at that particular time. No. I</p> <p>299 thought I'd got work sorted, a little bit antsy boyfriend which I can sort, you</p> <p>300 know. Let's move forward. I mean at forty-odd it's time to get things sorted</p> <p>301 out and now I'm nearly fifty and it's all gone to shit again unfortunately. But,</p> <p>302 hey ho. So that was it. I was thinking things were getting there and it all just,</p> <p>303 bang, gone. Everything gone.</p>	
	<p>304 I: You talked about some coping, coping experiences and some of the</p> <p>305 supports and resources and you've mentioned some, like your sister that was</p> <p>306 very helpful for you, and some other, other people but you also mentioned</p>	

PARTICIPANT: Christine

	307	some resources and supports that were not available to you or some that you	
	308	didn't really, didn't benefit you.	
Feeling vulnerable L311	309	P: Yes. Erm, I remember one particular instance. I went to, I think it was a	voluntary counselling service – not a clear recollection. Didn't pursue it?
	310	kind of voluntary counselling service but by this time I was very, very, very,	
	311	very stressed. Not having any medication of any kind. I couldn't remember	
	312	what it was. The next thing shouldn't have been allowed to have been	Dissatisfied with the next counselling service – inflexible if she couldn't make the set times. Blunt response.
Unsupported L314	313	allowed to have been a counsellor because he really, really did and said well	
	314	if she can't make it on a set time at a set day then we can't help you. Just like	
Anger L315	315	that. Unfortunately, I went down stairs kicked the plate glass window in,	I went down stairs kicked the plate glass window – Angry
	316	which is obviously stuff coming out, I did, I was navigating things coming	
	317	and going but I was just so outraged that there was no liability, no kind of,	Felt neglected and unsupported.
	318	nothing. Work wouldn't be flexible; the counsellor wasn't flexible so there	
Restricted access to support L319	319	was no way I could access anything. Telephone counselling from the RCN	Restricted access to support because of inflexibility.
	320	but that's, you know, six sessions of talking to somebody. Not really	
	321	effective. Not really. I rang the Samaritans quite a lot. I would be on the	Tried telephone counselling for 6 sessions but that was it. Needed more sessions/time?
Limited support L320	322	phone to them for every excuse like the cats [Laughs] Come and sit down. So,	
	323	yes, I did ring the Samaritans and I am now one of them but the only one I	Rang Samaritans a lot. I would be on the phone to them for every excuse like the cats [laughs]. She was desperate and lonely. She needed to talk. Now a Samaritan herself. Found it really useful.
	324	remember was the one that was no use to me whatsoever. And was, you	
Free access to support L322	325	know, I'm not even going to bother talking to you about it. I did ring the	Didn't want to disclose one support that was unhelpful.
	326	Survivors of Bereavement by Suicide line but found myself hearing other	
	327	people's stories and ending up counselling them rather than them helping me.	SODS – telephone contact but weren't skilled. She ended up helping them and not the way round. Preached to turn to god – thinks this inappropriate for a helpline. Expectations were not met.
Making a difference L323	328	I think that is an organisation that needs to look at the way it operates really.	
	329	So I got stories of other people's suicides. I was preached on more than one	Drank alcohol a lot. End of her tether.
Wanting to be heard L327	330	occasion and told to turn to God which I think is entirely inappropriate from	
	331	the helpline, really. So there was that. Lots of alcohol. And after the plate	Really angry. Wanted to smash it again. So much pain. Took medication in the end because nothing else helped. Wanted talking therapy. Needed to express herself.
	332	glass window kicking in accident, accident, incident. I did it on purpose, I	
Self-medicating with alcohol L331	333	wanted to smash something and I wanted to smash it again. I went on to	
	334	Fluoxetine grudgingly because there was nothing else. I think if I'd have had	
	335	some talking therapy and my GP, bless her, was very sympathetic at the time	

PARTICIPANT: Christine

Medication as a last resort L334	336	and she did refer me to their counselling service. I don't know why I want to	Wants to be a counsellor, questions it: She wants to helps others, will this help her?
Being understood L336	337	be a counsellor because it must be very hateful now looking back on it. But	GP referral to counselling service. It didn't materialise due to service contract finishing. Felt no choice to take medications in the end. She needed something.
Desire to help others L337	338	apparently that service was ending the contract with the GP so I got a call	Screaming and crying constantly for months. Lots of pain, distraught, anger.
Disappointed L339	339	from the Manager saying, 'I don't know if I'm going to be able to see you.'	Started meds after the inquest in Feb back to work in April. Had to pay for window damages.
Feeling desperate L341	340	Okay. So the only thing really that was going to help me come back to life	A lady from one of the counselling services listened to her out of service. She needed to talk and it helped her. complete stranger – surprised by this. She was being heard.
Depression L344	341	was medication and that's, I just went for it in the end. It was all I could do. I	I had two mentors – at work? Controlled her. She couldn't be herself, felt suffocated. One of the mentors lost a brother to suicide but found out after she left. Organisational control over controlling her?
Reaching out L351	342	couldn't see any other way out of sitting there screaming all day long and I	
Lack of control L353	343	did. I must have screamed for two months. I was just crying and crying for	
Identifying with others L355	344	months it was awful. So, no, so I managed to get drugs. So when, did I start	
Secret grieving L366	345	started, shortly after the inquest which was in January . Now when I did the	
	346	smashing window thing I had to pay one hundred and fifty quid. Erm, I went	
	347	back to work in March . And Lara , how could I have forgotten Lara . The	
	348	lady that was working there and she was commuting down from Scotland and	
	349	she was being, she's been amazing all the way through. So she was just like	
	350	this complete stranger and one day we were walking across town Y and I	
	351	came pouring out to her so. So she was good. She was like the only person	
	352	there that knew. I had two mentors but they were more interested in	
	353	controlling me and making sure I didn't say the wrong thing. I remember	
	354	being in the room with one who subsequently after I left, found out that a	
	355	couple of years previously his brother had killed himself and I was in a room	
	356	with a young man, a young banker, with the same freckles, the same age as	
	357	Mark was, the same name as Mark , the same beard, same freckles on his	
	358	arms and Cliff was in front and I was behind him and he was dying. Bless	
	359	him, he had a brain tumour and the only word he could say was, 'fuck'. But	
	360	he was very expressive with it and I just, and he was frightened because he	
	361	didn't know what was happening and he's got vertigo. So we were cleaning	
	362	him and I was just, you know, soothing him down saying it's alright Mark	
	363	and I was just like, I was just holding this man on his side behind him and	
	364	Cliff was wiping the tears away. I just, I just couldn't stop myself. He didn't	
	365	see me but I was just literally, there was no way I could stop the tears coming	
			She was with a patient that had remarkable similarities to the partner. She experienced transference? Or was she trying to help herself grieve through this patient. Being part of the funeral would have helped her.

PARTICIPANT: Christine

Painful reminders L368	366	because it was just like, it was exactly the same. He looked like him, he was	Doesn't want to be working in the area of nursing? It's too painful for her.
Punishing the self L369	367	wearing brand X as well and it was, oh my god, I don't want to be in this	I probably should have not been such a stubborn cow – knows it wasn't healthy for her working with death all the time.
Becoming more confident L371	368	situation any more. It's too hard. So but I fortunately managed to swallow it	Joined the Samaritans. stringent interview process - surprised at this or surprised she got offered the job? Does she question her worth? Confidence?
Helping the self through others L373	369	and I think I probably should have not been such a stubborn cow and gone to	Wants to help others but can't help herself directly. don't know whether I use it as an escape - deliberate avoidance. Can't face her emotions? Too painful. occasionally I will just have a meltdown and I'm just in bits – she has these moments and wonders if she tackles it head on, she will lose it completely. Events, dates trigger her crying. Fear of losing control. floods of tears and it never seemed to turn- crying can be uncontrollable. She will always be sad but feels better after crying sometimes. Relief?
Painful reminders L381	370	do something else really. Fortunately, and then I joined the Samaritans last	Others think she has coped extremely well.
Relief L384	371	year and they have a very stringent interview process and they were happy	
Meeting others' expectations L386	372	with me working. But the thing is, and I don't know, I don't do it consciously	
	373	but if I'm looking out for somebody else I can be perfectly fine but I don't	
	374	think that's such a good place to be, I don't know. I don't know whether I use	
	375	it as an escape. And then occasionally I will just have a meltdown and I'm	
	376	just in bits. Just crying and crying and crying. It was on the bus. It would have	
	377	been the anniversary, the day after the anniversary of the first day we got	
	378	together which also just happened to be my brother-in-law's birthday. So I	
	379	woke up miserable, couldn't remember why and then looked at the date. So I	
	380	was going down to put flowers on his grave and I got on the bus to work and	
	381	there's a hen party singing Abba songs. I went you bastards. So I was sitting	
	382	at the top of the bus just in tears, floods of tears and it never seemed to turn. I	
	383	don't know. I don't suppose it will ever go away but sometimes things are	
	384	just so sad you just have to sit and have a bloody good cry really.	
	385	I: How do you think other people think you coped?	
	386	P: Everybody thinks I'm marvellous and the strongest thing on the planet and	
	387	isn't she wonderful.	
	388	I: Okay. And how, how have they drawn those conclusions? What did they	
	389	see? What did they know about you?	

PARTICIPANT: Christine

Considering others L392	<p>390 P: I don't know. I really don't know. I mean there were very few people, 391 which now I come to it is bizarre, actually saw me break but then I didn't 392 want to upset them so. I think our, our best friend got quite a lot of anger and 393 horror because he was also friends with Mark's brother and he was trying to 394 mediate and I just would, don't know, that hideous man. I'm not interested. 395 So he got quite a lot of flak. And he would say to me, 'Are you alright?' and I 396 would say, 'No.' But because I wasn't in a little jellified heap in front of 397 them, they'd just assume you were fine. So I think, it's all coming back to me 398 now. I did go and see his friends over in county X but one of those is being, 399 well they're all being, you know, they've just distanced themselves from me 400 now so they, you know, I don't really have anything to do with them 401 anymore. But some of his other friends up there, some up near where you are 402 and other places, yes, you know, we have Facebook because it's not 403 geographically possible to get there but friends with them. But no. Apparently 404 I'm wonderful.</p>	Not sure why people think she coped well.
Appearance is deceiving L396		<p>She does know, she didn't show feelings around others. She put on brave face so to avoid upsetting others. Their best friend was angry – someone who understood what she went through. He was a mediator between her and the brother. He was concerned and she was honest. She wasn't understood. She was suffering inside but no one really saw it and or accepted it. that hideous man. I'm not interested – avoids it. It a problem, she's angry still. Injustice.</p>
Losing friends L399		<p>Visited his friends. Trying to keep connected with him? they've just distanced themselves – another dead link. Uses Facebook to keep connected with his other friends. There are his friends, not theirs? Apparently I'm wonderful – Isn't that a compliment? In this case it's being dismissed and not having a voice.</p>
Maintaining friendships L403		<p>Professionals would think she has coped over time. She's very resilient – disagrees. Most of her friends think she's okay. She's not. Her sister knows better, she knows her well. But did she reveal more because of trust?</p>
Relationship safety L413		<p>Close sister relationship. She is true in front of her sister. They both trust each other.</p>
Trust L415	<p>405 I: So, thinking about some of the people that you've already mentioned, you 406 know, you've talked about certain mentors or your work environment, people 407 that you've worked with, your sister, maybe some of the resources that you 408 tapped into. If, if I was to ask them, you know, how, how, 'How do you think 409 Christine has coped following this suicide?' What do you think they would 410 say to me or describe to me?</p> <p>411 P: I think the professionals would probably say she's adjusted very well. 412 She's very resilient. I think ninety-nine percent of friends would say oh she's 413 okay. She's over it and coping well. Or my sister would go ha, ha, ha, that's 414 bollocks because she knows very well how it is. Though she's the only person 415 really that I can, I don't know. She's the only person where it really actually 416 comes out because she knows everything and the same with her. So if it's 417 going to come out of her it's going to come out with me. Yes, I think she feels</p>	

PARTICIPANT: Christine

Shared experience L419	418 inhibited about being sad. I don't know why because they're still dead, aren't they? It doesn't matter how they died. They are both still dead. But she	Isn't she inhibited at times? Shared experience with sister despite type of death.
Trust L422	420 sometimes feels embarrassed if she gets upset. She shouldn't really. I had no embarrassment about coming downstairs going [Wailing] Give me a cuddle, I'm upset which is a good thing to have but it's only her. So I think people	Trusts and feels safe with the sister but wishes it was exactly like that for the sister. but it's only her - only expressing herself with the sister.
Traumatic L426	422 generally, I know the counsellor I went to when I moved down to city Y and I worked in an oncology ward for a year, and kind of though I probably had post-traumatic stress disorder. I don't know whether I did or not. I did, did	Worked in oncology - changed speciality and saw a counsellor. Counsellor's impression was PTSD. She's not sure though identifies with some of the typical symptoms. Never formally diagnosed. she thought I was fine so she signed me off -worked related counselling or set sessions? Now she knows more -thinks it might have been PTSD? Counselling was a set prescription and not individualistic. NHS quick fix on me -superficial and not addressing the core.
Feeling insignificant L429	426 occasionally deal with symptoms of that but she thought I was fine so she signed me off. I'm beginning to think, having learned more about it now, is that she wasn't a particular good counsellor and was, you know, doing an	Feels like a circle being pushed into a square hole. She had to fit it, not the other way round. validated you're feeling okay so you feel okay - but she wasn't okay. Dismissed, insignificant and devalued.
Un-regarded L433	428 NHS quick fix on me, which isn't really a helpful thing. Sorry if you don't agree but I don't think you can cure or make anything any more manageable in six weeks. I don't think it's, I know it's cost limited but I think it's probably counterproductive because it makes you feel as though somebody has validated you're feeling okay so you feel okay. Actually you're not okay.	
Desire to be free to express the self L422	434 So not okay, but because somebody's said to you, 'That's fine, you don't seem to have anything more to talk about,' you think it's alright. So I don't know. That's the theory. 437 I: It sounds like, from what you're saying, that a lot of people saw different, different sides to your coping and I'm kind of just wondering whether the type of relationship you had with your sister, of who she was and your relationship together, you were who you were. Is that, is that a right, is that a right assumption? 442 P: well, not all the time, sometimes. But most of the time I am as I am with her. Whereas with other people I am as they need me to be. It's not what I think I should be but what they need me to be in order for it to be easier for	True to herself with her sister. Others - she behaves as they want her to be. Can't be herself. Why?

PARTICIPANT: Christine

Appeasing others L444	445	them, I think. I just, one person saying, because we had a big par- Christmas	
	446	party and some of our friends came over from the other side of the world.	
	447	This was Christmas , I think it was the Christmas after he died. I don't	
	448	know. Time is not working very well. I just remember one of our friends	
	449	coming up to me and saying please tell me you're alright. I said, 'I'm sorry, I	
Accepting L451	450	can't, because I'm not.' I don't know what to do with her now. It's alright	
	451	neither do I just, it just as it is.	
	452	I: Has the suicide changed you as a person?	
	453	P: Erm, yes. Definitely. It makes you look at things entirely differently and I	
Outlook in life has changed L456	454	thought I was looking at things entirely differently, having been involved in	
	455	palliative care for like ten years. But no, not until you actually experience that	
	456	and I know it's entirely different but it just alters your view really I think.	
	457	I: How has your view changed?	
Open-minded L458	458	P: Erm, a lot more patient these days. A lot more tolerant. A lot more looking	
	459	for reasons why people do things without leaping in and getting, I used to get	
	460	livid about silly things. Actually quite childish when you look back on it, I	
Changing priorities L460	461	wouldn't have, I probably, unfortunately and I planned them two grown up	
	462	which is a bit horrifying, yes. So I'm, I don't know whether that's a normal	
	463	thing or whether people go the other way but I'm a lot more, I don't know.	
	464	Just, I mean just silly things like if somebody cuts us up on the road and the	
Deeper thinker L466	465	road rage kicks in so I really don't know. He might be driving to the hospital	
	466	or might have really freaked out and it might be something happening. So I'm	
	467	always giving people the benefit of the doubt or wondering why they're doing	
More empathic L469	468	what they're doing rather than leaping in and assuming this has pissed me off	
	469	so I'm going to shout about it. So I'm a lot less, lot less judgemental. I listen	
	470	more to people and try and understand them more rather than just leap into	
			<p>Recalling events and time is difficult. Overwhelming experience.</p> <p>Friends want her to be okay. They can't cope with it. Don't know what to say. She was honest – friends don't know how to support her. Recognises as he doesn't know either how to help herself. Just accepting.</p> <p>Suicide has changed her entirely, her life.</p> <p>Changed views. Outlook on life. Worked in palliative care for like ten years – expected this to influence her outlook but the suicide changes her views completely. It's all death but she nursed people who were dying. The suicide is sudden. It's a different process. She needed to have a process.</p> <p>lot more patient, tolerant</p> <p>Now tries to understand and look at the bigger picture.</p> <p>More responsive than reactive. I used to get livid about silly things – priorities and meanings have changed.</p> <p>Thinks more deeply, put situations in to perspective.</p> <p>lot less judgemental</p>

PARTICIPANT: Christine

Valuing life L472	471 the defensive which I probably used to do a lot. Yes, and I think well, do I 472 want that pair of shoes? Yes, I do, sod it. I might be dead tomorrow so I'm 473 going to enjoy what I can while I can but that's really only kicked in, I would 474 say, this year. Actually making a conscious thing, yes, well stop being so 475 fucking miserable and get on and do something. It's easy to sit in a huddle. 476 It's much more comfortable I think, to be depressed. Having been depressed, 477 I know what it's like. I think it's, and I know it's not easy, but you can, I 478 believe, with effort, scoop yourself out of it before you get there. Well I can. I 479 know a lot of people can't. But I recognise, because I'm not on the fluoxetine 480 any more, I've been off that a couple of years, but I recognised in my head 481 when I'm going to start getting like that and I can take measures whether it be 482 a long walk in the countryside, a razz and a dance, a read, a scream, a run 483 down to the beach and throw stones at the sea, I can kind of pull myself out of 484 there but I don't think I've ever got back to being completely okay. And I 485 don't know whether I will. It's always going to be there. I don't know. I'm 486 much more philosophical, much more patient, much more enquiring. I'm not 487 as angry or selfish as I used to be which I suppose could have gone the other 488 way really.	471 the defensive which I probably used to do a lot. Yes, and I think well, do I 472 want that pair of shoes? Yes, I do, sod it - treats herself 473 Wanting to enjoy life. Values life and wants to live it. 474 This motivation is only recent - getting better, getting 475 through it. 476 Engages in self-talk to motivate her. 477 It's much more comfortable I think, to be depressed - hard 478 work to be positive and living. Had depression.
The self as a motivator L478	479 I know a lot of people can't. But I recognise, because I'm not on the fluoxetine 480 any more, I've been off that a couple of years, but I recognised in my head 481 when I'm going to start getting like that and I can take measures whether it be 482 a long walk in the countryside, a razz and a dance, a read, a scream, a run 483 down to the beach and throw stones at the sea, I can kind of pull myself out of 484 there but I don't think I've ever got back to being completely okay. And I 485 don't know whether I will. It's always going to be there. I don't know. I'm 486 much more philosophical, much more patient, much more enquiring. I'm not 487 as angry or selfish as I used to be which I suppose could have gone the other 488 way really.	479 Effort is required. scoop yourself out of it before you get 480 there - really depressed? Different stages of being scooped. 481 At the beginning her sister did and she did a bit later on. It 482 had to come from her. Well I can. I know a lot of people can't 483 - I can (motivation) fear of ending up like those that can't.
Non reliance on medication L480	489 I: How do you see yourself in the future?	489 Stopped anti-depressants two years ago. Can do it. Things 490 have changed over time. Raised awareness of mood and self- 491 help to prevent low mood such as walks, dance, reading, 492 screaming. Can control it now but not complete back to be 493 herself. A changed person. philosophical, much more patient, 494 much more enquiring - calming and soothing.
Engaging in self-help activities L482	490 P: Say again?	490 angry or selfish as I used to be - has let go of this.
Personal growth L487	491 I: How do you see yourself in the future?	491 No plans for the future.
Living in the moment L496	492 P: I don't know really. I don't have any plans at the moment. There's stuff 493 going on that's beyond my control so I can't really sort anything out until 494 that's sorted. But, I don't know. Don't know. Have no idea. I have no plans 495 other than the cat. Pussy want's his dinner, but it's not time yet. So really just 496 trying to enjoy things rather than make big plans and set myself tasks. Just try	496 Life with her cat. Enjoying in the moment. No big plans and setting tasks - expectations, hard to reach, can be tiring and deflating.

PARTICIPANT: Christine

Increased self-worth L505	497 doing things that I actually enjoy rather than things that I think I ought to do, 498 if that makes some sense.	Doing what she wants. Putting herself first.
Ongoing work on the self L507	499 I: So that's something that you do now that you'd like to continue doing? 500 P: Yes. I'd rather toddle off to work, do my work, come home, have a nice 501 dinner, cat and go out dancing. You know, just try and enjoy things a little bit 502 because I'm conscious of the fact that I never really made a huge amount of 503 effort to do anything for me. Despite my job, my selfish streak. I don't know, 504 it's just like I was always looking out for other people. I need to make a 505 conscious effort to actually look out for me and make sure I'm okay really. So 506 I was going to go on to the counselling degree at the end of this year but I'm 507 just not now. I'm not ready for it. I need to do some work on myself.	Enjoys work and leaving work at work. Nursing was a constant reminder of death and her experience in his death. Enjoy home life and dancing. More content. Acceptance.
Fully occupied 512	508 I: Right. Is it still part of your longer term plan though, to go on to do, 509 become a counsellor?	Making more time for herself.
A sense of satisfaction L516	510 P: I think so, yes. I would like to do it. I would, I was considering going on to, 511 erm, volunteer for CRUSE and do bereavement counselling maybe. I still do 512 the Samaritans though that's proving difficult at the moment with a full time 513 job that's shift work but that's always rewarding once you've done it. Once 514 you've been there. It's difficult to get there sometimes but once you've spent 515 literally hours. I mean the last, I did take a month off and then the last time I 516 did their work, I spoke to three people that really, really benefitted from 517 having somebody to talk to. So that makes it, you know, that's always 518 rewarding to think you've actually helped somebody. So that's nice. So 519 maybe something voluntary in the future. I don't know. I don't really. Getting 520 old.	Valuing herself more. Increase self-worth. Still work in progress, not ready for the counselling degree yet. She comes first for now.
		Works for Samaritans and holds down a full time job. Keeping quite busy still. Wants to do more volunteer work. Wants to help others, she really wasn't helped much.
		Can take time off when she needs it? Can get a bit too much sometimes?
		A sense of accomplishment helping others. Listen to them. She wanted to be heard.
		Conscious of age and what she wants to do. Might be bit too much for her?

PARTICIPANT: Christine

Taking life as it comes L525	<p>521 I: Is there anything, erm, else that you'd like to talk about. Something that</p> <p>522 you wanted to raise that you haven't quite covered yet?</p>	<p>Is she talking about herself here? What does she hope for? Her life how will it pan out? Is she talking as it comes and waits and sees?</p>
Treated an insignificant L528	<p>523 P: I don't know really. No, I don't think so. I just want to, I mean once you've</p> <p>524 got all your results together, what do you hope you're going to find out? Or</p> <p>525 are you just going to wait and see?</p>	<p>No help for partners that are not married/common law relationships. I wasn't his next of kin - no help at all. Insignificant.</p>
Injustice L533	<p>526 I: Wait and see.</p>	<p>Frustrated with the legal system.</p>
Significant L539	<p>527 P: Yes, because I just think there is. There seems to be nothing for people in</p> <p>528 my situation. If we'd have been married or we'd have been living together I</p> <p>529 would have got help. Because I wasn't his next of kin, and it's a horrible</p> <p>530 thing to know that when, once you're dead that body belongs to your next of</p> <p>531 kin. Did you know that? That's legally the, you are legally their possession</p> <p>532 once you're dead. So that was it. That was, that's the sum of my involvement</p> <p>533 was ringing the Police, breaking into the house, not actually being arrested</p> <p>534 but being locked in a Police van to make sure I hadn't murdered this person.</p>	<p>She was like a stranger, a passer-by who reported an incidence. Felt like a criminal. Injustice.</p>
Being valued L541	<p>535 Erm, went to the funeral director to see him and they made him look like a</p> <p>536 little Chinaman and when I touched him I could feel all the stitches under his</p> <p>537 T-shirt which was awful and they'd squished his eye bags. He had really</p> <p>538 baggy 'Barry Norman' eyes and they'd squashed them out and flattened</p> <p>539 them. Oh my God. What have you done to him? Went to the funeral, went to</p> <p>540 the after funeral. To my credit there were hundreds of people around me and</p> <p>541 nobody round his brother, so that's fine. That makes me complete. But that,</p> <p>542 that's where it stopped and there is nothing. There's nothing. I mean I don't</p> <p>543 know how people; other people like me manage. I could imagine they</p> <p>544 probably end up killing themselves because there is nothing. There's no,</p> <p>545 there's no helpline. If somebody dies in an accident, people are all over you.</p> <p>546 If somebody dies slowly, people are all over you. If somebody's murdered</p> <p>547 there's something there for you. If you know them at school. If you'd have</p>	<p>they made him look like a little Chinaman - she knew him. They changed him, at this point he was different and she wasn't involved. An outsider.</p> <p>To my credit there were hundreds of people around me and nobody round his brother, so that's fine - Some acknowledgement of who she was at the funeral. People thought about her. They sympathised. That was it. Really feels unsupported because of the suicide and her status. It was really bad - can't see how others coped. probably end up killing themselves because there is nothing - what about her? people are all over you - not with her. Discriminated because it was suicide and she was insignificant.</p>

PARTICIPANT: Christine

Discriminated against L549	548	been at school, there would have been people there for them. There are people	Help for other deaths – stigma
	549	there for the people he worked with but actually for me, nothing. I've still got	She was a worth a leaflet.
	550	it. Little Victim Support leaflet. A little square of paper like that. Ring these	
	551	people.	
Devalued L550	552	I: Sounds like-	
	553	P: I'm not a victim of anything. I don't understand why you would say that.	I'm not a victim of anything – positive outlook. She's a survivor.
A survivor L553	554	I: It sounds like that, because you weren't legally married, you know, and you	
	555	talked about the role of the next of kin and your involvement because of, you	
	556	know, the relationship that you had. Do you think that has affected the way	
	557	you coped with the suicide?	
	558	P: I think it has and I remember speaking to somebody who was describing a	
	559	similar situation but I have to be careful what I say, and, erm, it's like your	Disenfranchised – deprived, excluded. No rights.
Deprived L560	560	disenfranchised. Yes, you're upset but it's not actually your business now.	
	561	Nothing to do with you. We need to do the ends of stuff and. So when, erm,	
	562	for example, and I don't if anything's been on because I've not been watching	
	563	the exciting suicide on telly at the moment, but there's child abuse in	
	564	EastEnders for example and there's a helpline. If there's a murder, there's a	I don't if anything's been on because I've not been watching the exciting suicide on telly at the moment – can't face it, too upsetting, but there's child abuse in EastEnders for example and there's a helpline – suicide itself the support is not there. Feels disadvantaged and unsupported.
Frustration with lack of support L566	565	helpline. If there's illness, there's a helpline. And what matches is if there's	
	566	suicide, there's a helpline. There doesn't seem to be anything for people who	
	567	are just banned from affairs of someone you love and they're dead. But	
	568	because you're not the legal partner, go to school with them, go to work with	
No rights L568	569	them, whatever, there's nothing. I mean I don't know how other people	No status because they weren't married. Feels unsupported and not recognised.
	570	manage. Just because I had a slight pain in my head and thank goodness for	
	571	the Samaritans or else I probably would be dead but, you know, there is.	
Dismissive L570	572	Somebody's in an accident you get a leaflet, call these people. Somebody dies	I had a slight pain in my head – wasn't that bad compared to others? And had support from Samaritans, she would be that bad and probably been suicidal herself.
	573	in hospital, call us, do this. Here's a leaflet, ring these people. Nothing.	

PARTICIPANT: Christine

Unsupported L575	<p>574 Nothing, nothing, it's just nothing. There's nothing there which is just 575 horrifying. Nothing to do. There's nowhere to turn to. Whereas it seems for a 576 lot of other things there is somebody to turn to. If he'd been run over, there's 577 a helpline. If he'd died of cancer, there's a helpline. If he'd been murdered, 578 there's a helpline. You know, so it's like, I don't know. It's, it's a thing 579 people don't want to accept it happens, I think. It's just the last, you can have 580 everything else. You can die every other way but if you kill yourself, ooh we 581 don't talk about it. It's very much, we don't, we don't need to know about 582 that, thank you. So I rather hope that at some point, I know the Samaritans 583 are working with CRUSE to try and set something up for the suicide 584 bereaved but it would just be nice if you could just Google something and a 585 number popped up that you could talk to. Just at the moment I didn't, well, 586 just at that moment, there may be something now. I haven't looked recently 587 but it was like there was nothing and I was, yes, a victim of domestic 588 violence. What? It was registered as domestic violence, actually it wasn't 589 registered but that was because of his job. So, yes. Yes, it just feels like 590 there's nothing for the people and I'd like there to be something for people, 591 somewhere for people to turn to. I mean having all the bereavement resources 592 in my head I still struggled to find help and I just wonder what other people 593 do and the consequences of not being able to find any help are just too 594 horrible to imagine really.</p>	<p>Repeats the type of supports for others but not for her.</p> <p>Struggles with all the supports out there but not for her.</p> <p>people don't want to accept it happens - Suicide is stigmatised and discriminated against</p> <p>Wants service to improve. It's really needed.</p> <p>Aware of support being developed. But needs easy access to find a number to call if it exists. Needs to be accessible.</p> <p>She experienced domestic violence. This wasn't recognised because of partner's job. Feels ignored and insignificant. Kept quiet and suffering in silence.</p> <p>Wants others to have a better experience than hers.</p> <p>Even knowing what limited resources are available it's still hard to get help. Suitability, flexibility. Knows her situation could have been a lot worse.</p> <p>Circumstances affecting accessing support. Two layers of difficulties. Limited and accessing. Frustrated.</p> <p>The work environment is not supportive. Not permitted - not allowed. Stopped and held back.</p>
Needs awareness to support L584		
Victim of domestic abuse L587		
Out of reach L592		
Employer as a barrier to support	<p>595 I: Is the struggle other than not being legally, you know, I suppose married or 596 in that sense, is the struggle to do with accessibility or suitability or both?</p> <p>597 P: Both I would say. So one, there isn't anything and the urge to find 598 something. Especially in the situation I was in. So wonder so many nurses kill 599 themselves because you can't actually have any help. You're not permitted it 600 because it's, so I guess that's kind of looking into the counselling side of 601 things. Making it more flexible. I don't know. I mean I have a few bits of</p>	

PARTICIPANT: Christine

Specialist support L603	602 CRUSE but I think that was way beyond her abilities but it was just little bits 603 and bobs, you know. Nothing consistent, nothing geared up for suicide	Wants to make a difference and provide flexibility through a new career. Some counselling gave some support but not regular, thinks support is not speciality enough. SOBS – unhealthy approach. Kept people stuck, in the same place years later.
Needing to recover L607	604 bereavement without wallowing in self-pity basically which is not what I 605 wanted. Because the suicide, Survivors of Bereavement by Suicide think 606 was just, it wasn't, I didn't find it healthy. It was like there were still on ten, 607 twenty years, just as upset, just as grief stricken, just as blaming and not 608 actually seeking to find a way out of that. It was like 'oh here's my mood. I 609 can keep it because that makes me, me kind of thing' and I don't know 610 whether I'd want to do that bit as well because it's a different thing. There's 611 really nothing rational to help you cope, I don't think. There doesn't seem to 612 be. I don't know whether there is since but there, I just didn't seem to be able 613 to find anything that suited my needs. So not being able to take refuge in the 614 ordinary rituals also. It would have been different if it had been more do you 615 mind if I do this but it's like no, you're not doing it. There's nothing for you 616 to do, just keep out of it. So that was awful. I don't know, it just there was 617 nothing. There was nothing. There was nothing. And there's still not really 618 anything that I can find that's really of any use. So that's a shame.	
Individualistic needs L613	619 I: Is there anything else you'd like to, to add? 620 P: No, I don't think so. I feel like I've been ranting at you. 621 I: Are you okay to leave, leave it there? 622 P: Yes, absolutely. 623 I: Well, thanks very much for your time. 624 P: Alright then.	Support needs to be individualistic. to take refuge in the ordinary rituals also – needed to be involved in his funeral. TI would have helped her. There was nothing and still is nothing. No support.

Appendix I: A case example of clustering themes

Who was I?

The then 'self' before suicide	Concern for partner	L12	he was very depressed
	Unsure of partner's problem	L23	I didn't think it was always just that
	Long term relationship	L29	seven and a half years
	Good relationship	L43	never really had like a massive row or anything like
	Providing safety	L71	I think he felt like in front of me he didn't have to put on the act
	Feeling encouraged	L75	because he'd quit the job that was causing him a lot of stress
	Feeling hopeful	L78	he so- kind of seemed to be more like just interested in stuff
	Planning to move in together	L190	we'd gone to view the house in the morning
	Partner's cannabis use	L123	he used to smoke a lot of weed
	Helping the partner	L113	I'd just been trying so hard to kind of make, do things that make him happy
	Feeling deceived	L138	when we first started going out he was kind of appeared on the face of it to be kind of super confident

Who was I?

The then 'self' before suicide	Assisting partner	L149	ended up taking the day off work to try and get him to the dentist
	Respecting partner	L158	you can't physically drag someone to a hospital
	Reduced intimacy in relationship	L164	he just like <u>always</u> seemed like we were best friends
	Job was stressful and long hours	L177	I was really stressed at work and I spent like a l- you know, long hours in the office
	Partner helped with chores	L180	he always used to look after me when I got in from work
	Being cared for	L182	he was kind of very caring and attentive.
	Excited about moving in together	L196	sort of kind of getting a house with him
	Life was getting better	L199	that actually things are coming together
	No time for friends	L211	always just struggling with time
	Weekends together	L217	we'd been together so long but hadn't lived together properly
	Being cautious	L231	I'm pre-warning you so it's not a shock if it does happen

Who was I?

The then 'self' before suicide	Planning to spend quality time with partner	L226	I just had free holiday to use up and I just booked it to spend time with him
	Taking the relationship for granted	L242	like whatever happened in life it was just going to be me and him
	Professional development	L247	the work side to get that, improve my job

Who did I become?

Depression	Guilt	L185	my head was in work, it wasn't kind of where it should be
	Self-blame	L203	like I was just juggling so many balls. I can't believe the one I dropped was him
	Poor memory	L315	I can't even remember, like the weeks, months, some days
	Poor self-care	L317	It was an achievement if I'd get up and have a bath
	Lack of energy	L318	then I'd be tired and then I'd want to go back to bed
	Panicky	L321	very panicked
	Distraught	L328	I was in a right state
	Shock	L462	I think the months like I swear for months at the beginning I was just in shock
	Numb	L465	it's like as if you know like if there's a bit explosion you can lose your hearing and your sight
	Denial	L495	like I was kind of very much like I wanted to look after all his stuff
	Contemplated suicide	L669	I've just got to try and do anything to just keep myself here
	Suicidal thoughts	L679	you think about suicide yourself a lot

Who did I become?

The changing 'self'	Tormented by thinking	L260	I try not to think, to think about the future or the past too much. Just because it, it just drives you crazy
	Changed enjoyment	L285	I can't go out drinking, drinking because I'll just get too depressed
	Getting to know partner's estranged family	L348	all very surreal kind of meeting all these people after and, who were kind of strangers to me
	Comforting others	L475	I found that everyone else was coming up to me and just crying on my shoulder and I was kind of the one comforting other people.
	Mixed relationship with partner's estranged family	L622	I really just don't know how to feel about them like
	Perceives being blamed by others	L638	it's like they don't accept depression as a good enough answer
	Failed partner	L706	you just feel like you've kind of massively failed on that

What motivates me?

Motivation	Life commitments	L322	I just kind of get on with it
	Believing recovery is possible	L388	advice on how to get through it
	Ownership of recovery	L408	Like it's all in my head
	Partner's suicide	L667	when it comes down to it it's either like you live or you die
	Keeping the partner's memory alive	L684	knowing then if I died then who would look after his stuff

What did/do I need?

Needs	Financial security	L198	I'd been like unemployed for a couple of years
	Giving a good impression	L238	the first couple of years at work you tend to work super hard to kind of prove yourself
	To be comforted	L352	I found myself comforting his dad rather than, you know
	Not being a burden	L350	everyone was in pains
	Trust	L353	only really third parties that you could kind of talk honestly to
	Identifying with others	L375	I found that theirs was a very different experience
	Distraction	L428	I kind of just didn't want to be here
	Be in control	L504	I didn't want anyone else talking so it was kind of like something I had to do
	Identity	L506	I just didn't feel that anyone else knew him like I did
	Feeling safe	L529	It's kind of harder to hide it from her
	Protected time	L723	he booked me a double appointment
	Holistic support	L732	he was kind of looking at the whole thing
	Nurturing approach	L727	I saw him almost every week he was kind of like holding my hand
	Protective of partner	L689	just the desire to kind of look after him or defend him
	Worried about what others think	L481	I'm kind of thinking like people must

Time

It's a journey	Time has flown	L255	I can't quite believe that two years has gone past
	Counselling support is time limited	L412	Like that was good for a point but, but not ongoing

Support

Support (professional)	Timely counselling	L329	I had counselling for a bit straight like after the funeral
	non-judgmental support	L341	they're not people that are invol- like they're third parties
	Counselling helpful for a period of time	L409	like the counselling was helpful to a point but then it got to a stage where I was just like there's nothing more to say
	GP visits	L724	he'd talk to me about it
	GP as referring agent	L744	intermediary kind of thing
Support (voluntary/charitable)	Support group	L361	very helpful because it was kind of a scientific kind of side to it
Support (family, community, church)	Priest provide support	L326	he phoned up, I kind of went to see him

Support

Support (expectations)	HR follow up	L422	I kind of expected HR to email me or something but they never did
	Low expectations of services	L739	I was really lucky with him
Support (surprises)	Uncomfortable sharing in groups	L373	meetings but I didn't really go again because I just didn't like
	Insensitive friends	L399	what are you going to do with all his stuff?
	Limited support	L406	you take everything offered to you because there's not really, you kind of, a lot
	Others think she was strong	L460	they don't know how I was so strong
	People find it difficult to talk about it	L535	it's like they just feel awkward even broaching the subject
Support (Employer)	Assisted return to work	L420	let me go back for the first three weeks just part time

Support

Support (behaviour)	Engaging in group support for survivors of suicide	L357	I went to two things
	Keeping occupied	L438	so it's not just a big kind of endless gap of nothingness is good
	Seeking support online	L384	I found an online forum
	Normalising feelings	L391	it helps you recognise that feeling so, you kind, of knew you weren't alone
	Learning from others	L386	I found a lot of stuff on there
	Time off work	L419	I was just off work for four months
	Deliberate cognitive avoidance	L450	I'm not sure if that's going to backfire one day
	A fraudster	L480	gave out the award and like there's photos of me with like a big smile on my face
	Dealing with partner's affairs	L500	I kind of didn't want any help from anyone else
	Automatic pilot	L494	start doing practical stuff kind of mode
	Putting on a mask	L530	whereas other people don't
	Grieving with others	L625	then his mum wanted some which is fair enough
	Putting others first	L488	it just upsets them

Friends

Friendships	Making new friends	L380	meet someone who's got, had the closest experience to what you've had
	Going on holiday with a friend	L429	we went away
	Treated by friends	L430	they all put money together for me to go and have a spa day
	Close friend at work	L524	You have a joint CV
	Uncertainty of friends' views	L539	I think only one of my friends remembered
	Limited friendships	L580	I didn't just have anyone to ask

Who am I now?

The desired new 'self'	Fond memories	L37	we got together like at my leaving party
	No longer to blame	L57	for a long time like I used to think it was me
	Work-life balance	L234	the joke is it's more balanced now but then it's kind of a bit too late
	Some enjoyment	L264	I just kind of still sometimes I enjoy doing some things
	Living in the present	L258	I probably live in the present more which I guess is a good thing
	Finding peace	L293	I've never kind of been like an outdoorsy person particularly
	Socialising	L283	seeing friends and just going out to eat or something
	Back to work	L314	I guess it has got better in theory because, you know, I've gone back to work
	Putting the self-first	L522	I've probably become like I think I've become a bit selfish
	Assertive	L555	I just say to them like no
	Different priorities	L559	it's not the end of the world if something hasn't been done for the client
	Being kind to the self	L668	like eating healthier and doing yoga

Who am I now?

The undesired new 'self'	Uncomfortable talking about it	L30	I'm not sure where else like where to go with this
	Struggling to accept why the suicide happened	L96	he seemed to be less stressed
	Confusion about partner's behaviour	L65	it must be me that's causing it. But he'd kind of say it wasn't
	Confused about the suicide	L83	I felt like he had turned a corner
	Feeling sad at his distress	L119	he was like really crying and I'd never heard him cry before
	Lost in thought	L168	I can't remember where I started
	Life is work	L208	there wasn't, there aren't many other areas of my life
	Sadness	L266	I'm always going to be that, a bit sad
	Numb	L256	I feel quite numb to everything
	Never truly be happy	L275	know that kind of happiest moment in your life has passed
	Overwhelmed	L748	I feel like my mind is just, just as if its exploded
	Forgetful	L748	It's just been wiped like my memory's not very good any more
	Always doubting	L702	question everything about your relationship

Who am I now?

The undesired new 'self'	Thoughts are consuming	L304	that can either be like at home, just thinking or it can be anywhere
	Thoughts are controlling	L309	you just want to go home and you're never going to kind of enjoy it
	Heartache	L320	It's more like a, a constant ache rather than
	Consciously trying to forget thoughts	L448	I've had to literally just try and block everything out of my head
	Fear of losing others	L567	like my parents dying or, or my brother
	Feeling incomplete	L572	like massive trunks that are just kind of empty
	Contact with partner's family	L617	it's really messy
	Being alone	L578	now it gets to the weekend and there's just nothing to do really
	Struggling to accept a future without partner	L647	I always wanted children but now I've just kind of accepted that I'm not going to have them
	Feeling pressurised	L632	everyone like thinks that I should have the answers to everything
	Fear of getting depressed	L663	I do worry a lot about just ending up like really, really depressed
	Fear of being stuck	L657	I'm going to kind of live the rest of my life kind of just with my head still in twenty thirteen
	Drained by others	L699	everyone's kind of projecting their grief or their anger onto you

Reaching a State of Resolution

Intellectual acceptance	Uncertainty of relationship quality	L47	I always thought it was a very good relationship
	Looking for answers	L49	He was under major stress with his work
	Realising extent of the partner's depression	L29	he was okay but kind of just keeping his head above water
	Accepting partner's problems	L115	I think in the last year he did still have a, he had a lot of knock downs
	Accepting partner's problems evolved over time	L132	I don't know because he'd got in the habit of that last few years of doing like things that I kind of thought were a bit strange
	Identifying patterns	L232	so I always wonder about that
	Remembering on the anniversary	L254	because it was the two-year anniversary like, when was it?
	Life will never be the same	L270	I guess I kind of think that like my happiest times have gone past
	Reducing self blame	L370	she would class that as a counter sign
	Others lack knowledge	L404	I think they just don't really understand
	Not being alone	L454	lot of people in the world that kind of dealing with a lot of shitty stuff so you're not kind of the only one
	Making sense of limited friends	L544	our friendship groups didn't cross as much as some couples
	Positively remembering	L690	like trying to remember like the positive times with him

Appendix J: Master table of themes

<p>Manageability: reactions to suicide-related grief</p> <p>Louise: Without my kids I wouldn't be here and I, I mean that, hand on heart. If, the, the amount of times I contemplated suicide myself afterwards was unbelievable and it becomes a fixation in your head. So it's suicide, suicide, suicide. All the time. Page 19/476-479</p> <p>Erm, it was very difficult at the time and, even thinking back now, I can't even describe the pain of what happens. You have this disbelieve. It is raw. It is like somebody has put their hand down your throat and ripped your insides out. Page 1/10-13</p> <p>I went from probably being a size eighteen down to a size ten within the first few months. That, I couldn't eat. The thought of eating just absolutely, no, forget it. Page 18/445-447</p>
<p>Annie: They know that and they know that the, the smiley face isn't always what's, what's really going on. Page 8/212-213</p> <p>I've accepted that he's not here, erm, and that what happened, happened, erm, I don't know that I've dealt with what he did yet. Page 11/283-284</p>
<p>Cheryl: Really, [Sigh] right now it's just getting through the day without I guess panic attacks, without flashbacks, without anything to do with his death then I am happy. Page 1/19-21</p> <p>I mean right after my health was just completely deteriorated in shambles and only now am I able, you know, to be eating properly and working out properly and getting away from the medicines and getting my body on track so it definitely had an impact on me. Page 28/669-672</p>
<p>Rachel: Yes. I mean I hadn't had the depression for quite some time before he died. But after he died it really set in very badly and it's continued now for nearly fifteen years and I, I still have regular treatment for it. Page 9/211-213</p> <p>My depression is so great that I can't, I can't work. Erm, I'm not depressed twenty-four, seven days a week but, but I, it's sufficient enough for me not to be able to hold down a job. Page 7/172-174</p> <p>Erm, I, when I, I, when Adrie died I was admitted to hospital. I went to Hospital Z which I'm still treated, treated by. Page 12/277-279</p>
<p>Sharon: And so obviously you kind of, you think about suicide yourself a lot but the thing that's kept me going through it all I guess is, it's weird, it's like because it's like, it's like he's kept me going even though he's not here. Page 26/678-691</p> <p>I think the months like I swear for months at the beginning I was just in shock. Like I found that I kind of couldn't feel anything like I was like saying to a friend it's like as if you know like if there's a bit explosion you can lose your hearing and your sight and it's like, you know, people say that, you know, just for a second you really can't hear anything for a while or there's just, you know, just white light and then slowly your sight and hearing comes back. Page 18/462-468</p> <p>I can't even remember, like the weeks, months, some days I just couldn't even function like, you know, all I could achieve in a day was, you know, it was an achievement if I'd get up and have a bath and that was it and then I'd be tired and</p>

then I'd want to go back to bed. Page 12-13/315-318

Christine:

It's much more comfortable I think, to be depressed. *Having been depressed, I know what it's like.* I think it's, and I know it's not easy, but you can, I believe, with effort, *scoop yourself out of it before you get there.* Well I can. I know a lot of people can't. Page 19/476-479

That distressed, I was on, what did they give me? I think she gave me two point five milligrams by mistake. It's a lot isn't it? So I was taking a couple of those and ten milligrams of a benzodiazepine and *still running round the house screaming like a loony.* It didn't help me at all. Page 5/124-127

Tracey:

All they were interested in was getting me on anti-depressants and it's like I just wanted to scream at them. You know, *it's a reactive, it's a reaction to something that's happened.* Page 6/147-149

Can I just say I, er, *I've had flashbacks* to that and particularly, erm, strong smells and talking about burning... Page 6/156-157

And I think also I [Sigh] *struggle with the guilt* because I wasn't there for her and I let her down and I actually did have *suicidal ideations afterwards.* Page 11/291-293

Diane:

Erm, I was *suffering from PTSD* at the time and all sorts of other horrible iss-symptoms that I was experiencing because of what had happened and that was obviously making it, you know, a lot, lot worse. Erm, so I, I was, I was *pretty much on my knees for a long time* and it took me a long time to work my way back from that. Page 6/147-151

I suppose I was, *I was grieving as opposed to being depressed* but I, you know, th-the *kind of end result was the same thing* in my mind. Erm, and I did become depressed eventually. I g- I did suffer from depression and still do. Er, about a year after it happened, erm, because I've suffered from depression in the past, I knew it. *I picked it up.* Page 14/373-377

Manageability: supporting the self

Louise:

Certainly in the early days, *what helps you cope one week might not another week.* I know certainly with my writing I threw books at the wall and never said I'll write, I won't write another word. Erm, but, yeah, *I did go back to it.* Page 60/1566-1568

I coped with *coffee and fags* probably. That's how I coped and *writing and ultimately my boys.* And, I think, to be honest, that's, that stays the same through, throughout life now, you know. Page 57/1468-1470

And, when I first met her I didn't want to talk to her. That's a, that's, it's as broad as it, I wasn't ready to talk to somebody. I felt that I was, but I wasn't but that appointment had been made by them, you know, and *I wasn't ready for it.* But they left it as give us a ring which I did and I, I *eventually did start counselling.* Page 25/612-616

I don't want to be here and I just want to be with James. I just want to see James, you know, that kind of thing. I would say things like that, erm, but I was very *wary about things that I said* and I know when I went to, erm, maybe at first I wasn't but then you became aware that people are looking at you and thinking, you know, *she's cracking up,* you know, and things like that and it wasn't. I just think it's the grieving process. Page 28/692-698

I used to *set an alarm for quarter past three* in the afternoon so I, I went to pick the

kids up from school. Page 19/466-468

You had, breaking the routines had to be, erm, you *couldn't keep things the same* because it was *too painful*. Page 45/1134-1135

Annie:

Erm, I *didn't spend a day off on my own for the first six months* probably. I always had something in the day. So whether it was meeting somebody for lunch or coffee or whatever, there was always something. Page 5/127-130

Yes. I, I was *desperate to get back to work really*. My Doctor wouldn't let me go back for a while but, yes. Erm, I mean, it, it happened the middle of April and we had, I think we, we had people living with us. Page 26/635-637

And so, feeling sort of down, erm, and I find looking for *the positives helps me better so*, so thinking, 'Yes, actually I've hung a picture today. I'm, I'm, I can do this,' or 'I've sorted out the, the roof, the hole in my roof and I've done it on my own,' or *managed to buy a new car without anyone's help*. Page 9-10/237-241

Cheryl:

They have said extremely, extremely well and all this but, you know, I think that part of it is *faking it until you can make it*. Page 20/485-486

Maybe one day I was having a good day, my mum was having a bad day, you know, we'd, I'd pick her up. *It was vice versa*. I mean she was doing more of the picking up. Page 13/285-287

Oh, definitely like, erm, because, you know, I say I like to have my grieving days and get down but maybe there's a day where I have an exam or I have to go to work and there's not that option, you know, the *world doesn't stop just for you grieving*. Page 21/501-504

Like there was suicide workgroups and I hadn't, before I left I was like I, I can't do this yet. Like, *I'm going to wait until I come back but that's something I'm interested in when I go back, to go and use support groups*. Page 17/406-409

Yes. Normally I, I *have to work out. That is my release*. Page 2/27

Rachel:

I started a website and it, I had memorial pages and I also had a forum there which I ran with, erm, a friend that I had met through the original site. We were sort of like co-anchors if you like. Page 10/238-240

Days where I just, *I just don't do anything at all*. I just stay at home and I can't be bothered to do anything other than maybe take the dog for a walk or there are days where I don't do housework. Page 8/182-184

Erm, but we might go shopping, erm, and then come home or have a nice meal, watch TV, cuddle the dog. *Just a nice, normal day*. Page 20/458-459

Sharon:

I went to their annual meeting which was like a daylong kind of workshop where they have, erm, kind of, they have someone, erm, she was at University X and she researches into like causes of suicide and she kind of came and talked and there were some other people talking and *I kind of felt that very helpful because it was kind of a scientific kind of side to it* and also because where *she'd done so much research into it...* Page 14/357-362

I've just been trying to *keep myself busy* and, yes, even just the act of just kind of *going away and seeing the world* and you just kind of see that there's a lot of people in the world that kind of dealing with a lot of shitty stuff so *you're not kind of the only one*. Page 18/451-454

Mmm. I guess, also I, erm, I went on to a, *I found an online forum and that was for people that had lost partners, not just like it was for any kind of cause of death*, erm, but I found a lot of stuff on there, quite, er, helpful and a lot of that was even just people talking about, it wasn't necessarily how, you know, *advice on how to get through it*. Page 15/384-388

Because also with both of those trips it's, it's *partly just getting away from it all* so it's, they both required a lot of planning to go before so it just kind of *keeps you busy* doing stuff. Erm, so I think by putting, putting dates in the diary for stuff to do so it's not just a big kind of endless gap of nothingness is good. Page 17/434-437

Christine:

Erm, do you know, *I can't think of anything I was doing other than working*. I really can't. I would have been sleeping because we used to do long days so we do three long days and a day off. So I would have been basically asleep. So sleep and work really. Page 8/198-201

Lots of alcohol. And after the plate glass window kicking in accident, accident, incident. I did it on purpose, I wanted to smash something and I wanted to smash it again. I went on an anti-depressant grudgingly because there was nothing else. Page 13/331-334

But I recognise, because I'm not on the fluoxetine any more, I've been off that a couple of years, but I recognised in my head when I'm going to start getting like that and *I can take measures whether it be a long walk in the countryside, a razz and a dance, a read, a scream, a run down to the beach and throw stones at the sea, I can kind of pull myself out of there but I don't think I've ever got back to being completely okay*. Page 19/479-484

Tracey:

I'd walk through the town. I'd, you know, challenge myself, not challenge myself, *force myself to do things*. In one way it was like a *punishment but the paradoxical effect is it enabled me to actually move forward* which has been difficult to actually, yes, come to terms with because it's like that self-punishment has been the thing which has actually go me through it which, y- I mean, yes, it's almost like self, you know, it's almost like, erm, *self-harm being a good thing*. Page 11/306-312

Erm, but afterwards I just need to, I, I disappear and I go into the staff room and I just literally stare at the wall or stare at the tree out of the window and I practise that, *mindfulness* and I just allow whatever I'm feeling, whatever I'm thinking, I just accept it and just feel it and I don't not try and fight it or, you know, if I cry, I cry right if I don't, I don't. Page 20/566-570

Diane:

I wanted to soak up information. I wanted to try and understand why this had happened as much as I could and I found it incredibly helpful and it does feature stories, people's stories of how they were moved and how they dealt with it, what they found useful and the, the emotions that you're going through and... *It just kind of made me feel, okay I'm not a freak that I'm feeling like this*. So one minute I'm angry, next minute I'm incredibly feeling guilty for feeling angry, the next minute I'm- and it's like a, I don't know. It's like a pinball machine. You're being shot all over the place all the time, erm, and that just *helped me to understand that that was normal* and I was going through exactly the normal process, which was helpful. Page 9/241-251

I was really on *automatic pilot* at that point, trying to be practical and *find things that the police needed and sort of find solutions* to, you know, what seems like such trivial problems right now but that was the only way I dealt with it. Page 4/99-102 But the fact that *I managed to go back to work four weeks later*, erm, you know, I

wasn't really back on it in terms of my job but I managed to sort of scrape by. I suppose means that I probably did cope with it reasonably well but it was, it was so all consuming it didn't necessarily feel like that at the time. Page 15/397-401

Manageability: helpful support offered by others

Louise:

It's, you know, the village where I was, was fantastic. They **closed ranks** completely, you know, erm, we had reporters around, nobody would say a thing, you know. Mind your own business. **You leave her alone**. No we don't know where she lives.

Page 37-38/935-938

My statement with Peter, because everything was quite complicated, took three days to do one statement and, erm, I know, you know, **he was ring me any time**. He was absolutely brilliant. Page 25/604-607

The cards I got from people and the cards I got from **total strangers** and I, I know there was once I got an envelope which had **ten pounds** in it and it just said, 'Get something for the boys.' And it was obviously an old person who'd written it because the handwriting was really shaky and things like that. Page 38/949-953

Annie:

I, I, erm, sort of about once a week somebody would come round with a big sort of **bag full of meals** and just stuck them in the freezer. So I didn't have to think about that. Page 7/185-188

I did a month's **phased return at work** where I had admin rather than patient contact but from early March we were, we were back. Page 26/642-644

My GP was fantastic. She, she wasn't in on the Monday so she didn't find out until the Tuesday when she went in and she rang me. She **came round**. She spent forty-five minutes with us. Page 4/96-98

I can't remember what it's called, Help is at Hand, which was, was a **really useful resource**. Page 4/101-102

Cheryl:

You know, I'm like I would be fed up with me if I were you and she just laughs and, you know, **goes on caring about me**. Page 19/456-457

I mean you can go, there's millions of different ways and I think that that, that staying close to my family and I mean I don't know even how I would have done this alone but just that **strong, informal support** made, I mean that is probably what has made the most difference for me. Page 26/637-640

I'm, I'm not ready for that at all but I realised that someone had come to the site for me when everything, you know, when it happened at, I th- it was like eleven pm when he or when I arrived and so, to know that someone would come out that evening to help me. I, I didn't even know that was a service I was even using. I mean at that time you're not thinking about that at all but just thinking oh my gosh they, that guy completely made a difference. Page 16/368-374

Rachel:

she doesn't understand my depression per se, she gives me the **unconditional love** that only a mother can give and nobody else in my life has been able to do that. Page 15/348-350

She saw me **within a week** of Adrie's death and at that time I had private health care and after seven years my health care ran out and **she has continued to see me ever since it ran out free of charge**. Page 15/354-356

Sharon:

Erm, [Pause] I think the Priest because at first I was very kind of like, like panicky, like, because the whole act, kind of act of dying and what happens to you after and

stuff I was quite panicked and didn't know what to do, erm. Er, *I think he was also quite good* I guess with them because they are, both of them I guess, the *priest and the counsellor*, they're, they're not people that are invol- *like they're third parties*.
Page 13/336-341

Work were actually very, erm, they were quite supportive. They're very good in that, like, well I was just off work for four months, I think. I think it was in total and then when I went back *they let me go back for the first three weeks just part time*.
Page 16/418-421

So he was kind of like, because I saw him almost every week he was kind of *like holding my hand through it* and how little things changed and what, what. So he was kind of looking at the *whole thing...* Page 28/729-732

... he like *spent ages kind of talking to me* about, erm, your kind of, kind of mental, to help with me understand Harry and he then made sure that every, like every week for week he *booked me a double appointment* where I used to go in and he was like almost like a mini counsellor and he'd talk to me about it.
Page 27/720-724

Christine:

So she was just *like this complete stranger* and one day we were walking across town Y and *I came pouring out to her so*. So she was good. She was like the only person there that knew. Page 14/349-352

I rang the Samaritans quite a lot. *I would be on the phone to them for every excuse like the cats* [Laughs]. Page 13/321-323

She would make sure I was eating, for a start. Made sure I was going to the doctor's. That kind of thing. Just holding my hand or a couple of nights would be with her for about a week and I just couldn't be on my own. I had to sleep in the bed with her. I just couldn't be alone. It was just too bad. Page 8/186-189

Tracey:

Don't do emotional strokes, erm, and I certainly don't ask for them. And in fact if people give them I actually feel uncomfortable but it's that recognition and somebody actually saying, *'I can see you're struggling today*. Is, do you need anything?' and I'll go, *'That's all I needed.'* That, that's, you know, the fact that you've realised that I exist, you know, and, yes. Page 19/531-536

I phoned occupational health and I basically went, I didn't, I just told them I needed to see, I needed to see a counsellor. Erm, but I said, you know, *I don't want to see anybody in house* because again that was *back to the paranoia* and the fact that, you know, everybody knew... Page 17-477-480

I had a patient who was particularly suicidal and was quite openly talking about it which is the unusual bit and they put me down for this to actually be this person's nurse for the day and it was like no. It took the person a minute just to realise why and then suddenly *you could see the penny dropping* and they were able to say, 'Actually, ah, okay.' *I'll give you somebody else and somebody else can deal with that person*. Page 20/550-556

Anyway I had that, that was okay. I had to come in the next time. *They wouldn't let me do it over the phone again* so she just said, 'Come in any time today,' she says, 'Come in, just tell me who you are and I'll just get you in,' and she did that for me because they insisted I went every week to the Doctor and I'd just turn up when I could and she, she'd get me in and, and there were no questions or anything asked.
Page 16/427-432

Diane:

My, my boss became, erm, through this situation, *he became a very good friend of mine and he was absolutely amazing*. He was, he was probably the most amazing support through all of it, which I really didn't expect. Erm, so that was sh- that was a

surprise to me but, erm. Very quickly **they rallied round as a support network** even thought I'd only known them for an incredibly short period of time.
Page 16/436-431

Erm, and then I spoke to the woman that ran that group and, erm, a lady called Veronica, and she was amazing and **I must have been on the phone to her for about three hours**. Huh, poor thing. On a, on a public holiday. Page 6/165-168

Manageability: unhelpful support offered by others

Louise:

People who thought they were trying to be helpful by pretending James never existed. That didn't sit well with me, you know, having a conversation and it's the elephant in the room. **Nobody mentions him**. Page 36/899-901

People looking, people blaming, you know, something must have gone on that morning. You must have had an argument. We didn't. I wish we bloody had because at least then I could ta- justify, you know, erm. **People avoiding you**. That support isn't good and people who you really thought would be there for you, weren't.
Page 36-37/908-912

I do- I can't say there was really negative support because there **wasn't an awful lot of support**. Page 37/932-934

Annie:

Erm, but through that I did find out about the survivors of suicide group but, erm, some other people who'd had experience of their local groups and said sometimes you just sit around and everybody's miserable and, and, er, sort of **feeding off each other's misery** and I, I thought I really, I **don't want to risk that**, erm. Page 7/174-178

There's a counsellor that works out of there who, erm, **her interest really is bereavement** so I, I saw her for a few weeks, erm. I'm not so sure. I'm not the sort of, I'm not, I don't fit into the counselling, **counselling group very well**.
Page 8/195-198

And they, erm, they **know who to signpost people** to, you know. They, the- the phone, the phone line. You just give them a, erm, but there's, **there's nothing**.
Page 5/112-113

Cheryl:

So I met up with a counsellor but I realised that it was very, it was **how do you get over test anxiety** and how did, and **I don't feel like she was able to take on such a**, you know... Page 16/882-884

Rachel:

Erm, and while I was there I contacted a support group for people that, erm, they said they specialised in bereavement by suicide and I had one meeting with them and I didn't find that helpful at all because the person that I saw was a **grief counsellor but she hadn't been bereaved by suicide**. And I didn't feel that she, she could help me. Page 12/279-283

And I frequented that for quite some time. Erm, but I found that that was a little bit too, erm, **too depressing because it focused on death all the time**. Page 10/222-223

Sharon:

Erm, and the weird thing is, is, since I've kind of gone back it's like **no one has said anything ever**. Like I kind of expected HR to email me or something but **they never did**. Page 16/421-423

Like someone who was saying to me, I think the week after his funeral, saying oh, so, what are you going to do with all his stuff? Er, **if it was me I'd want to get rid of it all**. I can help you do a boot sale if you want. There's one coming up soon. So I was like, no. [Laughter] I just, and then, I don't know like there's, I think and I guess it's just, it's people like, and I do know people don't mean bad. Page 16/398-403

Christine:

I had two mentors but they were more interested *in controlling me and making sure I didn't say the wrong thing.* Page 14/352-353

I'd just started my first nursing job at a hospice in town Y and they were badgering me to come back to work. I did have four months out but when I went back to work I said I need to find some counselling or some bereavement counselling or something. And everybody does it, it's a set day, it's a set time, that's how counselling works. And I said to them please *can I have X day off every week? No.* By the by please don't tell anybody what happened. Page 4/97-103

I'm beginning to think, having learned more about it now, is that she wasn't a particular good counsellor and was, you know, *doing an NHS quick fix on me*, which isn't really a helpful thing. Sorry if you don't agree but I don't think you can cure or make anything any more manageable in six weeks. Page 17/427-431

But the full time Chaplain said she would try and look out some help for me, *didn't bother.* Page 6/143-144

The Police gave me a victim support leaflet but there isn't anything. It's like boom! They're dead. Deal with it yourself. *Nothing at all. Nothing, nothing.* There was nothing. Page 7/165-167

Yes, I would love to ring the bank, yes I would absolutely love to go the registry office and get ten copies of the death certificate. That would be lovely. I'd love to organise the funeral. Love to tell the benefits office. I'd love to tell work but *I wasn't permitted to do that.* Page 7/166-170

Yes, because I just think there is. There seems to be *nothing for people in my situation.* If we'd have been married or we'd have been living together I would have got help. Because *I wasn't his next-of-kin*, and it's a horrible thing to know that when, once you're dead that body belongs to your next-of-kin. Did you know that? That's legally the, you are legally their possession once you're dead. Page 21/527-532

So I got stories of other people's suicides. *I was preached on more than one occasion* and told to turn to God which I think is entirely inappropriate from the helpline, really. Page 13/329-331

Tracey:

And the final straw for me was a female *GP who kept referring to Jennie as he* and I was saying Jennie, she took her own life. Page 16/442-444

I got told if I wanted to see counselling *it would be six months' waiting list* so I wouldn't be able to see anybody. I couldn't contact, the, *there was nothing else they could do for me.* Page 16/450-452

I'm sitting there, crying, physically my, it doesn't happen now but my leg literally would be shaking because, from the trauma and *I had to tell them* that my partner died and I needed a sick note and they just, *made me tell the story and it was a different Doctor every time.* Page 16/437-440

Diane:

I faced all sorts of *really horrible conversations* and were being very ignorant and sort of adhering to the common stigma that you hear around mental health and suicide from work colleagues, from people that I'd known, his work colleagues, all sorts of people. It was really quite, I was really shocked and the only way I can describe it is like, *it's the most brutal way someone can pull the rug from under your feet* and I literally, genuinely did not understand a single thing about the world any more. Page 5/118-125

And he said, 'Well, you could go and see Cruse. The problem *is we don't actually*

know that you're bereaved because, you know, his body hasn't been found.' Which I thought was an *incredibly insensitive* thing to say but at the time I was so upset that I just kind of walked out and went, 'Okay, fine,' and accepted it. Page 8/225-229

Erm, and, yeah, so the rest of the time I, I think I must have been, I found a counsellor quite quickly myself, erm, and I think I must have had counselling for pretty much a year. *I spent an awful lot of money on it.* Erm, so, yeah, I'm not particularly happy that I had to do that myself to that extent. I would have liked to have help in, you know, some other way but that was, *that was the only route that I could find at the time that would work for me.* Page 9/251-257

It was a, it was a drop-in, erm, reception. It was in the middle of the day but at that point I was still signed off work. *I wasn't at work so it was okay.* Page 10/261-263

Erm, and the Police weren't, wouldn't come, *weren't very forthcoming.* They weren't very helpful. She was giving me information which *I wasn't sure if it was accurate, true or not and so I was making phone calls.* Page 16/421/424

Oh no, I rang the Head Office, that's right, and asked them for my nearest group which was *over an hour and a half drive away. That was the closest.* Page 6/163-165

Attaching meaning: rumination

Louise:

The next day deal with, okay, he hung himself. The next day deal with it was his choice. You know, and you have to break it down because you cannot, you can't get your head around the whole thing. *It's massive.* Page 29/725-728

And I thought what does she mean by that because every day for I, I couldn't even tell you how long, the only ima- image I would see, constantly, even, I can see it now, even as I'm sat talking to you I can see what I found, there. *But it's not there all the time now and it moves to the side but it just takes.* Page 34/843-847

Annie:

I've withdrawn a bit from that now because I feel actually I, I need to start moving forward *rather than keeping going over and over it.* Page 7/170-172

Erm. I think, I think because I was, *I was like if I keep busy I don't need to think about it.* I just need to keep busy, erm, which I think was good to a point but at some point you do need to deal with it. Page 5/130-133

Cheryl:

I mean there's only so many times that you can just *replay and replay a scenario* in your head before you just get exhausted and I just think that *exhaustion* of okay, I'm helpless, there's nothing I can do to change this and then just realising, okay you have *no control.* Page 7/142-146

Where now it's a lot, I think it's becoming, *I would like to say I think it's becoming easier to get out of it* whereas before it just was whenever it happened, it happened whereas *now I think I have a little bit more control* of my, even of my bad days. Page 6/433-436

Rachel:

I just *don't do anything at all* and I *obsess* about Adrie and [Sigh] I want to make contact with anyone who may, may know him or knew of him or I, last week I wanted, it was his seven- it would have been his seventieth birthday last Saturday and that affected me quite badly and I wanted to make contact with his son. Page 8/185-189

Erm, a good day is one where the sun's shining and *I can just forget about things for*

<i>a while</i> and do something nice. Page 7/170-172
<p>Sharon: I guess that's all <i>when it's more in my head</i> of when, you know, I think about Harry or think about stuff in the past or [Pause] I know, and that's the some, that can either be like at home, just thinking or it can be anywhere. It can just, it's just when your <i>kind of thoughts kind of overtake what you're doing.</i> Page 12/302-306</p> <p>And just like trying to <i>remember like the positive times</i> with him. Page 26/690</p>
<p>Christine: I think there was something else going on which then <i>blends into the conspiracy theory.</i> Was there something going on at work that I didn't know about? So I don't know that. Page 11/270-271</p> <p><i>I thought I was quite brave</i> but I haven't cried yet. I did once, last week. I did cry because I danced to Jail House Rock with a man and that was a thing I'd wanted to do and so <i>I had a little weep then but. That was odd.</i> Page 11/258-261</p>
<p>Tracey: But I would <i>stand there and I would imagine what it felt like</i> and what she saw and, and try to actually physically <i>put myself into that position and imagine,</i> you know, the feelings, the emotion, the, that detachment because she, there's pictures if you see people burning on the internet, they run round. She didn't. <i>She just stood there.</i> Page 12/330-334</p> <p>But a good day is that <i>I can actually leave that and that's in its own,</i> that's, I wouldn't say it's, it's certainly not in a box or anything like that but it's there but <i>I don't have to immerse myself in it now.</i> Page 13/353-355</p>
<p>Diane: Erm, I couldn't stand music being played. I couldn't watch television. I, <i>I couldn't stand any kind of mental stimulation</i> because I had so much, I think, going on in my mind <i>that I was trying to work my way through.</i> Page 13/356-359</p> <p>I remember the first time <i>I realised I was actually enjoying myself in, in, socially in some way and I hadn't thought about it.</i> I hadn't thought about him and I hadn't felt guilty about the fact that I was happy. <i>And that was a real shock.</i> Erm, but that came, I don't know, maybe eighteen months afterwards. So it's, yeah, the days that are good are just the ones where I, I'm at peace with what happened as much as possible and <i>I don't feel such, so, consumed by it still.</i> Page 12/324-331</p>
Attaching meaning: motivation to survive
<p>Louise: And that's when I had to make a turning point because life had to go on. I was left without choices. <i>I had to go on.</i> And you almost <i>make these pacts with yourself</i> which is right, okay, pull yourself together. Page 25-26/627-630</p>
<p>Annie: <i>I have a job to do. I have a son that needs me.</i> Erm, you can't just go to bed and stay in bed and feel sorry for yourself. You have to get up and get on with life... Page 12/297-299</p> <p>And I thought, 'No, he won't. I'm going to make sure that me and John come out of this experience as <i>well as we can do and that it's not going to ruin the rest of our lives.</i>' Page 12/303-305</p>
<p>Cheryl: I'm like I don't like it, well, like I want to just think about him and be stuck in that time where everything was great. But it's just, that's, <i>that's not ideal.</i> Page 21/494-496</p>
<p>Rachel: There are <i>two people in my life that without them I wouldn't be here.</i> One is my mum and the other one is my Psychiatrist... Page 15/351-352</p>

I was thinking this morning I wish I wasn't here but I, I was also, was thinking this afternoon but *what that would do to my mum and I couldn't put that*, her, put her through that and I *couldn't put my Psychiatrist through that* because it would be a real slap in the face to her. Page 23/524-527

Given the way in which Adrie died I suppose *it must have taken me some kind of strength to have come through it* because it was an horrific thing to have gone through. Page 18/411-413

Sharon:

But just kind of the desir- like just kind of wanting to be the one that's like, because I've got all his stuff at my house, like I've got his ashes, so I wanted to be, knowing then *if I died then who would look after his stuff*. Page 26/681-684

Christine:

I decided I've got to go out and get a life because I'd just been sitting in this house *being black widows* basically and not socialising and not getting out and not seeing anybody else and just sitting there thinking shall we go out? It was easier just to stay in. So I had to make a *conscious effort to get out, even into work again*. Page 10/228-232

Tracey:

The, the *only person you can rely on is yourself*, you know, but many people can hold your hand or anything else but you've got to do it yourself. There isn't, there isn't a magic pill, wand or, or anything else. Page 11/289-291

Diane:

I did suffer from depression and still do. Er, about a year after it happened, erm, because I've suffered from depression in the past, I knew it. I picked it up. I went to the Doctor's and I, you know, had some counselling, had some tablets and got myself s- *sort of back on the straight and narrow again*. Page 14/375-379

Attaching meaning: changing relationships

Louise:

And I think that's why you get a *fear of building up friendships* because you don't want it to happen again. You don't want to become friends with somebody because you feel as though you've got this thing what's going to *pass onto them* and it's, it's not good. Page 21/511-514

Two have, two people who I really thought were good friends, couldn't deal with it. Couldn't deal with it. Didn't know what to say to me. Didn't, but *I suppose they were grieving too*. You know, they we- they were friends of James' as well but I felt really let down by them. Page 37/913-916

I think that's because, I think it's because *it causes her more pain than me*. So you step away from it because you don't want to cause somebody some pain and you don't want to be thought of as the person who is maybe causing that per- person pain. Page 47/1175-1178

Annie:

I've got *new ones that are single mums*. Erm, because I've got more in common with them than I have with a family. Page 20/489-490

Cheryl:

We're in this together and it was very, *we're very, very strong and close now*. Page 13/298-299

Or are you having a good day and just, I found, I mean it's really, it's, it stinks to think this but you really find out who your true friends are when something like this happens. And I had people messaging me that we have, I don't know, years and years ago a feud or this and that or a little argument and *we stopped talking and I had people messaging me like hey I know, you know, we haven't talked in forever*

<i>but I'm here. Page 18/431-437</i>
<p>Rachel: Erm, fr- as regards friends, I've lost friends because I became th- the-in <i>my angry stage of grief</i>, er, I fell out with them, erm, because <i>I directed my anger</i> and I regret that very much. I've tried to make amends since but they haven't wanted to reconcile. Page 14/310-313</p>
<p>Sharon: I guess a lot has changed with Harry, like because his family were not a part of our life at all before he died. I mean I, he did, like I knew his dad. Even me and his dad, he didn't like Harry did a very good job at managing to keep us apart like, erm, so that's <i>all a bit strange now having this whole kind of extra family that I know though Harry but we didn't know each other before.</i> Page 22/581-586</p>
<p>Christine: I did go and see his friends over in county X but one of those is being, well they're all being, you know, <i>they've just distanced themselves</i> from me now so they, you know, I don't really have anything to do with them anymore. Page 16/398-401</p>
<p>Tracey: So I don't have to tell people about that but it's <i>hard to try and build new relationships</i>. I don't, I don't mean relationships as a partner but, but new friendships. Page /242-244</p>
<p>Diane: Friends that I've known for <i>twenty plus years</i>, decided that <i>they no longer wanted to be friends with me</i> and they, I don't know whether that was <i>fear</i> of what had happened, whether it was <i>ignorance</i>, whether they decided to judge me or him for what had happened. I don't know. Page 4/114-118</p>
Relating to others: need for a humanistic approach
<p>Louise: He doesn't put me under any pressure. He never bad mouths James. He never bad mouths me. Erm, <i>he just accepts</i> my pa- past and he just, you know. Page 12/311-313</p>
<p>Annie: And I felt cheated because everybody else had the time to say goodbye and I really wanted to <i>speak to somebody in the same situation as me</i>. Erm, be- because I needed somebody, someone else <i>who got it.</i> Page 6/147-149</p>
<p>Cheryl: I don't think that she is skilled for this and so we ended up going to someone that dealt with PTSD and sort of these anxiety and just these, you know, specific things and I went for, until I came here pretty much I was seeing her once a week regularly and it definitely is <i>just nice to have someone to talk to that's not, that's just there to listen.</i> Page 17/889-893</p>
<p>Rachel: Er, she <i>understands</i> every nuance of my character, of all my problems, erm. <i>I trust her implicitly</i> and she knows everything about me. Absolutely everything. Page 16/365-367</p> <p>Well we, we're very close and always have been but she's just always there for me, erm, she <i>doesn't judge me.</i> She's just constantly supportive. Page 15/341-342</p>
<p>Sharon: I found that everyone else was <i>coming up to me</i> and just crying on my shoulder and <i>I was kind of the one comforting other people.</i> Page 18/474-476</p>
<p>Christine: I did ring the Survivors of Bereavement by Suicide line but found myself hearing other people's stories and <i>ending up counselling them rather than them helping me.</i> Page 13/325-327</p>
Tracey:

And just, **just hear me**. And I say I don't want anything. I don't need anything from you. I don't need you to fuss around me or anything else. Page 21/587-589

I think my sister-in-law as well, although she lives in Town Y, she's somebody I can actually phone and again, **she just listens without judgement**. Page 18/503-505

Diane:

My parents, they're quite, you know, they're, they're reasonably elderly and they just, **they couldn't really understand what was happening**. Didn't really want to know too much about it, I don't think, erm, and found it very, very difficult because, erm, I think a. there was the stigma but I think they thought I might do something similar because I was in such a distressed state. Erm, so I **quite quickly learned not to talk to them about it too much**. Page 17/450-455

Relating to others: identifying with other survivors

Louise:

You know, we had **nothing in common apart from suicide**. That's all we had in common but we found a common ground and I would say some of those people are grieving far worse than I was and the, some had lost sons. Page 32/801-803

I don't know what my first message was, erm, but it was probably along the lines of hi, I'm Louise, my husband James, and people responded and told you their stories. And then you would ask a question and say, you know, erm, I feel as though I'm going mad and their responses would be you're not going mad. We've all been there, you know, and it **was reassuring to know that oh, my God, I'm not going mad**. Page 31/778-783

Annie:

Er, people so it was, it was helpful to engage with them **because they got it** and, and there was also a lot of **useful information** about inquests and sort of what to expect at an inquest. So that was helpful at the time. Page 7/170-172

Cheryl:

I didn't have anyone that was really, everyone was very sensitive and it was, that friends and just I even met people out of the blue that were **going through similar stuff** and that just, that really helped knowing **that they made it through. They're ten years down the line. It's going to be okay**. Page 18/437-441

Rachel:

Erm. Erm, I'm very fond of the people that I have met all over the world. Er, we have this **common bond**. Page 14/330-331

Hers is a different kind of bereavement because it's her son, erm, but it, it's a similar kind of thing. **It's, it's both suicides**. Both are a horrific way to die. So as, as tragic as it is, **something good has come out of it**. Page 14/327-329

Sharon:

So it kind of made you feel that actually well like, yes, I know what that feels, it helps you recognise that feeling so, you kind, of **knew you weren't alone**. Page 15/390-392

Erm, I went to one of the SOBS meetings but I didn't really go again because I just didn't like, I don't know. I didn't like talking about it so much and also I found that at a lot of those meetings it's always people that have lost kids or sons and daughters. **Whereas I found that theirs was a very different experience**. Page 15/371-375

So I'm still kind of friends with her. So that was good I think, to meet someone who's got, had the **closest experience to what you've had**. Page 15/379-381

Christine:

There doesn't seem to be. I don't know whether there is since but there, I just didn't **seem to be able to find anything that suited my needs**. Page 24/611-613

Tracey:

Erm, I went to SOBS because I thought being around people that have lost people

by suicide I, *I don't know whether it was because it was too fresh*, you know, still too traumatised but I physically couldn't talk. *I couldn't talk at all.* Page 17/464-466

Erm, but the one thing I would like and the one thing that isn't there is, and it's impossible, is *obviously I saw what I saw and I deal with that and nobody else did.* So nobody can truly have that connection because nobody's experienced it, what I experienced and I think I was searching for that and that's why I looked on the internet *because I was trying to find a connection and an understanding.* Page 18/505-510

Diane:

Erm, so I've always felt *my story is a little bit different to other people's* and it's, I've never been able to find some to share that experience with and, and for them to, *sorry for me to feel that they really, really, really, genuinely understand, is how I felt.* And there's always, *obviously there's always going to be some differences* and *some unique aspects to everybody's story* but, you know, I haven't come across anybody yet where the body wasn't, you know, found straight away. Page 7/198-204

Relating to others: developing compassion for others

Louise:

It's, in, in fairness, *I am, if somebody wants me, I'm there.* And it's very hard to put yourself first. Very hard to put yourself first. That doesn't sit well with me. Don't do things like that. Don't do things like that. Page 36/891-893

Annie:

That how you look at things is, is different, erm, and the sort of *people become more important.* Page 13/338-339

Cheryl:

So it's just that *I feel like now I have that need to go forward* and like I have, have friends now that will come to me and like hey I'm having an off day or so and so's having a hard time and for me to be able to say like, 'Okay,' you know, this is just my experience but this is how, you know, what I think is good for dealing with stuff and I think that just helping others is definitely- It makes me feel like it wasn't, that his death wasn't in vain. *That it wasn't, you know, for nothing.* Page 14/316-322

I'm definitely more accepting. Definitely no, *no judgement* whatsoever. I see people, like I give people, like I don't know I just feel like I'm definitely a *lot more empathetic* or, you know, I look at a family, you know, like I have no idea what they're going through. I can't, you know, I'm, who am I to judge? Page 24/566-570

That's, it's very hard but it's nice knowing okay, that's a horrible thing but now I might be able *to prevent, you know, a couple more people, people who are feeling this and that.* You know, I've had people tell me, you know, like oh my gosh talking to you has helped so much and, you know, *that just, it feels good.* Page 14/330-334

Rachel: N/A

Sharon:

I've just got to try and *do anything to just keep myself here* and so I just like try and get like eating healthier and doing yoga and doing *whatever makes me happy* and go travelling. Page 25/668-670

Christine:

So I'm always *giving people the benefit of the doubt* or wondering why they're doing what they're doing rather than leaping in and assuming this has pissed me off so I'm going to shout about it. Page 18/466-469

Tracey:

Yes. I mean as, a, as an RMN yourself you can understand that we, erm, we use black humour as a coping strategy and *you hear things now which I would have said before and I just cringe and it makes me go cold.* Page 21/597-599

Diane:

In many ways it's changed me for the better. Erm, it's certainly made me more *compassionate towards others*, made me more thoughtful. Erm. It's obviously made me much more aware of mental health issues and suicide and I've, you know, I've become, you know, very interested in that and *read up on lots of information* about it. *Do a bit of volunteering*, try and *help other people* who might, you know, unfortunately, be in a similar situation which I find very fulfilling and also quite therapeutic. Page 17/460-466

Changed perception of self: the changed self

Louise:

I don't tolerate nonsense. I don't suffer fools. I say what's on my mind. I'm *very upfront and very open*, probably too much. Page 15/373-375

Erm, but *I aren't fearful any more either*. Erm. I've become an extremely strong person and emotionally strong. It takes a lot to get me down. Erm. Be that I don't know whether that's a, a, you know, it's just a front or whatever. I just, I think I've become very *hardened off to life*, to a certain extent. Page 13/323-327

Annie:

I mean I, I've got a stammer, obviously, but I, I hid behind Patrick. He did all the ringing round, sorting things out, erm, and I've had to do it. *I've stepped up and I've become this more confident*, er, erm, and I, there's, there's just things that me and John do on our own that we would never have done a year ago. Page 12/309-313

All these things that have, I've had to take on as extra, erm, and *life is really busy, yes. And yes, sometimes I resent that*, I think. [Laughter] *I didn't sign up for this*, you know, erm, yes. Page 14/358-360

Cheryl:

I view the world has definitely changed my outlook on it and life's short and I've been, I definitely wouldn't say well my riskiest behaviour since the suicide was I purchased a motorcycle and never rode it once. Page 24/574-576

Rachel:

It's destroyed my life completely. Absolutely destroyed it. *I'm not the person I used to be.* I used to be vivacious, life and soul of the party, erm. I d- I told you I wasn't sociable but I was, I say I wasn't sociable, *I was, I'm not a party animal but I was always a very outgoing person* and a laugh a minute and if I did go out socially I would be the one holding court. Page 21/477-481

Sharon:

Yeah. And, whereas before I'd enjoy going out drinking, now I just can't drink, like really, like I kind of have a glass of wine but I just find that it just, I can't go out drinking, *drinking because I'll just get too depressed, like it's just not good.* Page 11/285-288

I probably care about different things now and I've probably become like I think I've *become a bit selfish, not like in a mean way but just to cope.* Like I've got to do whatever I've got to do to kind of get through. Page 21/551-554

Christine:

Erm, a lot more patient these days. *A lot more tolerant.* A lot more looking for reasons why people do things without leaping in and getting, I used to get livid about silly things. Page 18/458-460

I'm much *more philosophical, much more patient, much more enquiring.* I'm not as angry or selfish as I used to be which I suppose could have gone the other way really. Page 19/486-488

Tracey:

It's, people do and, but I think, for me as well, it's been a journey because I think it's because I've seen the counsellor as well, I'm much more in touch with my feelings

and emotions than I ever was before and **more self-aware**. And I think that's why in some ways do I need to see a counsellor still? No. But it's, it enables me to look more deeply into myself which I never did before. **I hadn't got a clue before and I was quite naïve, I suppose, in a lot of ways.** Page 22/606-612

Diane:

Erm. It's made me, it's made me, erm, **put up with less crap actually**. [Laughter] Erm, if I feel people are not treating me particularly well or there's a situation I'm not comfortable or happy about, erm, I have less, I have more ability now, more **compunction to be able to say, 'No, I'm sorry, this is not for me,'** erm, and do it, you know, in a considerate and, you know, proper way rather than just throwing my hands up in the air and going, 'No, sod off everybody.' Page 17/467-473

Changed perception of self: new possibilities in life

Louise:

I'm in the process of **buying my house**. I've got a good **job**. **Might be a manager** this time next week and if I don't get it I've still got a job I love. Page 50/1279-1280

Annie:

One of the things I thought in the early days was hang on I'm forty-two and I've got probably another forty years ahead of me and **I don't want to spend them on my own**. Page 22/552-554

Cheryl:

Yes, **I still do pretty much want the same things** as when he was, when he was alive. It's just now that's it's going at my pace. **It's going at a much slower pace.** Page 26/623-625

Rachel:

I have thought **at times of restarting** it but I'm not sure that I'm emotionally at a place where I can deal with it just at the moment. Page 10/229-231

Sharon:

Like just, it sounds a bit weird but like nature and kind of going, like my parents live, live down, they've moved down to county X. So like actually, whereas **I used to hate it because it was boring** [Laughter] **I kind of don't mind it now**. It's just quite peaceful and, and, you know, when I've been travelling, just kind of seeing like pretty landscapes and stuff, I don't know. It's, **it's quite relaxing**. Page 11-12/290-295

Christine:

I would like to do it. I would, I was considering going on to, erm, volunteer for CRUSE and **do bereavement counselling** maybe. I still do the Samaritans though that's proving difficult at the moment with a full time job that's shift work but that's **always rewarding once you've done it**. Page 20/510-513

Tracey:

The sad thing is any relationship I'd have, there, there'd be three people in it and it would take a, you know, the right person to, er, to actually be in a relationship with two other people because it's, Jennie's still there and I think that's a lot to do with the co-dependent, you know, relationship as well. Erm, but **I think being aware of that** and being more aware as a person **that's not going to happen again**. Page 23/630-636

Diane:

I hope that I'll be in another relationship and all those sorts of things. Erm. I don't feel quite ready for it yet so at the moment I'm not worrying about it but, erm, as I said to you, my mum is not very well. Page 19/519-521

Changed philosophy of life: appreciation of life

Louise:

So, I think it's left me with feeling, you do **only have one life** so you'd better make the most of it. Page 56/1445-1446

Annie:

<p>Erm, and maybe I've been a bit reckless in the last year with what I've spent but it's like, if I can, if I can capture two weeks of a holiday and make memories, that's more important than money in a savings account. Page 13/334-337</p>
<p>Cheryl: Like I want to live every day to the fullest and I really wasn't like that before I, I was kind of like it'll, it'll happen, whenever. And now it's just like I feel like I am pressed for time almost. Page 24/584-586</p>
<p>Rachel: When, when they're good, they are very good. No, didn't I say very good, that they're, when they're good they're, they're nice. They're, they're just normal. Page 19/430-432</p>
<p>Sharon: Like it's funny because it's, it's, because I remember like after he died I just kind of used to think well, like when it comes down to it it's either like you live or you die. Page 25/665-667</p>
<p>Christine: Yes, and I think well, do I want that pair of shoes? Yes, I do, sod it. I might be dead tomorrow so I'm going to enjoy what I can while I can but that's really only kicked in, I would say, this year. Page 19/471-474</p>
<p>Tracey: But now I can actually go out, enjoy myself and then the next day I'm not, my, my body's not punishing me. Page 13/363-364</p>
<p>Diane: So, as I say, it's kind of a, it's, it's, it's a double edged sword: some things, you know, I'm, I'm quite grateful for. It's shown me what's important in life and what isn't important in life. It's made me make decisions where, and maybe I've, you know, procrastinated for some time because I didn't know. Page 18/493-497</p>
<p>Changed philosophy of life: new priorities</p>
<p>Louise: I see myself sorting my house out, doing some renovations. Carrying on working, still being with Bill and still, erm, remembering James on the 16th of March. That's how I see it. Page 50/1286-1289</p>
<p>Annie: He is what comes first and until he goes to university, he's my number one priority. Erm, after that, who knows? I might look for another relationship or, erm, I have certainly not ruled it out. Page 23/558-560</p>
<p>Cheryl: I have a lot more need for getting stuff done. Like doing exciting things. Like since he passed away I've travelled all over Europe. I've, I'm going to India in a couple of weeks before I, you know, leave here and I'm like I'm just crossing things off like crazy off my bucket list because it's just like you don't know. Page 24/580-583</p>
<p>Rachel: And in February of this year she was diagnosed with breast cancer. Fortunately, they got it quickly and she is to all intents and purposes, cured of it. She had an operation and they got it all out and she's undergoing radiotherapy. At the moment, as we speak, she's, I've taken her today for her third session. Erm, and, erm, she's got fifteen sessions in total but she's, she's clear of that, you know. Page 22/495-500</p>
<p>Sharon: I probably just, not less effort but I just try not to let it, you know, it's not the end of the world if something hasn't been done for the client on a certain date. Page 21-22/560-562</p>
<p>Christine: I've taken up dancing. I do jiving and lindy hopping which is interesting. And yes,</p>

<p>yes, just trying to get myself, <i>trying to look after myself</i>. Actually it's the first time I've made a conscious effort to look actually look at how I am and try and look after me. <i>But it's actually taken quite a lot of effort to do that.</i> Page 9/216-220</p>
<p>Tracey: Yes, erm, <i>just empty and lonely</i>. Erm, and I'm trying, you know, I've joined a club, erm, you know, just to get out and about and I'm trying slowly to build new friendships but, er, sort of there's like a, a <i>block there</i>. Page 9/237-240</p>
<p>Diane: She has, erm, she has dementia so <i>I'm helping to look after her at the moment</i> and so my life is kind of, you know, <i>I'm working</i> and then I, I'm helping to look after her and it's kind of, it's quite hard to look very far ahead in that kind of situation because obviously it all revolves around how quickly and, you know, the illness progresses and what happens with her. Page 19/522-526</p>
<p>Changed philosophy of life: living in the 'here and now'</p>
<p>Louise: My husband and me now, <i>absolutely fantastic relationship</i>. Page 11/286-287</p>
<p>Annie: So I'm <i>making the most of what we've got now</i> and, erm, attempting to give him really the best sort of life he can have. Page 13/321-322</p>
<p>Cheryl: I mean really, I feel like one of my biggest downfalls used to be that <i>I was living so much in the future</i> but now it's, <i>I feel like kind of relaxed and I'm not planning out every second</i>. That I'm not like on this time line where I need to have a house by four years and I need to have this and that and all in this time line and it's kind of just relaxing to take a breath and say you know what? <i>I know what I want</i>. Page 26/616-621</p>
<p>Rachel: <i>I don't contemplate a future for myself because I can't see one</i>. I actually, erm, see that, as soon as <i>anything happens to my mother, I think that I will probably kill myself</i>. Page 21/491-493</p>
<p>Sharon: I used to worry a lot about the future and it felt like I wasn't living in the present. Well, I guess now <i>I probably live in the present more which I guess is a good thing</i>. Erm, you know, <i>I don't really tend to, I try not to think, to think about the future or the past too much</i>. Page 10/256-260</p>
<p>Christine: <i>I have no plans other than the cat</i>. Pussy want's his dinner, but it's not time yet. So really just trying to enjoy things rather than make big plans and set myself tasks. <i>Just try doing things that I actually enjoy rather than things that I think I ought to do, if that makes some sense</i>. Page 19-20/494-498</p>
<p>Tracey: <i>I haven't really thought that far ahead</i>. Page 22/623</p>
<p>Diane: Do you know what? <i>I genuinely don't know</i>. I, I, that's one of the things I still struggle with. I, I, <i>I pretty much am a day-to-day person at the moment</i>. I can maybe look a few weeks ahead but, you know, or maybe the rest of this year for instance, but. It's almost like it's taught me, <i>don't look too far ahead because you never know what's going to happen</i>, and I certainly wasn't expecting that to happen. Page 19/509-514</p>