Personal and Professional Experiences of Suicide

Amanda Haines

This thesis is submitted in partial fulfilment of the requirements

for the degree of Doctor in Clinical Psychology

Faculty of Health and Life Sciences, Coventry University

Department of Psychology, University of Warwick

May 2019

Contents

Tables, Figures and Abbreviations

Tables

Chapter I

Chapter II

Figures

Chapter I

Chapter III

Abbreviations

MHP	Mental Health Professional
IPA	Interpretative Phenomenological Analysis
CMHT	Community Mental Health Team
IPTS	Interpersonal Psychological Theory of Suicide

Acknowledgements

I would like to thank the men who took part in this research for their time and honesty. Their willingness to share their experiences with me has made this research possible. Thank you also to the Mental Health Professionals who provided these men with information about the study so that they could have a voice in this research.

My supervisors, Tony Colombo and Marianna Perdikouri, thank you for imparting your wisdom and expertise. Tony, I am grateful the time you have offered me, from our meetings at the early stages to the final weeks of writing. Thank you for guiding me throughout this journey and teaching me about the world of research. Marianna, your ongoing encouragement has provided me with strength to complete this thesis. Thank you for providing a safe and containing space for me to reflect on my experience.

My fellow Clinical Psychology Trainees have been a tremendous support during this research. I truly value our friendship and feel privileged to have met you all. I would also like to acknowledge my family for believing in me throughout my Clinical Psychology Training.

Finally, and most importantly, I would like to thank my husband, Chris, who has kept me grounded and nurtured through the highs and lows of this research. Thank you for being there by my side and supporting me through this milestone in my life.

Declaration

This thesis has not been submitted for a degree at any other university or institution. The content of this thesis is the authors own work apart from the following collaborations. This thesis was completed by the author under the supervision of Dr Anthony Colombo (Research Director, Coventry University) and Dr Marianna Perdikouri (Clinical Psychologist). The named supervisors were involved in the initial design of the research and have provided guidance and feedback throughout. The validation of coding for the empirical research was also supported by an independent colleague who was familiar with Interpretative Phenomenological Analysis. The design of the research documents for the empirical research, including the advert, participant information sheet, consent form and interview schedule, were created in collaboration with experts by experience. A quality assessment of the papers included in the literature review was conducted by a peer researcher to assess the inter-rater reliability of quality scoring.

Chapter I: 'The psychological impact of client suicide on mental health professionals: a meta-ethnographic synthesis' has been prepared with the view to submit to Suicide and Life-Threatening Behaviour by Amanda Haines, Dr Anthony Colombo and Dr Marianna Perdikouri. Chapter II: 'Young men's interpersonal experiences following a suicide attempt: an Interpretative Phenomenological Analysis,' has been prepared for submission to Suicide and Life-Threatening Behaviour by Amanda Haines, Dr Anthony Colombo and Dr Marianna Perdikouri. The findings will also be presented at The University of Warwick Psychology Postgraduate Research Day.

Summary

This thesis explores the experiences of suicide from three distinct perspectives; Mental Health Professionals, young men who have attempted suicide and a researcher in the field.

Chapter one is a systematic review of the psychological impact of client suicide on Mental Health Professionals. A meta-ethnographic synthesis of 17 studies identified three key themes; 1) *distress, 2) blame and 3) taking control*. The findings are discussed in relation to previous reviews. Overarching issues relate to the damaging and lost-lasting psychological impact of client suicide. This review has implications for the development of postvention guidelines to support Mental Health Professionals following a client suicide.

Chapter two is a qualitative research study of young men's interpersonal experiences following a suicide attempt. Semi-structured interviews were conducted with four males, aged 27 to 34 years, recruited from Community Mental Health Teams. Using a method of Interpretative Phenomenological Analysis, three key themes emerged from the data; 1) *sense of self, 2) fear of self and 3) reconnecting with oneself*. The findings are discussed in relation to the current literature and the Interpersonal Psychological Theory of Suicide. Clinical implications and directions for future research are also discussed.

Chapter three is a reflective paper on the challenges of conducting qualitative research on suicide from the perspective of a Trainee Clinical Psychologist. Gibbs' (1988) six stage model of reflection is used to structure the author's reflections on three key challenges; 1) r*esponsibility;* 2) *emotional labour;* and 3) *fear of suicide.* These challenges are discussed in the context of the current literature.

Overall Word Count: 19594 (at submission)

Chapter I: Literature Review Paper

The Psychological Impact of Client Suicide on Mental Health Professionals: A Meta-Ethnographic Synthesis

In preparation for submission to Suicide and Life-Threatening Behaviour

(See Appendix A for author instructions for submission)

Overall chapter word count (excluding abstract, tables, figures and references):

7832 (at submission)

Abstract

Objective: The aim of this review is to synthesise the research on the psychological impact of client suicide on qualified Mental Health Professionals. Method: Four databases (CINAHL, PsycINFO, Scopus and Medline) were systematically searched using the key terms 'health professional', 'client', 'suicide' and 'impact', and their synonyms. Reference lists of the final studies were also searched and attempts were made to search for unpublished grey literature. Seventeen studies were included and quality assessed. A meta-ethnographic approach was used to analyse the qualitative data. Results: Three main themes were identified; 1) *distress,* which is both intense and enduring, 2) *blame,* through being blamed and blaming oneself and others; and 3) *control*, which describes adaptive and maladaptive strategies used in an attempt to regain control of one's wellbeing. Conclusions: The findings have implications for postvention guidelines to support Mental Health Professionals following a client suicide. These are focused on minimising the damaging and long lasting psychological impact of client suicide.

Word count: 158

Key words: Suicide, Mental Health Professional, Psychological Impact, Qualitative Research, Postvention

Introduction

The aim of this systematic review is to synthesise the literature exploring Mental Health Professionals' (MHP) experiences following a client suicide. 'MHPs' are broadly defined to include any practitioners who provide services to improve a person's psychological wellbeing. 'Client suicide' is defined as the death of a person who used the services of a MHP, caused by self-injury with the intention to die.

Approximately 800,000 people die by suicide each year (The World Health Organisation; WHO, 2018). Of those who die by suicide, 57% have contact with a MHP in their lifetime, and 31% within 12 months of their death (Stene-Larsen & Renefolt, 2019). Within Community Mental Health Teams (CMHTs), 86% of MHPs experience a client suicide (Linke, Wojciak & Day, 2002). Among MHPs, client suicide is experienced by 79% - 92% of Psychiatrists (Landers, O'Brien & Phelan, 2010; Rothes, Scheerder, Van Audenhove, & Henriques, 2013), 55% of Psychiatric Nurses (Takahashi et al., 2011), 33% of Social Workers (Jacobson, Ting, Sanders & Harrington, 2004), 31.5% of Psychologists (Finlayson & Simmonds, 2018), and 23% of Counsellors (McAdams & Foster, 2000).

Those exposed to suicide are at an increased risk of suicidal behaviour themselves (Campos, Holden & Santos, 2018). This extends to non-family members of the deceased (Maple, Cerel, Sanford, Pearce & Jordan, 2017), including professionals such as Firefighters and Police (Cerel, Jones, Brown, Weisenhorn & Patel, 2018; Kimbrel et al., 2016). There is evidence to suggest that MHPs in training experience greater distress following a client suicide than those who are qualified (Ellis & Patel, 2012). Providing support to those exposed

to suicide is part of a global suicide prevention initiative known as postvention (WHO, 2014). Postvention usually entails providing support, such as bereavement counselling, to family and friends of those who have died by suicide (Public Health England, 2016). However, despite evidence that client suicide can cause MHPs severe distress (Wurst et al., 2013), there is little guidance on how they could be supported. A recent study emphasised the importance of extending postvention to ensure the wellbeing of MHPs, who are often the ones providing postvention to others (Maple, McKay, Hess, Wayland & Pearce, 2019). The National Institute for Health and Care Excellence (NICE, 2018) has recently released draft guidelines which recommend that those who are affected by suicide, including professionals who provide support, should be identified and provided evidence based support. NHS England's Serious Incident Framework (2015) advises that staff involved in an investigation of a serious incident, including suicide, should have access to support, however, less than half of NHS staff involved in a suicide incident are actually offered support (Oates, 2018). In order to provide evidence based support, NICE (2018) recommend research into the needs of people who are affected by suicide.

Evaluation of Previous Reviews

The most recent systematic review conducted by Séguin, Bordeleau, Drouin, Castelli-Dransart and Giasson (2014) reviewed 37 studies on qualified and trainee MHPs' reactions to client suicide. Studies were published between 1980 and 2012 in peer reviewed journals. Findings show that MHPs experience shock and sadness following a client suicide, with greater emotional responses in those who lacked support from others or felt close to the deceased client. MHPs

were also found to become hypervigilant or avoidant when working with other suicidal clients.

Young (2012) conducted a similar systematic review of 12 studies, published in peer-reviewed journals between 1988 to 2011. This focused on the reactions and coping behaviours of qualified MHPs working in the public sector following a client suicide. Findings indicated that MHPs experience shock and sadness, as well as denial, grief, low mood, anger, guilt, self-blame, a sense of responsibility and self-doubt. MHPs were also found to respond with increased awareness and caution towards their suicidal clients. Furthermore, MHPs found it helpful to receive informal support from their colleagues, family and friends.

Other related reviews have explored the reactions to client suicide in specific professions including trainee Psychiatrists (Fang et al., 2007) and qualified Psychiatrists and Psychologists (Harris, 2007). These reviews highlight the personal and professional impact on MHPs, as well as the barriers to support, following a client suicide.

Rationale and Aim of the Current Review

Previous literature reviews on the experiences of MHPs are limited in three ways. Firstly, reviews have been largely based on quantitative research and therefore lack an in-depth insight into MHPs' experiences. More recently there has been a range of qualitative studies providing an experiential understanding of MHPs' psychological wellbeing following a client suicide which have not yet been reviewed. Secondly, there has only been one previous review which focuses on the experiences of qualified MHPs from a range of professions (Young, 2012). Other reviews have either included trainee MHPs (Fang et al., 2007; Séguin,

2014) or focused on specific professions (Harris, 2007). Furthermore, Young (2012) excluded MHPs working in private practice which limits the applicability of the findings to this group of professionals. Finally, previous reviews have excluded unpublished grey literature researching MHPs' experiences of client suicide, the findings of which should be included as part of the overall review evidence base to reduce publication bias. This is a bias towards positive findings due to the view that negative results are less likely to be published (Higgins & Green, 2011).

This review aims to address these limitations by synthesising the qualitative evidence from the most recent published and unpublished research on qualified MHPs' experiences following a client suicide. The purpose of this is to produce a new conceptual framework which can be used to inform postvention guidelines to support MHPs. Thus, a meta-ethnographic review will be carried out to address the question: What is the psychological impact of client suicide on MHPs?

Method

Systematic Literature Search

Search Process

A comprehensive search of four electronic databases was completed. Three databases in the field of psychology and nursing (CINAHL, Medline, PsycINFO) were chosen due to their relevance to the review topic, along with one broad ranging database (Scopus). Searching each database separately allowed for the use of the thesaurus to search for terms indexed by subject headings. Searches were carried out between November 2018 and March 2019 using a search

strategy developed in consultation with an expert librarian. Attempts were also made to search for unpublished grey literature via the website 'www.opengrey.eu' in order to reduce publication bias. Furthermore, the reference lists of the final studies included were hand searched for relevant studies.

Search Terms

The PICO search tool (Population, Intervention, Comparison, Outcome) is recommended as an effective tool for a comprehensive search of qualitative literature (Methley, Campbell, Chew-Graham, McNally & Cheraghi-Sohi, 2014). For the purpose of this qualitative review, the PICo variation of this tool was employed which organised the key terms under the headings 'Population', 'phenomenon of Interest' and 'Context*'* (Stern, Jordan & McArthur, 2014). The following key terms were identified; 'health professional' (population), 'client' and 'suicide' (phenomenon of interest), and 'impact' (context). The key term 'health professional' was chosen to conduct a broad search of studies which may include MHPs. Different mental health professions were included as synonyms. A scoping search identified the common synonyms for the key terms that are used in research on the current review topic. These synonyms were included in the search strategy along with variations in spelling, e.g. Counsellor and Counselor. Table 1 displays the key search terms with their respective synonyms and location.

Table 1.

Key Search Terms

Key Search Terms	Synonyms	Location
Health Professional*	Psychologist*	Title, Abstract and Key
	Nurse*	words
	Staff	
	Counsellor*	
	Counselor*	
	Psychiatr*	
	Clinician*	
	Worker*	
	Therapist*	
	General Practitioner*	
Client*	Service user*	Title, Abstract and Key
	Patient*	words
	In-patient*	
	Inpatient*	
Suicid*	-	Title, Abstract and Key
		words
Impact*	Response*	Title, Abstract and Key
	Experience*	words
	Effect*	
	Reaction*	

Search Strategy

All key terms were searched for in the title, abstract and key words of studies. The Boolean logic operator 'AND' was used to combine the key terms and 'OR' was used to search for the synonyms of key terms. Keywords and their synonyms were truncated using the symbol '*' to search for all possible word endings. Proximity searching was used to specify how closely the terms 'client' (or synonyms) and 'suicide' were together in an article. To increase the sensitivity and specificity of the search, a limitation of two words between these terms in any order was set (i.e. 'adj2' for Medline and PsycINFO, 'w2' for CINAHL and 'w/2' for Scopus).

An identical search strategy for the key terms was conducted for each database. The studies retrieved were limited to qualitative studies in line with the inclusion criteria. The strategy for this varied due to different limiter options on each search platform. For searches of Medline and PsycINFO the limit 'qualitative (best balance of sensitivity and specificity)' was applied. For CINAHL the thesaurus search option was used which retrieves studies containing 'qualitative studies' in their subject heading. This was combined with a search for the term 'qualitative' in the whole text of studies. This combined search strategy for qualitative studies aims to generate high sensitivity and specificity in CINAHL (Wilczynski, Marks & Haynes, 2007). Limiter or thesaurus options are not available in Scopus, therefore, 'qualitative' was searched in the whole text of studies. The search strategies used for each database are displayed in Appendix B.

Inclusion and Exclusion Criteria

Studies retrieved from database searches were exported to RefWorks which allowed for duplicates to be removed electronically. The remaining studies were then screened by the reviewer in two stages.

Stage 1: the titles and abstracts were screened and retained if they met the following eligibility criteria: (a) written in English; (b) written or published between 2000 - 2019; (c) are peer reviewed; (d) explore qualified MHPs' experience of client suicide; (e) use a qualitative or mixed methods methodology; (f) are accessible in full text. Where these criteria could not be determined from the title or abstract, studies were retained for the second stage of screening.

Stage 2: full text studies were read and retained if they met the inclusion criteria (Table 2). A pragmatic decision was made to only include studies published, or written, in the last 20 years (between the years 2000 – 2019) in order to prioritise recent findings, that reflect more modern working practices, since recommendations for supporting clinicians following a client suicide (Kleespies & Dettmer, 2000). Studies were included if they had any qualitative findings on the topic of client suicide, and excluded if these findings could not be disentangled from quantitative findings, or from other topics, such as suicidal behaviour, self-harm, or suicide attempts. Studies were also excluded if they focused on irrelevant topics including suicide risk factors, assisted suicide or the outcome of suicide interventions. Studies exploring experiences, impact, effects, responses or reactions of/to client suicide were included. Studies which focused on the attitudes, beliefs, evaluations, opinions or judgements about client suicide were excluded.

In terms of the population, studies were included if they used a sample of qualified MHPs, including Psychiatrists, Psychologists, Counsellors, Therapists, Psychiatric Nurses and Social Workers. This review focuses on qualified MHPs therefore studies which focused on trainee MHPs were excluded. Whilst the search included the term 'General Practitioner', the eligibility criteria was narrowed down to exclude general practitioners since a number of studies on this population did not specify whether they had received mental health training. Studies which explored the experiences of general health professionals, such as general Nurses, were also excluded.

Reviews, epidemiology studies, case studies, studies examining the psychometric properties of a scale or studies using a quantitative research design were excluded since they did not meet the inclusion criteria. No limits were placed on the form of qualitative design, epistemology, country, the recruitment process or data collection method.

Table 2.

Inclusion and Exclusion Criteria

Criteria	Inclusion	Exclusion
Language	English	Not in English
Year Written	Between 2000 and 2019	Prior to the year 2000
Peer Reviewed	Published in a peer reviewed journal or non-published peer reviewed doctoral theses	Not published in a peer reviewed journal or is an undergraduate or masters level theses
Research Design	Qualitative or mixed methods design	Critical or literature review, epidemiology research, psychometric properties of a scale, case studies or quantitative research design
Topic	Studies exploring client suicide	Studies investigating clients who self-harm, are suicidal or attempt suicide. Studies on suicide risk factors, assisted suicide or the outcomes of suicide interventions.
Experience Explored	Experiences, impact, effects, responses or reactions following client suicide	Attitudes, beliefs, evaluations, opinions and judgements
Population Group and Context	Qualified MHP	General health professionals (including General Practitioners) or trainee MHPs

Classification of Studies

A 'Preferred Reporting Items for Systematic Reviews and Meta-analyses' (PRISMA) diagram reports the process of research selection in Figure 1 (Moher, Liberati, Tetzlaff, Altman, & Prisma Group, 2009). The database searches retrieved 1058 studies. Three additional studies were identified; two through reference lists of included studies (Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000; McAdams & Foster, 2002) and one through a grey literature search of www.opengrey.eu (Harris, 2007). After removing 318 duplicates, a total of 743 studies remained for screening. After reviewing the titles and abstracts, 700 were excluded due to not being relevant, leaving 43 full texts to be assessed for eligibility. Of these studies, 26 were excluded for the following reasons; the methodology was quantitative (n=8); participants were general health professionals (n=6); unable to distinguish experiences of client suicide from other experiences (n=4); unavailable in English (n=3); on evaluations, opinions or judgements about client suicide (n=2); unable to distinguish qualitative from quantitative findings (n=1); unable to identify whether participants are MHPs (n=1); and a case study (n=1). This left 17 studies that satisfied the inclusion criteria.

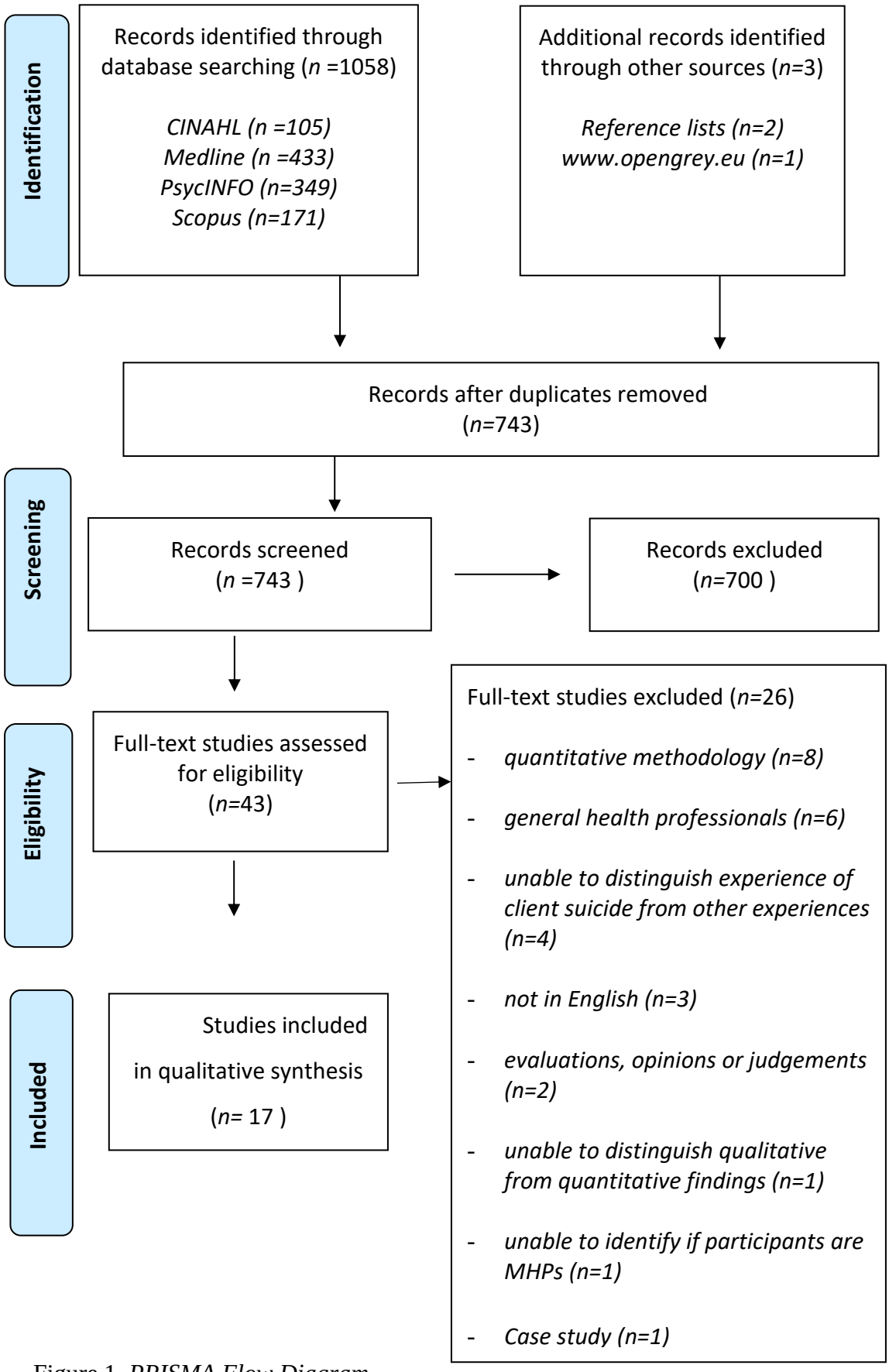


Figure 1. *PRISMA Flow Diagram*

Quality Assessment

A quality assessment was important to determine the accuracy of the findings from the studies included in this review. The checklist from the Critical Appraisal Framework (Appendix C; Caldwell, Henshaw & Taylor, 2011) was used to assess the quality of the 17 studies identified from the systematic literature search. This was chosen because it includes detailed guidance on how to assess qualitative research. All studies were scored against 18 quality criteria. Each study was rated as '0' if the criterion was not met, '1' if the criterion was partially met and '2' if the criterion was fully met (Boeije, van Wesel & Alisic, 2011). In total, each study received a quality rating between 0 – 36 by adding the scores for all 18 criteria (Appendix D).

All 17 studies were quality assessed by the reviewer and independently by a peer researcher. The quality rating and Kappa value for each study are reported in the first column of Table 3. Quality scores varied from 19 to 36 and Kappa values varied between .64 and 1.00 suggesting a moderate to almost perfect level of agreement in ratings (McHugh, 2012). The reviewer and peer researcher reached 100% agreement in their rating of 8 studies. They disagreed on one criterion for seven studies (94% agreement) (Darden & Rutter, 2011; Finlayson & Simmonds, 2019; Kimball, 2015; Overfelt, 2015; Sanders, Jacobson & Ting, 2005; Tillman, 2006) and on two criteria for two studies (88% agreement) (Ting, Sanders, Jacobson & Power, 2006; McAdams & Foster, 2002).

It is important to highlight that there are a number of problems with assessing the quality of qualitative studies. Firstly, there are numerous quality assessment tools (Noyes, Popay, Pearson, Hannes & Booth, 2008), however, there is limited guidance on which tool is appropriate for meta-ethnography

(Barnett-Page & Thomas, 2009). Secondly, many quality assessment tools were developed to assess quantitative research and it is questionable whether the quality of qualitative and quantitative research can be assessed by the same criteria (Ring, Ritchie, Mandava & Jepson, 2011). Thirdly, there is little agreement on what makes qualitative research of high quality (Dixon-Woods et al., 2007), therefore excluding studies may remove insightful findings from the review (Campbell et al., 2011). Whilst the quality of the studies included in this review were assessed and considered, no studies were excluded on the basis of these limitations.

Characteristics of the Literature

The key characteristics of the 17 studies included in this review are summarised in Table 3. Of these 17, five were unpublished doctoral theses (grey literature) which reduces the impact of publication bias. One grey literature study was retrieved from 'www.opengrey.eu' (Harris, 2007) and four grey literature studies were retrieved from the database searches (Silverthorn, 2005; Moody, 2010; Kimball, 2015; Overfelt, 2015). Studies were written or published between 2000 - 2019. The majority used a qualitative research design, whilst three studies used a mixed methods approach. Thirteen studies collected data via interviews and four used a questionnaire. Ten studies focused on the experience, effect, reactions or responses of MHPs to client suicide. The remaining seven studies included findings related to the aim of this review, but with a more specific focus including; the experience of client suicide in light of a consolation model (Talseth & Gile, 2007); responses or experiences of working with suicidal clients (Awenat et al., 2016; Morrissey & Higgins, 2018); experiences following the death of a client (Harris, 2007); and the experience of support and resources following a

client suicide (Finlayson & Simmonds, 2019; McAdams & Foster, 2002). Where only part of the findings were extracted for the purpose of this review, a '*' is presented in the 'key findings' column of Table 3.

All studies were conducted in Western countries, with the majority based in the United States of America (USA) (*n*=10). Other countries included England (*n*=2), Ireland (*n*=2), Australia (*n*=1), Canada (*n*=1) and Norway (*n*=1). The studies involved a broad range of MHPs including; Psychologists (*n*=7), Social Workers (*n*=7), Counsellors (*n*=5), Psychiatrists (*n*=5), Nurses (*n*=2), Support Workers (*n*=1) and Marriage and Family Therapists (*n*=1). One study did not report the type of MHPs included. Seven studies reported the settings in which participants worked in which included; inpatient mental health services (*n*=4), CMHTs (*n*=3), private services (*n*=3), medical or state hospital setting (*n*=2), academic settings (*n*=2), and military settings (*n*=1). Eight studies reported the range of time since the client suicide which varied from six weeks to 30 years.

Table 3.

Key Characteristics of the Reviewed Studies

Author(s), Date, Location, Quality Rating, Kappa	**Aim or Research Question**	**Design and Sampling Method**	**Sample Characteristics**	**Data Collection and Analysis Method**	**Key Themes (* part findings)**
Awenat, Peters, Shaw-Nunez, Gooding, Pratt & Haddock, 2016 England 31/36 K=1.00, p=.000	To investigate staff experiences of working with in-patients who are suicidal.	Qualitative Purposive sampling	*n*=20 (Nurse *n*=8, Support Worker *n*=2, Psychiatry *n*=4, Psychologist/ Social Worker/ Occupational Therapist *n*=6)	Interviews Thematic analysis	*Maintaining business as usual; blame and fear of blame; severe and enduring effects; suicide as inevitable and untreatable.

Christianson & Everall, 2009 Canada 33/36 K=1.00, p=.000	To explore the experience of School Counsellors who had lost clients to suicide.	Qualitative Purposive sampling	7 School Counsellors	Interviews Grounded Theory	A perceived lack of control and attempts to regain control; personal challenges within their professional context; personal and professional impact; the importance of support systems and self-care.
Darden & Rutter, 2011 USA 33/36 K=.81, p=.000	To seek an in-depth exploration of the phenomenological experience of Psychologists who navigated a client's suicide.	Qualitative Purposive sampling	6 Psychologists (university *n*=1, private practice *n*=2, and state hospital *n*=3)	Interviews Consensual Qualitative Research	Suicide viewed generally as a priority but out of a psychologist's control with limited professional agency. Case specific sense of responsibility, failure and trauma. Pre-suicide risk assessment and post suicide assessment of whether should have done something differently. The experience of being notified

	about the suicide, initial response of shock and disbelief and requirements to maintain role post-suicide. Personal and professional impact through approaching suicidal clients with hypervigilance, increased enquiry and emphasising intervention. Unexpected emotions during research interview, legal implications and training. Recovery is facilitated through talking, time, colleague support, acknowledging limitations and a memorial service. Recovery is hindered through isolation and administrative clashes. Varied experience of clients family.

Finlayson & Simmonds, 2019 *Australia* 35/36 K=.64, p=.001	To explore the extent to which Psychologists felt their workplace was supportive following a client suicide.	Mixed methods Purposive sampling	56 Psychologists	Self-report questionnaire Thematic Analysis	Private practice as an isolating experience; struggling silently in a workplace where grief is not openly acknowledged; resorting to work colleagues or peer support; stifled grief and adjustment in an investigation action; disturbed relationships in team; open communication and ongoing support.
Harris, 2007 (Grey Literature) *England* 35/36 K=1.00, p=.000	To explore the experiences of Clinical Psychologists following the death of a client.	Qualitative Purposive sampling	4 Psychologists 2-7 years since client suicide	Interview IPA	*Personal impact (emotional impact, personal meaning); professional impact: (clinical implications, training); Support seeking (support, processing and closure); professional individuation.

Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000 *USA* 19/36 K=.83, p=.000	To obtain information about therapists reactions to the suicides of patients in their care.	Mixed methods Purposive sampling	26 therapists (Psychiatrists *n*=21, Psychologists *n*=4, Social Workers *n*=1) 0 – 5 years since client suicide	Semi-structured questionnaire, narrative case description and workshop *Analysis method not provided*	Emotional reactions; shock or disbelief; grief; guilt; fear of blame or reprisal; anger and betrayal; self-doubt or inadequacy; shame or embarrassment; patterns of emotion; changes therapists would make in treatment; support from colleagues and supervisors; interactions with relatives; impact on practice.
Kimball, 2015 (Grey Literature) *USA*	What is the clinician's experience of client suicide?	Qualitative Purposive sampling	*n*=10 (Counsellors *n*=3, Masters of Social Work	Interviews Narrative inquiry	The tsunami initial impact (shock; grief; anger; sadness); picking up the pieces (professional helplessness and professional doubt); rebuilding: the road back (activating, being

34/36 *K=.64, p=.004*			*n*=2, Masters Level Psychologists *n*=3, Psychologists *n*=1) 5 – 23 years since client.		heard is healing); enduring effects (grief, guilt, residual trauma, vigilance and feeling absolved).
McAdams & Foster, 2002 *USA* 21/36	To assess the accessibility and usefulness of resources to frontline	Qualitative Purposive sampling	66 Counsellors	Telephone interview *Analysis method not provided*	Personal support systems (family, friends, professional colleagues; personal therapist); contact with deceased client's family (funeral attendance; personal visit); supervisory support (meeting(s) with supervisor,

K=.82, p=.000	professionals who had experienced client suicide.				administrative review, psychological autopsy); education and training.
Moody, 2010 *(Grey Literature)* *USA* 36/36 *K=1.00, p=.000*	To examine the impact of client suicide on the MHP.	Qualitative Purposive sampling	*n*=6 (Social Worker *n*=2, Counsellor Intern *n*=2, Psychiatrist *n*=1, and Counsellor Supervisor *n*=1)	Interviews Phenomenological approach	Emotional responses; cognitive inquiry; lack of support; coping mechanisms; cognitive restructuring; need for training.
Morrissey & Higgins, 2018	To explain mental health nurses'	Qualitative	33 Mental Health Nurses	Interviews	(*)Safeguarding against anxiety (Retracing their steps, defensive debriefing, seeking

	responses to clients	Purposive	(inpatient and	Grounded Theory	absolution, increased surveillance, soothing
Ireland	with suicidal	sampling	community		self).
35/36	behaviour.		services)		
K=1.00, p=.000					
Murphy et al., 2019	To examine the personal and professional impact	Mixed methods	79 participants	Questionnaire Thematic analysis	Personal distress; professional distress; professional development; changes in professional practice; support.
Ireland	of service user	Purposive			
32/36	suicide on MHP.	sampling			
K=1.00, p=.000					
Overfelt, 2015	How have Mental	Qualitative	11 Mental	Interview	Personal impact (initial thoughts, initial
(Grey Literature)	Health Counsellors		Health		feelings, physical effects, mental and
	been affected	Purposive	Counsellors	Phenomenological	emotional effect); professional impact (initial

USA 34/36 K=-.64, p=.004	personally and professionally by their experience of a completed client suicide?	sampling	(CMHTs *n*=4, private *n*=5, military *n*=1, mental health hospital *n*=1) 1 – 10 years since client suicide	analysis	reactions, legal concerns); spiritual effect (spiritual conflict/growth); coping skills (resiliency or post traumatic growth); supportive relationships (relationship with co-workers, relationships with supervisor or agency); postvention support (support received, support needed; training recommended).
Sanders, Jacobson & Ting, 2005 *USA*	To examine the impact of client suicide on Social Workers.	Qualitative Random selection	145 Social Workers 0.36 – 30 years since client	Self-report questionnaire Constant comparative	Reactions following suicide (deep sadness and depression, trauma and shock, feelings of professional failure, anger and irritability, self-blame, worries and fears); reactions at time of survey (continued emotional reactions,

33/36 K=.82, p=.000			suicide	analysis	changes in practice, reconciliation, power and control issues, nothingness).
Silverthorn, 2005 *(Grey literature)* *USA* 33/36 *K=1.00, p=.000*	To explain how Marriage and Family Therapist's experience client suicide.	Qualitative Purposive sampling	11 Therapists (private practice *n*=4, mental health or community-based agency *n*=3, university clinic *n*=2, medical setting *n*=2)	Semi-structured interview Constant Comparative Method	Impact (personal grief reactions, guilt and self-doubt, sensitivity to suicidal issues); coping (the meaning making process; therapists role, suicide does not make sense; prior experiences with grief and coping; social support; institutional support; supervisor as support; colleagues as support, atmosphere of trust; friends and family, disenfranchised grief; barriers to social support; other forms of coping); training (professional training; therapeutic work for suicidal clients; self-care

			1 – 26 years since client suicide.		following suicide; what is needed during training).
Talseth & Gilje, 2007 *Norway* 32/36 K=1.00, p=.000	To describe Psychiatrists' responses to patients' suicidal deaths in the light of a model of consolation.	Qualitative *Sampling method not provided*	5 Psychiatrists employed by a psychiatric hospital	Narrative interviews Thematic Analysis	(*) Inner dialoguing with self through knowing, reflecting, remembering, sensing, valuing, reasoning, judging and discerning; unburdening grief emerges through shifting perspectives (unburdening grief surfaces through telling, listening, reading and reflecting; teaching about past experiences of suffering releases own grief and gives meaning).

Tillman (2006) *USA* 28/36 K=.89, p=.000	To research the effect of patient suicide on clinicians.	Qualitative Purposive sampling	12 Psychoanalytic Therapists (Clinical Psychologist *n*=6, Psychiatrist *n*=5, Social Worker *n*=1) 6 weeks – 12 years since client suicide	Interview Thematic Analysis	Traumatic responses (initial reaction, dissociation, traumatic intrusion, avoidance, somatic symptoms); affective responses (crying, sadness, anger, grief); treatment specific relationships (review and reconstruction of work with the patient, contact with or sense of responsibility to the patient's family); relationships with colleagues (personal analyst, supervisor, peers); risk management (fear of lawsuit); grandiosity, shame, humiliation, guilt, judgement, blame); a sense of crisis (professional identity, loss of faith about psychodynamic/intensive

					treatment, concerns about competence); effect on work with other patients.
Ting, Sanders, Jacobson & Power, 2006 *USA* 32/36 K=.70, p=.000	What are the reactions experienced by Mental Health Social Workers after a client suicide completion?	Qualitative Purposive sampling	25 Social Workers A few months – 25 years since client suicide	Telephone interviews Constant comparative method	Denial and disbelief; grief and loss; anger (anger at the client, anger at the agency and society); self-blame and guilt; professional failure and incompetence; responsibility; isolation; avoidant behaviours; intrusion; changes in professional behaviour (changes in practice, changes in the professional environment); justification; acceptance.

Analytic Review Strategy

Meta-synthesis is a method of integrating findings from qualitative research to expand understanding of an experience (Lachal, Revah-Levy, Orri & Moro, 2017). Of the different types of this method, interpretative synthesis aims to produce a new overarching interpretation of the findings (Campbell et al., 2011). Meta-ethnography (Noblit & Hare, 1988) was chosen as the most appropriate method for the current review since it can be used to produce a conceptual framework to inform guideline development (Noyes et al., 2018). The seven phases of meta-ethnography (Noblit & Hare, 1988) were followed in this review.

Phase 1: the reviewer scoped the research and identified the review question; 'what is the psychological impact of client suicide on MHPs'. Ethical approval was gained from Coventry University to conduct this systematic review (Appendix E).

Phase 2: the reviewer conducted a systematic search of the literature and selected 17 studies based on inclusion and exclusion criteria (Table 2).

Phase 3: all 17 studies were read in alphabetical order by the first author's surname. Information on the research context was extracted from the introduction and methods sections of each study. Concepts, defined as meaningful ideas (Toye et al., 2014), were extracted from the results and discussion sections (Schütz, 1962). This included participant quotes and the researchers' interpretations. The phrasing of these concepts was taken directly from the primary studies to remain close to the original interpretations.

Phase 4: common concepts across the studies were identified and organised into a table as suggested by Britten et al. (2002). For instance, 'blame

and responsibility', 'control over preventing suicide', 'emotional impact' 'experience of support' and 'personal and professional growth' were the concepts identified in this phase (see Appendix F for an example).

Phase 5: using the table of concepts, the reviewer compared the concepts across the studies and identified common themes. For each concept, a map was created of the common themes. For instance, the concept 'control over preventing suicide' was translated into the themes; 'acknowledging limitations', 'hypervigilance', 'avoidance' and 'powerlessness' (Appendix G).

Phase 6: the reviewer then discussed the themes with the research team and identified three key themes, each with two sub-themes. A line of argument synthesis was deemed to be appropriate since the findings of each study were reciprocally related and the aim of the review is to understand the whole experience of the psychological impact following a client suicide. This method uses interpretation to organise the similarities and differences between studies (Nobit & Hare, 1988). Alternative interpretations of the findings were considered; for example, one possible line of argument was that MHPs make sense of the client suicide by attributing 'blame', 'talking it through with others' and 'acknowledging limitations'. However, this interpretation diluted the concept of 'blame' which was an overarching theme across studies, therefore, 'blame' was identified as a key theme which included the concept 'acknowledging limitations' within the sub-theme 'self-blame'. The concept of 'talking it through with others' was then organised within the theme 'control' and under the sub-theme 'regaining control'.

Phase 7: The key themes and their sub-themes are expressed in the results section with supportive quotes from participants in the included studies.

References within the results provide an example of which study, or studies, demonstrate the finding, however, not all studies relating to each finding have been cited.

Reflexivity

According to Noyes et al. (2018) it is important for the reviewer to consider their own biases and pre-existing beliefs which may impact the interpretation of the findings. The reviewer of this research is a Trainee Clinical Psychologist. It is the experience of the reviewer that Clinical Psychology training does not provide information on what to expect and how to respond in the event of a client suicide. The reviewer, therefore, had a vested interest in researching this topic in order to learn how qualified MHPs experience client suicide. Whilst the reviewer does not have experience of client suicide, they have experience of working with clients who are at risk of suicide. Prior to conducting this review, the reviewer held the belief that MHPs are responsible for their client's wellbeing and, therefore, are responsible for minimising the risk of suicide. When working with suicidal clients, the reviewer had experienced anxiety about whether they have done enough to reduce suicide risk and fear that they would be blamed if their client completed suicide.

Results

A meta-ethnographic synthesis of 17 studies exploring the psychological impact of client suicide on MHPs revealed three key themes; 1) *distress* which is both intense and enduring; 2) *blame* towards oneself or others, and being blamed by others; and 3) *control* which involves engaging in adaptive or maladaptive strategies to gain control of one's wellbeing. All 17 studies referred to these themes. These themes and their respective sub-themes are outlined in Table 4.

Table 4.

Themes and sub-themes

Themes	Sub-themes
Distress	Intense (There are layers of emotions which are pervasive and have a physical and cognitive impact).
	Enduring (Memories remain active through rumination and environmental triggers, and recovery is hindered by a sense of isolation and a lack of support).
Blame	Self-blame (A sense of responsibility for clients, self-doubt and guilt).
	Other-blame (There is an experience of blaming others and being blamed by others).
Control	Regaining control (Control is regained through self-care, engaging in postvention activities and having a sense of closure).
	False control (Hypervigilance, holding fatalistic beliefs and avoidance can respectively affect relationships with other clients, lead MHP to question the value of their profession, or leave it.)

Distress

Following a client suicide, MHPs experience unpleasant emotions, physical states and cognitions which impact their level of functioning both personally and professionally. This experience of distress is described in terms of its intensity and duration.

Intense

Distress following a client suicide can be intense for three reasons. Firstly, there are multiple layers of emotions experienced including; "sadness" (Sanders et al., 2005), "fear" (Christianson & Everall, 2009) "shame" (Hendin et al., 2000), "anger" (Ting et al., 2006), "grief" (Hendin et al., 2000), "guilt" (Murphy et al., 2019) and "shock" (Darden & Rutter, 2011).

The intensity of these emotions may vary depending on individual circumstances. MHPs who have unresolved emotions from a previous (Moody, 2010; Ting et al., 2006) or recent loss (Overfelt, 2015) can experience a more intense emotional impact than those who have "dealt with death" either personally (Darden & Rutter, 2011) or professionally (Silverthorn, 2005). The emotional impact can also be experienced more intensely by those who have known their client for longer (Overfelt, 2015) or felt close to their client (Murphy et al., 2019).

Secondly, the distress experienced by MHPs following a client suicide is pervasive and can invade one's personal life.

> "*You just don't leave it there at the door. I took that sadness home with me." (Overfelt, 2015; p. 97).*

"There were some marital difficulties for me. At times I felt like I needed a different kind of support from my husband, so that was a challenging piece of it along the way" (Kimball, 2015; p. 95).

MHPs have also been found to experience intrusive, traumatic thoughts (Sanders et al., 2005).

"I was having a difficult time sleeping. I have incredible nightmares. To this day, at night time, it's like his face exploded and all I remember was blood and remnants" (Christianson & Everall, 2009; p. 162).

Thirdly, the distress has a physical and cognitive impact on MHPs with reports of "fatigue", (Overfelt, 2015), "numbness" (Tillman, 2006), feeling "nauseous" (Ting et al., 2006) "confusion" (Sanders et al., 2005), "poor concentration", "crying" and "eating problems" (Silverthorn, 2005).

"I was not prepared at all for the fact that I would be paralyzed by my own fear and grief and unable to do anything." (McAdams & Foster, 2002; p. 240).

Enduring

The distress experienced following a client suicide has been described as "long lasting" (Hendin et al., 2000) for three main reasons. Firstly, memories of the experience remain active through a process of rumination.

"I can't stop thinking about the client." (Ting et al., 2006; p. 336).

Environmental cues can also trigger memories.

"…a year later. I had brought a brand of shampoo (…) and just the smell of the shampoo made me feel nauseous (…) it dawned on me that it was the smell my client had…it made me realise how profoundly stirred I was by her death." (Ting et al., 2006; p. 336).

Secondly, isolation, particularly in private practice (Finlayson & Simmonds, 2019), can hinder recovery. Colleagues or supervisors have been found to become distant after a client suicide and MHPs have felt excluded from investigations (Kimball, 2015; Tillman, 2006). Some MHPs were not informed directly about their client's suicide and instead "found out inadvertently", for example through reading their client's notes (Darden & Rutter, 2011; Awenat et al., 2017). MHPs can also isolate themselves due to a fear of being judged by others (Kimball, 2015; Silverthorn, 2005).

"*I felt talking about it would be admitting weakness (…) so I never talked to anybody about it."* (Ting et al., 2006; p. 335).

Thirdly, the distress can be enduring due to a lack of support from others (Moody, 2010; Murphy et al., 2019; Sanders et al., 2005).

"*The workplace did not really address the issue at all; it was not spoken about in an open way."* (Finlayson & Simmons, 2019; p. 8).

For instance, there was a sense that others assumed that MHPs would not be affected by client suicide and therefore do not need support (Awenat et al., 2017; Christianson & Everall, 2009; Overfelt, 2015).

"I didn't really feel like they thought it would be something that would be difficult for me" (Silverthorn, 2005; p. 87).

Blame

Client suicide can raise issues of blame for MHPs. This is experienced through blaming oneself for the client suicide and blaming, or being blamed by, others.

Self-blame

Self-blame is experienced in three ways. Firstly, MHPs often hold a sense of responsibility for their clients leading them to perceive client suicide as a professional failure and to experience guilt (Talseth & Gilje, 2017; Ting et al., 2006; Sanders et al., 2005).

"…feeling like I was somehow partly responsible, like I should have been able to do something because, here I am a therapist and she is going to therapy for help..." (Silverthorn, 2005; p. 73).

Secondly, self-doubt is common for MHPs following a client suicide leading them to question their competence (Hendin et al., 2000; Moody, 2010; Tillman, 2006).

> *"...a client committed suicide, does that mean that I didn't do my job, does that mean I'm not very good at being a therapist"* (Silverthorn, 2005; p. 88).

There is a process of "retracing their steps" (Morrissey & Higgins, 2019) to uncover whether they had overlooked something, or could have done something to prevent the suicide (Awenat et al., 2017; Harris, 2007).

> *"you ask yourself over and over what did I not pick up, were there any signs, did he try to tell me?* (Morrissey & Higgins, 2019; p. 953).

Thirdly, in an effort to manage the self-blame, MHPs acknowledge their personal and professional limitations (Darden & Rutter, 2011; McAdams & Foster, 2002). This includes an understanding that suicide can be difficult to predict.

> *"people do commit suicide. And sometimes you will not see the signs"* (Moody, 2010; p. 87).

There is an acceptance that they cannot help everyone, that clients may need more than MHPs are able to offer and that some people do not want help (Harris, 2007; Ting et al., 2006).

> "*I have acknowledged that I cannot possibly save all my clients."* (Sanders et al., 2005; p. 207).

There is also the understanding that suicide is ultimately a client's choice (Kimball, 2015; Ting et al., 2006).

> *"…whether we like it or don't like it it's their life and their choice and it's not up to us."* (Moody, 2010; p. 85).

Other-blame

There are three ways that MHPs experience blame in relation to others. Firstly, MHPs are often blamed by others, including the client's family (Overfelt, 2015; Silverthorn, 2005; Tillman, 2006).

> *"I was aware that my client's family needed to blame someone – I was a good target for that."* (McAdams & Foster, 2002; p. 236).

MHPs can also feel blamed by their own organisation or colleagues (Awenat et al., 2017; Morrissey & Higgins, 2019; Murphy et al., 2019; Sanders et al., 2005).

"*I had this clinical director, and during the staff meeting when we were talking about what happened, he made a comment in front of the whole entire staff, sort of blaming me, saying, 'I wouldn't want to have his blood on my hands if I were you'*" (Ting et al., 2006; p. 334).

MHPs are therefore in a vulnerable position for being investigated and facing legal action (Hendin et al., 2000). This raises concern about their professional reputation (Darden & Rutter, 2011) and job security (Kimball, 2015).

"It's awful but it's like well…who's to blame?...and people will be like oh god did you write that down, did you do this, did you do that? (…) it is a scary…because (…) you'd be sacked and you'd lose your job" (Awenat et al., 2017; p. 104).

Secondly, some MHPs blame others (Darden & Rutter, 2011; Kimball, 2015).

"I carried a lot of anger for the system. If she had gotten the help that she needed when she should have gotten it, she might have still been alive" (Christianson & Everall, 2009; p. 160).

This includes the client (Murphy et al., 2019; Overfelt, 2015).

> *"She hadn't cooperated with the treatment, hadn't let me treat her"* (Hendin et al, 2000; p. 2024).

Thirdly, to manage this sense of blame, MHPs seek reassurance from others (Kimball, 2015; Overfelt, 2015; Talseth & Gilje, 2007). Some MHPs find it helpful to receive reassurance from their supervisor or the family of their deceased client.

> *"As the one person [supervisor] who knew best exactly what I had done with the client, it was his reassurance that carried the most weight in convincing me that I had not done something wrong"* (McAdams & Foster; 2002; p. 237).

> *"When I had spoken to the husband and the family and then I realised I wasn't going to get attacked, that really helped. I think it was more important for me to know that they didn't hold me responsible or blame for or that they felt like my input wasn't enough, it sounds very selfish but it was important for me that they felt I had done all I could from a professional point of view"* (Morrissey & Higgins, 2019; p. 953).

On the other hand, reassurance from colleagues was not always helpful in alleviating blame and responsibility (McAdams & Foster, 2002; Tillman et al., 2006) and could be seen as an "empty gesture" (Hendin et al., 2000).

Control

The experience of distress and blame following a client suicide can leave MHPs experiencing a sense of anxiety and lack of control. Attempts are therefore made to regain control of their personal and professional wellbeing. Adaptive ways of doing so can lead MHPs to regain their sense of control and ability to continue in the profession, whereas maladaptive ways, which seem to provide little more than a false sense of control, lead MHPs to question the value of their profession and consider leaving it.

Regaining Control

There are three adaptive ways that MHPs regain a sense of control after a client suicide. One way is by engaging in self-care, for example through "journaling" (Overfelt, 2015) and "spiritual practices" (Christianson & Everall, 2009)**.**

> *"I used relaxation techniques to deal with the client loss (...) especially in the beginning I became very tearful at work, so I turned the lights off, turn on the music and just sit there so that I wouldn't get overwhelmed so I could continue with the rest of my day."* (Moody, 2010; p. 84).

Self-care also involves seeking support from one's supervisor, colleagues, family, friends, or therapist (Darden & Rutter, 2011; Finlayson & Simmonds, 2019; Harris, 2007; McAdams & Foster, 2002).

> "*All of us were able to talk and debrief; it was very validating for me*" (Ting et al, 2006; p. 338).

"*I was devastated and my supervisor was a lifesaver for me during that time." (*Tillman, 2006; p. 169).

Talking to others with similar experiences is reported to be particularly helpful (Hendin et al., 2000; Talseth & Gilje, 2007; Tillman, 2006).

"I remember discussing this with some very experienced colleagues afterwards and asking them, what did you do to cope with this? It helped hearing about their experiences and how they coped." (Morrissey & Higgins, 2019; p. 953).

A second way is through engaging in postvention activities. This involves supporting others who are impacted by suicide and engaging in training initiatives and service improvements (Christianson & Everall, 2009; Darden & Rutter, 2011; Murphy et al., 2019; Ting et al., 2006).

"I am comforted in knowing that my input during the administrative review and subsequent changes in our programme may lessen the chances of such losses in the future" (McAdams & Foster; 2002; p. 237).

Some MHPs use their experience to educate others about suicide (Kimball, 2015; Hendin et al., 2000; Silverthorn, 2005).

"I reflected over and over on my emotional reactions to this powerful suicidal death … Whenever I lecture about how to meet people who have suicidal thoughts, I connect it to this experience.' (Talseth & Gilje, 2007; p. 627)

A final way that MHPs take control is through a sense of closure. This can be achieved through mourning rituals such as attending a client's funeral and visiting their client's family (Christianson & Everall, 2009; Harris, 2007; Hendin et al., 2000; McAdams & Foster, 2002).

"…I went to his funeral. I said goodbye to him" (Ting et al, 2006; p. 338).

Closure can also be achieved by reflecting on one's experience (Finlayson & Simmonds, 2019) and regaining confidence in one's competence.

"I know I can cope with this, I know I can get beyond this, and I can become a normal and competent Clinical Psychologist again"" (Harris, 2007; p. 70).

"*Oddly, I trust myself more because I had a vague gut feeling about the client, so I listen to my intuition more"* (Sanders et al., 2005; p. 207).

False Control

Some responses to client suicide provide a false sense of control. It is common for MHPs to become hypervigilant to manage the threat of future client

suicides (Darden & Rutter, 2011; Kimball, 2015; Overfelt, 2015). This involves a diligence about suicide risk assessment (Hendin et al., 2000; Silverthorn, 2005).

> *"I was hyper-vigilant, cautious with people and taking no risks at all"* (Morrissey & Higgins, 2019; p. 953).

However, this can lead to overcautious responses and impact one's relationship with clients (Kimball, 2015; Tillman, 2006; Silverthorn, 2005).

> *"it was like I just wanted everyone to be wrapped up in cotton wool so that they could be protected … I desperately needed everyone else to be okay"* (Harris, 2007; p. 67).

On the other hand, some MHPs become avoidant (Christianson & Everall, 2009; Finlayson & Simmonds, 2019; Overfelt, 2015; Sanders et al., 2005). For example reengaging with their work routine whilst suppressing their thoughts and feelings about the client suicide.

> *"the suicide was such a trauma … details of that night were buried"* (Darden & Rutter, 2011; p. 326).

Some avoid taking on suicidal clients or consider leaving their profession.

> *"I would try to turn down [suicidal] cases if know I can't be effective."* (Ting et al., 2006; p. 335).

> *"I felt responsible, inadequate, fraudulent, absolutely stupid for not picking up the clues. I contemplated leaving the profession."* (Sanders et al., 2005; p. 204).

A final way that MHPs develop a false sense of control is by holding fatalistic beliefs that suicide is not preventable (Awenat et al., 2017; Christianson & Everall, 2009). Whilst this frees them of their sense of responsibility, it brings a sense of powerlessness (Sanders et al., 2005) and leads them to question the value of their profession.

> *"Personally, the loss of the client made me realize that again, I really do not have enough power to stop people from doing what they want to do (...) how much work actually works? Like how long of an affect [sic] does short term treatment have?"* (Moody, 2010; p. 85).

Discussion

This review aimed to address the question: 'What is the psychological impact of client suicide on MHPs?' A meta-ethnographic synthesis of 17 studies identified three key themes; 1) *distress,* which can be both intense and enduring; 2) *blame,* through being blamed and blaming oneself and others; and 3) *control,* which describes strategies used in an attempt to regain control of one's wellbeing.

Distress

This review found that MHPs experience layers of distressing emotions including sadness, fear, anger, grief, guilt and shock following a client suicide.

These findings have also been identified by previous reviews (Fang et al., 2007; Harris, 2007; Séguin et al., 2014; Young, 2012). This review also found that the intensity of distress can vary, depending on individual circumstances. A previous review by Séguin et al. (2014) supports the finding that greater levels of distress are experienced by MHPs who feel closer to their client, or receive less support from others. Furthermore, client suicide can lead to traumatic intrusive thoughts, disturbed sleep and impact personal relationships, as also identified by Young (2012).

A new finding from this review is that those with unresolved emotions from a previous or recent bereavement, and those who have known their client for longer, experience distress more intensely following a client suicide. This suggests that postvention support should be tailored to the individual needs of MHPs.

This review also raises awareness that distress following a client suicide can be experienced physically through fatigue, numbness, nausea, tearfulness, difficulties sleeping, and eating problems. Distress can also impact MHPs cognitively with experiences of confusion and poor concentration. The emotional, physical and cognitive impact of a client suicide combined can create an intensely distressing experience. It is therefore essential that MHPs are provided with the right support so that they can be effective in their roles.

Another new finding is that the distress experienced by MHPs can be long-lasting. This was primarily as a result of MHPs ruminating about their client and having experiences which reminded them of their client. Furthermore, the findings suggest that being isolated from other professionals can contribute to the long-lasting impact. This includes self-isolating due to a fear of being stigmatised

by others. Research has shown that perceived stigma is related to increased levels of psychological distress in those bereaved by the suicide of a relative or friend (Scocco, Preti, Totaro, Ferrari & Toffol, 2017). The findings of this review suggest that stigma may also be connected to distress in MHPs who experience a client suicide. This identifies a need to address stigma related to client suicide in mental health environments to reduce the risk of MHPs becoming isolated.

Blame

The finding that MHPs feel responsible for their clients' wellbeing and therefore experience self-blame, guilt and self-doubt following a client suicide is supported by previous reviews (Fang et al., 2007; Séguin et al., 2014; Young, 2012). In order to manage this self-blame, this review found that MHPs acknowledge their client's choice to end their life which corresponds with the findings of Young (2012). In terms of other-blame, the finding that MHPs perceive or fear others as blaming them is also supported by previous reviews (Fang et al., 2007; Séguin et al., 2014; Young, 2012).

New findings from this review suggest that MHPs are able to recognise their personal and professional limitations, including the difficulty in predicting suicide and accepting that they cannot help everyone. This highlights that a realistic appraisal of one's responsibility for a client's wellbeing may be helpful in managing self-blame. This review also found that MHPs seek reassurance from others to manage blame, however this was not always found to be helpful. Another new finding is that some MHPs blame others for their client's suicide, including the system they work in. Blaming others may have a detrimental impact on the relationships that MHPs have with other professionals in their team. This has the potential to further isolate professionals and limit their access to support.

Control

This theme describes how MHPs attempt to regain control of their personal and professional wellbeing. Some of these strategies have been reported in previous reviews. In terms of adaptive strategies, this review found that MHPs access various sources of support from their supervisor, colleagues, family, friends or therapist, which is also described by previous reviews (Fang et al., 2007; Harris, 2007; Séguin et al., 2014; Young, 2012). This review also found that MHPs regain a sense of control over their personal and professional wellbeing through closure. One way this can be achieved is through contact with the family of the deceased client, which was also found by Séguin et al. (2014). Another way is through personal growth, which is briefly mentioned by Young (2012). In accordance with past reviews (Fang et al., 2007; Gili et al., 2016; Harris, 2007; Séguin et al., 2014), this review found that MHPs can also engage in maladaptive strategies, such as becoming hypervigilant and over cautious. Furthermore, the findings describe avoidant strategies including leaving the profession, as identified by Young (2012).

This review identified additional strategies which have not been mentioned in previous reviews. Among the adaptive strategies, this review found that engaging in self-care, through relaxation, journaling or spiritual practices, can be a helpful way to manage the psychological impact of client suicide. Another helpful way to regain a sense of control is by engaging in postvention activities, such as supporting colleagues or family members of the deceased client, being involved in service improvements and educating others. These findings indicate a role for supervisors and managers of MHPs to encourage self-care after a client suicide and involve them in postvention activities.

Among the maladaptive strategies, this review found that some MHPs question whether suicide can be prevented. Instead of providing a sense of control, this leads MHPs to feel powerless and question the value of their profession. Responding in this way may have an adverse effect on the service that MHPs provide to other clients.

Overarching Issues

Across the three themes there are two overarching issues relating to the adverse psychological impact of client suicide. The first issue is that client suicide can have a damaging impact on MHPs' personal and professional wellbeing. Personally, client suicide can cause psychological distress which impacts MHPs emotionally, socially, cognitively and physically. Professionally, client suicide can impact MHPs' confidence in their professional abilities, leading them to blame others, become concerned about their reputation and job security and question the value of their profession. In addition to this, MHPs can become hypervigilant and over cautious when working with suicidal clients, or avoid working with them altogether to the extreme of leaving their profession.

The second issue is that this impact can be long-lasting. This review found that client suicide can continue to impact MHPs years later through rumination and reminders of their client. This review also highlights that recovery from the impact of client suicide can be hindered by a sense of isolation and a lack of support due to stigma and the assumption that MHPs are not impacted by client suicide.

Clinical Implications

This review highlights a need to ensure that the psychological impact of client suicide is not damaging or long-lasting for MHPs. These findings have two

main clinical implications for the development of postvention guidelines to support MHPs.

Firstly, to minimise the damaging impact, it is important for MHPs to be aware of how a client suicide can affect their wellbeing and how they can manage this. Having this awareness can facilitate MHPs to actively choose to engage in more adaptive strategies and recognise when their responses become maladaptive. This can be achieved in three ways. Firstly, reflective practice groups can provide a space for MHPs to share and normalise their experiences of client suicide and become more aware of the psychological impact it has on them (Horton-Deutsch & Sherwood, 2008; Thorndycraft & McCabe, 2008). Secondly, team formulation can provide a visual framework to understand how mental health teams collectively respond to client suicide in a non-blaming way (Johnstone & Dallos, 2013). Thirdly, clinical supervision has been found to reduce emotional exhaustion and negative attitudes towards service users in MHPs (Edwards et al., 2006). Supervision can also support MHPs to learn from their experience, address issues of professional confidence and reduce the possible negative impact on their treatment of other clients. Reflective practice, team formulation and clinical supervision are among the skill set of a Clinical Psychologist (Hurcom, Parnham, Horler, Horn & Davis, 2008; Onyett, 2007; Skinner at al., 2010). Clinical Psychologists often work as part of Mental Health Teams and are therefore well placed to facilitate this support. However, as this review has indicated, Clinical Psychologists can also be impacted by client suicide; therefore, it is important that providing support does not become the responsibility of one profession but of the whole team.

Secondly, early intervention is important to reduce the ongoing impact of client suicide. Critical incident stress management (CISM) is a model of intervention designed to support health professionals within 24 hours following an incident (Blacklock, 2012). This model can be adapted to take into consideration MHPs' past experiences in order to be more tailored to their needs.

Conclusion

Strengths and Limitations

This meta-ethnographic synthesis provides new interpretations which go beyond the description of findings in previous reviews and provides a more in-depth understanding of the psychological impact of client suicide on MHPs. The findings provide a conceptual framework which can be used to inform the development of postvention guidelines for MHPs. This review has generated new knowledge about the intensity and duration of distress following a client suicide, the tendency to blame others and develop fatalistic beliefs, as well as the adaptive strategies that MHPs can engage in to regain control over their wellbeing.

This review has three limitations. Firstly, although it covers a broad range of MHPs, there was not sufficient evidence to review how the psychological impact of client suicide differed for different groups of MHPs. Secondly, the reliability of the interpretations is limited. Whilst attempts were made to minimise reviewer bias by engaging in reflexivity and discussing the themes with the research team, only one reviewer was involved in reading the primary studies therefore the extent to which the interpretations were challenged by the research team was limited. Thirdly, more than half of the studies included in this review did not report the length of time since the participants experienced a client suicide. This meant that it was not possible to differentiate the short term from the

long term psychological impact of client suicide. Of the eight studies that did report the time since a client suicide, this ranged from 6 weeks to 30 years. The accuracy of memory recall is known to decrease with time, therefore this broad time frame limits the reliability of the findings from this review (Hassan, 2005; Thomsen & Brinkmann, 2009).

Future directions

A key finding of this review is that client suicide can have an enduring impact on MHPs. Further research is needed to understand the long term psychological impact on MHPs. Using a longitudinal mixed methods design, quantitative methods can be used to measure the change in variables of psychological impact over time, such as distress and self-blame, and qualitative methods can be used to develop an understanding of the nature and quality of these changes.

Whilst conducting the systematic search for this review, a range of qualitative studies on how trainee MHPs experience client suicide were found. This literature has not yet been reviewed therefore future reviews should focus on this population. This would provide an in-depth understanding of how qualified and non-qualified MHPs are impacted differently by client suicide.

References

Awenat, Y., Peters, S., Shaw-Nunez, E., Gooding, P., Pratt, D., & Haddock, G. (2017). Staff experiences and perceptions of working with in-patients who are suicidal: qualitative analysis. *The British Journal of Psychiatry, 211*(2), 103-108. doi:10.1192/bjp.bp.116.191817

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC Medical Research Methodology, 9*(59), 1-11. doi:10.1186/1471-2288-9-59

Blacklock, E. (2012). Interventions following a critical incident: developing a critical incident stress management team. *Archives of Psychiatric Nursing, 26*(1), 2-8. doi:10.1016/j.apnu.2011.04.006

Boeije, H. R., van Wesel, F., & Alisic, E. (2011). Making a difference: towards a method for weighing the evidence in a qualitative synthesis. *Journal of Evaluation in Clinical Practice, 17*(4), 657-663. doi:10.1111/j.1365-2753.2011.01674.x

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *Journal of Health Services Research & Policy, 7*(4), 209-215. doi:0.1258/135581902320432732

Caldwell, K., Henshaw, L., & Taylor, G. (2011). Developing a framework for critiquing health research: an early evaluation. *Nurse Education Today, 31*(8), e1-e7. doi:10.1016/j.nedt.2010.11.025

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C., & Donovan, J. (2011). Evaluating meta-

ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment. 15*(43), 1-164. doi:10.3310/hta15430

Campos, R. C., Holden, R. R., & Santos, S. (2018). Exposure to suicide in the family: suicide risk and psychache in individuals who have lost a family member by suicide. *Journal of Clinical Psychology, 74*(3), 407-417. doi:10.1002/jclp.22518

Cerel, J., Jones, B., Brown, M., Weisenhorn, D. A., & Patel, K. (2018). Suicide exposure in law enforcement officers. *Suicide and Life-Threatening Behavior*. Advance online publication. doi: 10.1111/sltb.12516.

Christianson, C. L., & Everall, R. D. (2009). Breaking the silence: school counsellors' experiences of client suicide. *British Journal of Guidance & Counselling, 37*(2), 157-168. doi:10.1080/03069880902728580

Darden, A. J., & Rutter, P. A. (2011). Psychologists' experiences of grief after client suicide: a qualitative study. *OMEGA-Journal of Death and Dying*, *63*(4), 317-342. doi:10.2190/OM.63.4.b

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., Bonas, S., Booth, A., & Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *Journal of Health Services Research & Policy*, *12(*1), 42-47. doi:10.1258/135581907779497486

Dransart, D. A. C., Heeb, J. L., Gulfi, A., & Gutjahr, E. M. (2015). Stress reactions after a patient suicide and their relations to the profile of mental health professionals. *BMC Psychiatry*, *15*(265), 1-9. doi:10.1186/s12888-015-0655-y

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil A., & Coyle, D. (2006). Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing, 15*(8), 1007-1015. doi:10.1111/j.1365-2702.2006.01370.x

Ellis, T. E., & Patel, A. B. (2012). Client suicide: what now? *Cognitive and Behavioral Practice, 19*(2), 277-287. doi: 10.1016/j.cbpra.2010.12.004

Fang, F., Kemp, J., Jawandha, A., Juros, J., Long, L., Nanayakkara, S., Stepansky, C., Thompson, L. B., & Anzia, J. (2007). Encountering patient suicide: a resident's experience. *Academic Psychiatry, 31*(5), 340-344. doi:10.1176/appi.ap.31.5.340

Finlayson, M., & Simmonds, J. (2019). Workplace responses and psychologists' needs following client suicide. *OMEGA-Journal of Death and Dying, 79*(1), 18-33. doi:10.1177/0030222817709693

Finlayson, M., & Simmonds, J. G. (2018). Impact of client suicide on psychologists in Australia. *Australian Psychologist, 53*(1), 23-32. doi:10.1111/ap.12240

France, E. F., Ring, N., Thomas, R., Noyes, J., Maxwell, M., & Jepson, R. (2014). A methodological systematic review of what's wrong with meta-ethnography reporting. *BMC Medical Research Methodology, 14*(199), 1-16. doi:10.1186/1471-2288-14-119

Harris, G. J. (2007). The Impact of patient/client death on mental healthcare professionals. (Unpublished doctoral dissertation). Coventry University. Coventry. England.

Hassan, E. (2005). Recall bias can be a threat to retrospective and prospective research designs. *The Internet Journal of Epidemiology, 3*(2), 339-412. Retrieved from http://ispub.com/IJE/3/2/13060

Hendin, H., Lipschitz, A., Maltsberger, J. T., Haas, A. P., & Wynecoop, S. (2000). Therapists' reactions to patients' suicides. *American Journal of Psychiatry, 157*(12), 2022-2027. doi:10.1176/appi.ajp.157.12.2022

Higgins, J. P., & Green, S. (Eds.). (2011). *Cochrane handbook for systematic reviews of interventions.* Version 5.1. The Cochrane Collaboration. Retrieved from http://handbook-5-1.cochrane.org/

Horton-Deutsch, S. A. R. A., & Sherwood, G. (2008). Reflection: an educational strategy to develop emotionally-competent nurse leaders. *Journal of Nursing Management, 16*(8), 946-954. doi: 10.1111/j.1365-2834.2008.00957.x

Hurcom, C., Parnham, L., Horler, M., Horn, N., & Davis, F. (2008). *Briefing paper: The role of psychologists working in crisis resolution home treatment (CRHT) Teams.* British Psychological Society, Leicester, UK. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Divisions/DCP/The%20role%20of%20psychologists%20in%20Crisis%20Resolution%20Home%20Treatment%20%28CRHT%29%20Teams.pdf

Jacobson, J. M., Ting, L., Sanders, S., & Harrington, D. (2004). Prevalence of and reactions to fatal and nonfatal client suicidal behavior: a national study of mental health social workers. *OMEGA-Journal of Death and Dying, 49*(3), 237-248. doi:10.2190/HPKQ-T700-EPQL-58JQ

Johnstone, L., & Dallos, R. (2014). *Formulation in psychology and psychotherapy: Making sense of people's problems.* New York, NY: Routledge.

Kimball, M. (2015). *Surviving the tsunami: The clinician's experience of client suicide*. (Unpublished doctoral dissertation). Michigan School of Professional Psychology, Michigan, United States of America.

Kimbrel, N. A., Pennington, M. L., Cammarata, C. M., Leto, F., Ostiguy, W. J., & Gulliver, S. B. (2016). Is cumulative exposure to suicide attempts and deaths a risk factor for suicidal behavior among firefighters? a preliminary study. *Suicide and Life-Threatening Behavior*, *46*(6), 669-677. doi:10.1111/sltb.12248

Kleespies, P. M., & Dettmer, E. L. (2000). The stress of patient emergencies for the clinician: incidence, impact, and means of coping. *Journal of Clinical Psychology*, *56*(10), 1353-1369. doi: 10.1002/1097-4679(200010)56:10<1353::AID-JCLP7>3.0.CO;2-3

Lachal, J., Revah-Levy, A., Orri, M., & Moro, M. R. (2017). Metasynthesis: An original method to synthesize qualitative literature in Psychiatry. *Frontiers in Psychiatry, 8(*269). 1-9 doi:10.3389/fpsyt.2017.00269

Landers, A., O'Brien, S., & Phelan, D. (2010). Impact of patient suicide on consultant psychiatrists in Ireland. *The Psychiatrist, 34*(4), 136-140. doi:10.1192/pb.bp.109.025312

Linke, S., Wojciak, J., & Day, S. (2002). The impact of suicide on community mental health teams: findings and recommendations. *Psychiatric Bulletin*, *26*(2), 50-52. doi:10.1192/pb.26.2.50

Maple, M., Cerel, J., Sanford, R., Pearce, T., & Jordan, J. (2017). Is exposure to suicide beyond kin associated with risk for suicidal behavior? A systematic review of the evidence. *Suicide and Life-Threatening Behavior, 47*(4), 461-474. doi:10.1111/sltb.12308

Maple, M., McKay, K., Hess, N. C., Wayland, S., & Pearce, T. (2019). Providing support following exposure to suicide: A mixed method study. *Health & Social Care in the Community. 27*(4), 965-972. doi:10.1111/hsc.12713

McAdams III, C. R., & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling, 22*(2) 107-121. Retrieved from https://search.proquest.com/docview/198716887/fulltextPDF/77FF3AA8FC9542CEPQ/1?accountid=10286

Mcadams III, C. R., & Foster, V. A. (2002). An assessment of resources for counselor coping and recovery in the aftermath of client suicide. *The Journal of Humanistic Counseling, Education and Development, 41*(2), 232-241. doi:10.1002/j.2164-490X.2002.tb00145.x

McHugh, M. L. (2012). Interrater reliability: the kappa statistic. *Biochemia Medica*, *22*(3), 276-282. doi:10.11613/BM.2012.031

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research, 14*(579), 1-10. doi:10.1186/s12913-014-0579-0

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: the

PRISMA statement. *PLoS Medicine, 6*(7), 1-6. doi:10.1371/journal.pmed.1000097

Moody, R. (2012). *The impact of client suicide on mental health professionals.* (Unpublished doctoral dissertation). Walden University, Minnesota, United States of America.

Morrissey, J., & Higgins, A. (2019). "Attenuating Anxieties": A grounded theory study of mental health nurses' responses to clients with suicidal behaviour. *Journal of Clinical Nursing*, *28*(5-6), 947-958. doi:10.1111/jocn.14717

Murphy, P. T., Clogher, L., van Laar, A., O'Regan, R., McManus, S., McIntyre, A., O'Connell, A., Geraghty, M., Henry, G. & Hallahan, B. (2019). The impact of service user's suicide on mental health professionals. *Irish Journal of Psychological Medicine,* Advance online publication. doi:10.1017/ipm.2019.4

National Institute for Health and Care Excellence (2018). *Preventing suicide in community and custodial settings: Postvention.* Guideline version (draft). Retrieved from https://www.nice.org.uk/guidance/ng105/documents/evidence-review-5

NHS England Patient Safety Domain (2015). *Serious incident framework. Supporting learning to prevent recurrence.* Retrieved from https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: synthesizing qualitative studies.* Newbury Park: Sage. doi:10.4135/9781412985000

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of Clinical Epidemiology, 97*, 49-58. doi: 10.1016/j.jclinepi.2017.06.020

Noyes, J., Popay, J., Pearson, A., Hannes, K., & Booth, A. (2008). *Qualitative research and Cochrane Reviews*. In: Higgins JPT, Green S, editors. Cochrane handbook for systematic reviews of interventions. The Cochrane Collaboration. Retrieved from https://s3.amazonaws.com/academia.edu.documents/37210401/0470699515.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1555965293&Signature=%2Bds%2FsCk%2F34TYmZvaoBMjGyydbjE%3D&response-content-disposition=inline%3B%20filename%3D20_Qualitative_research_and_Cochrane_rev.pdf#page=595

Oates, A. (2018). *Learning from suicide-related claims. A thematic review of NHS resolution data.* Retrieved from https://resolution.nhs.uk/resources/learning-from-suicide-related-claims/

Onyett, S. (2007). *New ways of working for applied psychologists in health and social care – working psychologically in teams.* British Psychological Society, Leicester, UK. Retrieved from http://www.wiltshirepsychology.co.uk/Working%20Psychologically%20in%20Teams.pdf

Overfelt, S. L. (2015). *The lived experience of mental health counsellors as suicide survivors: What supportive interventions were found to helpful?* (Unpublished doctoral dissertation). Capella University, Minnesota, United States of America.

Public Health England. (2016). *Support after a suicide: a guide to providing local services. A practical resource.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

Ring, N. A., Ritchie, K., Mandava, L., & Jepson, R. (2011). *A guide to synthesising qualitative research for researchers undertaking health technology assessments and systematic reviews.* Retrieved from https://dspace.stir.ac.uk/bitstream/1893/3205/1/HTA_MethodsofSynthesisingQualitativeLiterature_DEC10%5B1%5D.pdf

Rothes, I. A., Scheerder, G., Van Audenhove, C., & Henriques, M. R. (2013). Patient suicide: The experience of Flemish psychiatrists. *Suicide and Life-Threatening Behavior*, *43*(4), 379-394. doi:10.1111/sltb.12024

Sanders, S., Jacobson, J., & Ting, L. (2005). Reactions of mental health social workers following a client suicide completion: A qualitative investigation. *OMEGA-Journal of Death and Dying*, *51*(3), 197-216. doi:10.2190/D3KH-EBX6-Y70P-TUGN

Schutz, A. (1962). *Collected papers I: The problem of social reality*, ed. Maurice Natanson, The Hague: Martinus Nijhoff.

Scocco, P., Preti, A., Totaro, S., Ferrari, A., & Toffol, E. (2017). Stigma and psychological distress in suicide survivors. *Journal of Psychosomatic Research*, *94*, 39-46. doi:10.1016/j.jpsychores.2016.12.016

Séguin, M., Bordeleau, V., Drouin, M. S., Castelli-Dransart, D. A., & Giasson, F. (2014). Professionals' reactions following a patient's suicide: review and future investigation. *Archives of Suicide Research, 18*(4), 340-362. doi:10.1080/13811118.2013.833151

Silverthorn, B. C. (2005). *How client suicide impacts marriage and family therapists: Implications for coping and professional training*. (Unpublished doctoral dissertation). Michigan State University, Michigan, United States of America.

Skinner, P., Toogood, R., Cate, T., Jones, G., Prescott, T., Coak, A., & Rooney, N. (2010). Clinical Psychology leadership development framework. *Leicester, UK: British Psychological Society*.

Smith, M. J., Bouch, J., Bradstreet, S., Lakey, T., Nightingale, A., & O'Connor, R. C. (2015). Health services, suicide, and self-harm: patient distress and system anxiety. *The Lancet Psychiatry, 2*(3), 275-280. doi:10.1016/S2215-0366(15)00051-6

Stene-Larsen, K., & Reneflot, A. (2019). Contact with primary and mental health care prior to suicide: a systematic review of the literature from 2000 to 2017. *Scandinavian Journal of Public Health, 47*(1), 9-17. doi:10.1177/1403494817746274

Stern, C., Jordan, Z., & McArthur, A. (2014). Developing the review question and inclusion criteria. *The American Journal of Nursing, 114*(4), 53-56. doi:10.1097/01.NAJ.0000445689.67800.86

Takahashi, C., Chida, F., Nakamura, H., Akasaka, H., Yagi, J., Koeda, A., Takusari, E., & Sakai, A. (2011). The impact of inpatient suicide on

psychiatric nurses and their need for support. *BMC Psychiatry*, *11*(38), 1-8. doi:10.1186/1471-244X-11-38

Talseth, A. G., & Gilje, F. (2007). Unburdening suffering: responses of psychiatrists to patients' suicide deaths. *Nursing Ethics*, 14(5), 620-636. doi: 10.1177/0969733007080207

Thomsen, D. K., & Brinkmann, S. (2009). An interviewer's guide to autobiographical memory: Ways to elicit concrete experiences and to avoid pitfalls in interpreting them. *Qualitative Research in Psychology*, *6*(4), 294-312. doi:10.1080/14780880802396806

Thorndycraft, B., & Mccabe, J. (2008). The challenge of working with staff groups in the caring professions: The importance of the 'Team Development and Reflective Practice Group'. *British Journal of Psychotherapy*, *24*(2), 167-183. doi:10.1111/j.1752-0118.2008.00075.x

Tillman, J. G. (2006). When a patient commits suicide: An empirical study of psychoanalytic clinicians. *The International Journal of Psychoanalysis*, *87*(1), 159-177. doi:10.1516/6UBB-E9DE-8UCW-UV3L

Ting, L., Sanders, S., Jacobson, J. M., & Power, J. R. (2006). Dealing with the aftermath: A qualitative analysis of mental health social workers' reactions after a client suicide. *Social Work, 51*(4), 329-341. doi:10.1093/sw/51.4.329

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: challenges and insights for synthesising a large number of qualitative studies. *BMC Medical Research Methodology*, *14*(80) 1-14. doi:10.1186/1471-2288-14-80

Wilczynski, N. L., Marks, S., & Haynes, R. B. (2007). Search strategies for identifying qualitative studies in CINAHL. *Qualitative Health Research*, *17*(5), 705-710. doi 10.1177/1049732306294515

World Health Organization. (2014). *Preventing suicide: A global imperative.* Retrieved from http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf

World Health Organisation. (2018). *National suicide prevention strategies. Progress, examples and indicators.* Retrieved from https://apps.who.int/iris/bitstream/handle/10665/279765/9789241515016-eng.pdf?ua=1

Wurst, F. M., Kunz, I., Skipper, G., Wolfersdorf, M., Beine, K. H., Vogel, R., Müller, S., Petitjean, S., & Thon, N. (2013). How therapists react to patient's suicide: findings and consequences for health care professionals' wellbeing. *General Hospital Psychiatry*, *35*(5), 565-570. doi:10.1016/j.genhosppsych.2013.05.003

Young, H (2012). *Personal and professional reactions of mental health professionals to patient suicide: A systematic review of the literature*. (Unpublished doctoral dissertation). The University of Warwick, Coventry, England.

Chapter II: Empirical Research Paper

Young Men's Interpersonal Experiences Following a Suicide Attempt: An Interpretative Phenomenological Analysis

In preparation for submission to Suicide and Life-Threatening Behaviour
(See Appendix A for author instructions for submission)

Overall chapter word count (excluding abstract, tables, figures and references): 7890 (at submission)

Abstract

Objective: This research aims to explore young men's interpersonal experiences following a suicide attempt. Method: Four males, aged 27 to 34 years, were recruited from Community Mental Health Teams. One-to-one interviews were conducted using a semi-structured interview guide to gather detailed accounts of participants' experiences. Results: Interpretative Phenomenological Analysis revealed three themes; *sense of self*, which describes a loss of identity and a process of understanding and accepting oneself as a person with mental health difficulties; *fear of self,* which relates to a fear of reattempting and being stigmatised; *and reconnecting with oneself*, which involves a process of re-engaging with life and self-development. Conclusions: The findings are discussed in the context of the current literature and the Interpersonal Psychological Theory of Suicide. Clinical implications and research limitations are also discussed with recommendations for future research.

Word count: 136

Key words: Suicide, Male Mental Health, Interpretative Phenomenological Analysis, Postvention

Introduction

This research explores the interpersonal experiences of young men following a suicide attempt. Young men are defined here as adults between the ages of 20 and 40 years (Colarusso, 1992). A suicide attempt is a non-fatal self-injurious act with an intention to die (Hamza, Stewart & Willoughby, 2012). This research focuses on interpersonal experiences, which, according to the Interpersonal Psychological Theory of Suicide (IPTS), includes a sense of belonging and perceived burdensomeness (Van Orden et al., 2010).

Suicide is the leading cause of death in young men aged 20 to 34 years (Office for National Statistics, 2017) and is therefore a global public health concern (Naghavi, 2019). Compared to women, men are three times more likely to die by suicide (Office for National Statistics, 2017). Research suggests that this gender difference is due to men having a greater acquired capability for suicide through increased pain tolerance and fearlessness of death (Deshpande, Baxi, Witte & Robinson, 2016; Granato, Smith & Selwyn, 2015; Wolford-Clevneger et al., 2015). According to the IPTS, acquired capability for suicide increases the risk of a lethal suicide attempt (Van Orden et al., 2010).

A group of men who are at particularly high risk of suicide are those who have previously attempted suicide (Christiansen & Jensen, 2007; Nordström, Samuelsson & Åsberg, 1995). Almost half of young men who have attempted suicide re-attempt within seven years, of whom 12% die (Cleary, 2017). The World Health Organisation recognises the importance of providing support to those who have attempted suicide as a key part of suicide prevention (WHO, 2014). Guidance on developing a national suicide prevention strategy recommends specific interventions focusing on populations at greater risk of

suicide (WHO, 2018). Research with male suicide attempt survivors is therefore vital (Barroso Martínez, 2018; NICE, 2018; O'Connor & Portzky, 2018; Struszczyk, Galdas & Tiffin, 2019).

Previous literature

In 2017, Meissner and Bantjes explored the experiences of young South African men who had attempted suicide. Four students aged between 21 and 25 were interviewed. Through Interpretative Phenomenological Analysis (IPA) two themes emerged; '*turning away from others and self*' which described experiences before attempting suicide; and '*returning to the self and others*' which referred to experiences after attempting suicide. This related to having another chance at living and re-connecting with others, having courage to be themselves and talking as an alternative to suicidal behaviour.

Another study explored young men's access to mental health services and the factors that helped them maintain a desire to stay alive (Jordan, McKenna & Keeney, 2012). Thirty-six men from Northern Ireland, who had been actively suicidal at some point in their life, were interviewed using a grounded theory approach. The findings highlight barriers to accessing and engaging in services and the need for a variety of services that address issues of stigma. Participants described how their perceptions of what it means to be a successful man had an adverse impact on their self-esteem, distress and suicide risk, however, talking to others with similar experiences challenged their perception of masculinity and provided hope for the future. Participants also acquired new meaning in life and an appreciation that recovery can be long and challenging.

Biong and Ravndal (2007) explored the lived experience of suicidal behaviour in young Norwegian men suffering from long term substance abuse.

Four men aged 32 to 40 were interviewed one month to four years after attempting suicide. This research used a phenomenological hermeneutic approach and described an overarching theme of '*between death as an escape from pain and the hope of a life'*. The findings describe young men's experiences in terms of their relationships to themselves and others and reflecting on their existence.

In a study by Reading and Bowen (2014) eight male prisoners were interviewed about their perceptions, beliefs and abilities supporting their recovery from suicidality. Participants were aged 30 to 58 with experiences of suicidality from suicidal thoughts to attempts. Thematic analysis identified five themes; 1) '*sense of self'*, which related to understanding and accepting oneself and developing self-efficacy; 2) '*presence of meaning'*, which described a sense of fulfilment through employment, goal-setting and being a father; 3) '*connectedness*', which included support systems, spiritual connections, shared experience with others and feeling wanted; 4) '*shift of perspective'*, which involved seeing the bigger picture, appreciation of life and present focus; and 5) '*re-establishing control'*, which described thoughts which interrupted suicidal thoughts, emotion regulation and keeping busy.

Biong and Ravndal (2009) examined young men's experiences of suicidal behaviour, among other experiences of emigration and substance abuse. Four young men aged 30 to 40 were interviewed between one to four years following a suicide attempt. Participants described a turning point which involved reflecting on one's relationship to their family and society, the consequences of their suicide attempt, and how this led them to actively choose to seek help.

As part of a longitudinal study, Cleary (2017) explored young men's attitudes to treatment after attempting suicide. Four men aged 18 to 30 were

interviewed six to eight and a half years following a suicide attempt. Whilst one participant only attended out-patient treatment for a short time, the other three were in regular contact with services and perceived services to have met their needs.

Rationale and Aim

Previous studies on the experiences of young men who have attempted suicide are limited in three ways. Firstly, most studies focus on the experiences of young men before they attempted suicide, therefore there is a limited understanding of how young men experience life after a suicide attempt. Secondly, previous research has focused on specific groups of young men including students, those with an experience of substance abuse, immigrants and prisoners. This limits the applicability of the findings. Thirdly, two of these five studies focus on what supports young men to recover from suicidality (Jordan et al., 2012; Reading & Bowen, 2014), therefore providing a limited insight into the difficulties encountered following a suicide attempt.

This research aims to explore the lived experiences of young men following a suicide attempt. It is hoped that an in depth understanding can inform guidelines of how to support young men following a suicide attempt, reduce the risk of repeated attempts and improve their quality of life. The research question is: what are young men's interpersonal experiences following a suicide attempt?

Methods

Research Design

This research takes an interpretivist epistemological position which assumes that reality is constructed by those who experience it (Scotland, 2012). Previous research using a grounded theory approach has provided a theoretical

understanding of recovery experiences following a suicide attempt (Chi et al., 2013; Crona, Stenmarker, Öjehagen, Hallberg, & Brådvik, 2017). This study aims to explore the phenomenon of interpersonal experiences following a suicide attempt from the perspective of young men. IPA is therefore the most appropriate research design (Smith, Flowers & Larkin, 2009).

Participants

As required for IPA, a non-probability sampling design was used to purposively recruit a sample of young men who have attempted suicide (Pietkiewicz & Smith, 2014; Smith et al., 2009). Inclusion and exclusion criteria (Appendix H) were used to recruit a homogenous sample. Participants were included if they were male and aged between 20 and 40 years. Including service users of a Community Mental Health Team (CMHT) meant that they had access to mental health professionals should this be required during or following the research. Those currently receiving acute inpatient mental health treatment were excluded.

Participants must have attempted suicide within six to 36 months of the interview via any means available and with the intention to die. A minimum of six months since a suicide attempt was judged to be a sufficient period of time for participants to reflect on their experiences following this. Since memory recall can decrease in accuracy over time (Hassan, 2005; Thomsen & Brinkmann, 2009), a maximum time of three years since the attempt was deemed to be close enough for participants to remember their experiences in the early stages following their suicide attempt.

Those with active plans to end their life with the intent to act on them were excluded from participating in this research. Participants were also required

to understand and communicate in English and have the capacity to consent to take part in the research.

Recruitment

This research aimed to recruit a sample of at least six participants to allow for an in-depth understanding of each participant's experience (Reid, Flowers & Larkin, 2005; Smith et al., 2009). However, there are multiple barriers to young men seeking help for mental health difficulties (Lynch, Long & Moorhead, 2018) making this a difficult group to access. Between September 2018 and March 2019, four young men were recruited through NHS CMHTs within the Midlands area, UK. Whilst other sites for recruitment, such as charities and the private sector, were considered, the decision was made to recruit through the NHS to ensure that participants were able to access support from their local mental health crisis team if required.

Significant effort was made to recruit this difficult to access population. Firstly the researcher contacted the managers of four CMHTs and asked to attend their weekly clinical team meeting, of which three agreed. At these meetings, the researcher informed clinicians about the aim of the research and the inclusion and exclusion criteria. Information was also disseminated to team members that were not present. These methods of recruitment were repeated at least twice. Furthermore, the Lead Psychologist distributed an email to the Psychologists in the teams inviting them to identify any service users who may be eligible for this research.

Adverts (Appendix I) and Participant Information Sheets (Appendix J) were distributed to clinicians in person and via email. The advert contained key information about the research and an expression of interest form. Clinicians were

provided with pre-paid envelopes to make it easier for service users to express their interest in the research by post. An email address was also provided to allow potential participants to raise any questions that they may have or to express their interest in participating.

It is known that nine service users were approached by clinicians and provided with an advert and information sheet. The researcher received four expressions of interest forms. Contact was made with these four participants via telephone to check that they met the eligibility criteria and to arrange an interview. Participants were then emailed the details of the date, time and place of the interview along with a Participant Information Sheet to read prior to this. The four participants were aged 27 to 34 years (mean=31.5) and the time since their last suicide attempt ranged from eight months to three years.

Materials

An interview guide (Appendix K) was used to structure the interview. This was designed in a semi-structured open way to ensure that participants' experiences, along with the meanings associated with these, were captured. The interview guide contained open questions which were loosely framed around the four key constructs of the IPTS: thwarted belonging; perceived burdensomeness; acquired capability; and hopelessness (Van Orden et al., 2010). The interview guide was developed in consultation with the research team and two experts by experience.

During the interview, the researcher created a timeline of the participant's experiences (Appendix L). This was placed on a table in between the researcher and the participant aiming to provide a visual aid to support recall and clarify whether their experiences occurred before or after their suicide attempt. This

method has previously been used in research into the experience of attempting suicide and been found to support the collection of comprehensive data, to help build rapport and reduce power differentials between participant and researcher (Rimkeviciene, O'Gorman, Hawgood & De Leo, 2016).

Data Collection

One-to-one interviews were conducted with each participant and audio recorded using a Dictaphone. Conducting the interviews in person allowed for the use of a visual timeline. The duration of the interviews ranged from 43 – 105 minutes (mean= 82 minutes).

In an effort to assist participants to feel safe and comfortable in sharing their experiences, interviews were conducted at the premises of their respective CMHT. Prior to the onset of the interview the information on the Participant Information Sheet was reiterated. Furthermore, participants were informed that the clinician who provided them with information about the research was not involved in the research and that their participation would not have any effect on their mental health treatment.

Ethical Considerations

Ethical approval was granted by the Health Research Authority (Appendix M), NHS Research Ethics Committee (Appendix N), the NHS Trust Research and Innovation team (Appendix O) and Coventry University Ethics Committee (Appendix P).

Participants were provided with an information sheet and were given the opportunity to ask any questions before providing written consent (Appendix Q). Participants were informed that they had up to two weeks following the interview to withdraw from the research. Upon completion of the interview, participants

had the opportunity to voice any concerns, reflect on how they were feeling and discuss their immediate plans following the interview. Participants received a debrief sheet (Appendix R) which provided contact details of their duty team, crisis team and other mental health services. Each participant's lead clinician was informed of their participation in the research and provided with a copy of their completed consent form for their records. Following each interview, the researcher maintained their own wellbeing by contacting the research team to discuss any concerns and reflect on their experience of the interview.

All data was processed in accordance with the General Data Protection Regulation (Information Commissioner's Officer, 2018). Completed consent forms and expression of interest forms containing identifiable information were stored in a locked cabinet in an NHS building. Audio recordings were removed from the Dictaphone and stored on a secure OneDrive only accessible by the researcher. Audio recordings were transcribed into a password protected word document and anonymised by allocating a pseudonym and removing any identifiable information.

A safeguarding concern arose during one interview. With the participant's consent, the relevant information was passed onto the participant's clinician who completed a safeguarding referral. One participant described ongoing suicidal thoughts. Upon asking additional questions to assess the risk of suicide the participant reported that they did not have any active plans or intention to end their life. The researcher discussed their risk assessment with the clinical supervisor following the interview. From this discussion it was decided that it was not appropriate to break the participant's confidentiality since they were not at risk of immediate harm. Instead, the referring clinician was informed that their

patient had participated in the research and were advised to follow up with them. As with all participants, the researcher also emphasised the information on the Debrief Sheet (Appendix R) about services that they could contact for support. This included their local CMHT duty worker and out of hours crisis team, as well as third sector organisations including the Samaritans, Mental Health Matters and Campaign Against Living Miserably.

Analysis

IPA was employed to analyse the data from the interview transcripts. This method takes a phenomenological approach, which involves the identification of unique aspects of the experience emerging from the participant's perspective; a hermeneutic approach, which involves developing an understanding of this experience through the researcher's interpretation; and an ideographic approach, which involves searching for individual participant's experiences which may or may not overlap with other participants' experiences (Peitkiewicz & Smith, 2014). The six stages of IPA were followed (Smith, et al., 2009).

Stage 1: the researcher listened to each interview audio recording and transcribed them verbatim into a password protected word document. The researcher read each transcript multiple times to immerse themselves in the data. At this stage initial observations and interpretations were noted down in the researcher's journal.

Stage 2: the researcher recorded exploratory comments in three ways; *descriptive comments,* describing the content; *linguistic comments*, exploring the language used; and *conceptual comments*, reflecting the researcher interpretations (see Appendix S for an example).

Stage 3: emergent themes were developed from the exploratory comments whilst remaining grounded in the participants' responses.

Stage 4: these emergent themes were written onto pieces of paper and organised based on their similarities (see Appendix T for an example).

Stage 5: this process was repeated with the remaining transcripts.

Stage 6: the researcher examined how the themes for each transcript were connected and then organised superordinate themes and subordinate themes in consultation with the research team.

Validity

Attempts were made to ensure the validity of the findings. Firstly, a section of a transcript was coded by the clinical supervisor and compared to the researcher's codes. Secondly, participants, as agreed post interview, were invited to voluntarily provide feedback on whether the themes and interpretations reflect their experiences, however, none responded.

Reflexivity

The researcher was a 28 year old female Trainee Clinical Psychologist. Whilst the researcher did not have a personal experience of attempting suicide, they had experiences of others in their personal and professional life who had, and a personal experience of having a family friend complete suicide. A bracketing interview was conducted prior to data collection to identify the researcher's values, assumptions and beliefs in relation to suicide (Tufford & Newman, 2012). The researcher's beliefs included that suicide attempts can impact relationships and employment. The researcher was particularly sensitive to using the word 'failed' to describe the suicide attempt due to believing that participants may view themselves as a failure. The researcher was also interested

in post-traumatic growth following a suicide attempt. By explicitly identifying these pre-existing beliefs, the researcher was mindful of their potential influence and bias on the data collection and analysis.

Results

This study explored young men's interpersonal experiences following a suicide attempt. Three key themes emerged from the findings; 1) sense of self, which describes the experience of losing one's identity and then coming to understand and accept oneself as a person with mental health difficulties; 2) fear of self, which relates to a fear of reattempting suicide and a stigma driven fear of being judged; 3) reconnecting with oneself, which involves re-engaging with life and engaging in self-development. These themes are presented with their sub-themes in Table 1.

Table 1.

Themes and sub-themes

Themes	Sub-themes
Sense of self	Loss of identity (A sense of losing one's personal characteristics, a metaphysical sense of self and role in one's family can have a significant emotional impact).
	Understanding and accepting (A process of being understood and accepted by oneself and others as a person who has mental health difficulties and needs help from others).
Fear of self	Fear of reattempting (An awareness of one's capability to attempt suicide and a fear of relapsing to the point of reattempting)
	Stigma (There is a fear of being judged, a sense of shame about needing help and a belief that others lack understanding).
Reconnecting with oneself	Forced forward (Participants felt forced to accept help from others and were forced by themselves and others to reengage in life).
	Self-development (Through developing an awareness of one's thoughts and emotions, participants felt more in control of their actions and had a sense of hope for their future).

Sense of Self

This theme describes participants' experience of making sense of who they are following a suicide attempt. This involves a loss of identity and a process of being accepted and understood as a person who has mental health difficulties.

Loss of Identity

Before attempting suicide, all participants experienced loss in their lives, such as a loss of their job, home or significant relationships with others. After attempting suicide, their experience of loss was characterised by a loss of identity. This experience has three parts. Firstly, participants noted a loss of personal qualities.

> *"… I was quite mentally strong but I was you know, I was confident, I was outgoing, kind of care free, so when you go from that to attempting suicide, it's a big contrast between the two …"* (William, p. 11, lines 228 - 229)

> *"… I have become a different person (…) I find socially, I don't feel I've got the skills anymore …"* (John, p. 1, lines 5 - 6)

> *"… I don't feel I'm the person you know my partner met, all them years ago …"* (David, p. 1, lines 10 - 11)

Secondly, loss of identity was described in terms of an existential, metaphysical sense of self.

"… like a ghost almost (…) it's like my body is here but I'm not mentally fully here, it's like I should be dead (…) I feel dead inside, that's what I'm saying, I don't feel anything, (…) I feel like my soul has been ripped out and I'm just a human shell, that's a big statement and that is scary for me, (…) I don't know if I'm going to get that back …" (John, p. 18 - 19, lines 319 - 347)

"Some days, I could just cry because (…) I feel a part of me has died and it's never coming back …" (David, p. 3, lines 50 -51)

Thirdly, participants talked about a loss of a role within their family.

"… I'm letting down my partner and the kids, it makes me feel that I, part of me (…) is gone and will never return, and that's difficult to process …" (David, p. 1, lines 9 - 10)

"… I'm not a father in her life (…) I don't see my parents so I'm not a good son, don't see my grandparents so I'm not a good grandson …" (John, p. 14, lines 245 – 246)

"… worthless, (…) like I'd failed my kids …" (William, p. 6, line 105)

Understanding and Accepting

Participants described a process of understanding and accepting themselves and others with mental health difficulties. This is broken down into

three experiences. Firstly, participants developed an understanding of themselves through reflecting on their experiences. In the interviews, all participants talked about their childhood experiences.

> *"Well if I put it down to anything, I'd put it down to my, well you know, growing up …"* (Robert, p. 6, line 122)

> *"… I keep looking back at what's happened to make me the person I am …"* (John, p. 4, line 64)

A common reflection was that an understanding of mental health difficulties comes with experience.

> *"… I didn't know a lot about mental health (…) before I was one of these people who said 'you know you just need to cheer up, get yourself out, make yourself happy', now it's, I see it differently …"* (William, p. 16, line 359 - 362)

Reflecting on one's experience helped participants to not only understand themselves better, but to understand others with mental health difficulties too.

> *"… I now have a better understanding of mental illness through all the therapies and … you know medications and things … I can understand people's problems a lot better, maybe it's something you can't understand until you suffer from it yourself …"* (David, p. 12, lines 283 - 285)

Secondly, participants acknowledged and accepted that they need help from others in order to not relapse.

> *"… I'd been given a chance in life because it [suicide attempt] didn't work. And that chance I've had to take and that's why I'm here [mental health service]"* (Robert, p. 12, line 240 - 241)

> *"… acceptance that you are ill, you do need, well I'm on a lot of medication, (…) I'll be on it for probably life but what's the alternative? To go back to where I was? I can't do that."* (David, p. 10 – 11, lines 252 - 254)

Accepting help from others provided a sense of relief and safety.

> *"It was like a weight had been lifted …" (William, p. 13, line 292)*

> *"… relief (…) as crazy as it sounds you feel safe in there [inpatient mental health service] (…) you are put in kind of cotton wool and they give great care in there …"* (David, p. 10, lines 232 - 233)

However, this also came with a sense of vulnerability.

> *"… I guess you feel vulnerable you know, and that's hard to, that's hard to, that's hard to accept in itself …" (David, p. 12, lines 289 - 290)*

Thirdly, participants wanted to be understood and accepted by others.

> *"… I didn't expect sympathy I just wanted people to understand that I was, you know, I'm not always going to be in the best mood…" (William, p. 12, line 254)*

Some found that others accepted and understood them.

> *"… they've been great as well the schools … I was open with them … told them everything (…) they set up a support network…" (David, p. 11, lines 264 - 265)*

> *"… there's always someone out there who will listen and understand, it's just finding them"* (William, p. 12, line 272)

Talking to others who also experience mental health difficulties gave participants a sense of feeling understood and accepted.

> "*What I find helpful is talking to people who are suffering from similar problems"* (David, p. 10, line 238)

> *"… the only one that understands out of my family is my sister, she's been through like depression and stuff like that …"* (William, p. 10, line 210 - 211)

Fear of Self

This theme describes participants' fear about who they are as a person who has attempted suicide. This relates to two key issues, a fear of relapsing to the point of reattempting suicide and a stigma driven fear of being judged by others.

Fear of Reattempting

All participants reported a fear that they might reattempt suicide in the future. This was experienced in three ways. Firstly, participants reflected on their capability to attempt suicide.

> *"… I never saw myself as a person who would try and kill themselves and (…) it still shocks me that I've been down that road …*" (David, p. 4, lines 86 - 87)

> *"I never thought I would actually go through with it …"* (Robert, p. 5, line 98)

> *"Subconsciously, that's the worrying thing you know, it's not like I reached a decision that's it I'm going to do it, but all of a sudden I had all of these drugs in my house (…) like I'd not been taking it for this precise purpose …"* (John, p. 6, lines 106 – 108)

Having previously attempted suicide, participants sensed a risk of reattempting in the future.

"... If I do have a bad time or a bad night the same can happen again ..." (Robert, p. 10, lines 193 - 194)

"... I think because I've opened that door a couple of times, (...) that door will be ajar forever I think, as an option to escape." (David, p. 5, lines 106 - 107)

"... I probably will attempt to commit suicide again, I'm not saying I'm going to go home and do it now, but if you can do something once you can do it again, let's face it." (John, p. 14, lines 242 - 243)

Secondly, participants experienced their mental health as fragile.

"... the slightest bit of stress at the moment can set me on a down ..." (William, p. 14, line 318 - 319)

"... as soon as I have a positive thought, boom, boom, down, gone, gone, gone, gone, and that is difficult to live just normal day to day ..." (John, p. 23, lines 418 - 419)

"...when I dip into a not okay day its then a slow process to get back into an okay day, you know, sort of you fall off the hill but then you try and make your way back up again ..." (David, p. 1, lines 3 - 4)

This created a fear of relapsing to the point of reattempting suicide.

"... swings and roundabouts, I want to work, but I know for example if I put myself under any stress I'm just going to... I want to get myself stable first ..." (William, p. 17, lines 387 - 388)

"... I was scared that if I went home I would do it again and this time I would make sure it was final ..." (John, p. 3, lines 49 - 50)

"Doing it again probably, it's probably the only fear." (Robert, p. 10, line 208)

Thirdly, participants used strategies to manage the risk of reattempting suicide. All participants talked about pacing themselves.

"... I just take every day as it comes." (Robert, p. 2, line 26)

"... I suppose it's just baby steps, you got to make these small changes ..." (John, p. 23, line 417)

"... step forward and two steps back, that's a regular pattern, but the trick is not to go 3 or 4 or 5 steps back and to notice if you are slipping back that far." (David, p. 13, lines 314 - 315)

Some participants avoided talking or thinking about their experience of attempting suicide.

"... it's not something I want, I think about that often, try not to because, I don't want to kind of put myself back in that mind frame again ..."
(William, p. 14, lines 306 - 307)

"...just one of those things that, that I've erased from my memory very, very quickly and digging it back up is something that's not very, it's not something I'd like to be doing, it's shit." (Robert, p. 11, line 226 - 227)

Powerful memories of how others reacted to their suicide attempt were an important factor in the prevention of future suicide attempts.

"... seeing people's reactions after it's (...) a picture that sticks in your head and, in a way, it's a good thing because (...) if you can get back to that when you think of it, it takes you away from it." (William, p. 13, lines 280 - 281)

However, those who did not experience strong reactions from others continued to contemplate suicide.

"...you don't even get one person that knows you say, 'I know you are going through some shit right now, I want you to know I've always loved you, I've got your back' no one says that, so what's the fucking point ..."
(John, p. 24, lines 442 – 444)

Stigma

Participants felt stigmatised following their suicide attempt. This was experienced in three ways. Firstly, participants described a fear of being judged by others.

> *"... word gets around you know once you hear someone goes into mental illness hospital people think looney, lost it."* (David, p. 11, line 277)

Participants referred to a stereotypical view of masculinity, and feared that they could not meet these expectations.

> *"... I'm not who she probably expects me to be (...) strong, (...) leading the way, you know, head of the family, being able to cope with things, but it's just things I can't cope with anymore, at the moment anyway (...), I think she feels she's got to be the (...) man of the house ..."* (David, pp. 14 – 15, lines 351 - 354)

> *"... I don't feel like a man, I feel like a failure as a father ..."* (John, p. 24, lines 434 - 435)

Secondly, there was a sense of shame about needing and accepting help from others.

> *"... I was embarrassed to ask for help or I was embarrassed to admit that I was at that point where I needed it."* (William, p. 11, lines 238 - 239)

"It makes me feel, again, weak, inadequate. Even though they are offering help, I find it hard to accept help (…) I shouldn't be needing, maybe I don't deserve help …" (David, p. 3, lines 47 - 48)

The thought of receiving help from others came with a sense of being a burden.

"… I don't feel that people should have to listen, sit and listen to my shit …" (Robert, p. 13, line 259)

"…they don't need me interfering with their lives …" (John, p. 18, line 314)

"… I wouldn't want to unload on my wife constantly because she's been through a lot and she's been thought a lot through me and I don't want to put more on her plate …" (David, p. 13, lines 309 - 310)

Thirdly, participants did not believe that others could understand their experience of mental health difficulties.

"*… I sit and talk to somebody random that knows nothing, doesn't know how it feels, I mean you can't tell somebody that, you can't give them that emotion (…) what's in the heart is a hell of a lot different …"* (Robert, p. 13, lines 260 - 265)

"... I have these social workers they come around sometimes, but they always want to project on you an image that they have on the world, so they say 'let's go out, let's go out, you know, it's a beautiful day, it's a beautiful day' and they tell you 'life's ok, life's going to get better' and all this and you just think you're talking so much rubbish you have no idea because I can guarantee that half of the stuff I've gone through they haven't even experienced..." (John, p. 13, lines 236 - 239)

"... it just sounds like it's a joke to them, you know it just sounds like you're in a bad mood ..." (William, p. 10, lines 214 - 215)

Participants experienced others as avoidant when they learnt about their suicide attempt.

"... just said, 'you need to get help' and that was it, there was no more heard about it, no one spoke about it." (Robert, p. 8, line 157)

"... supposedly friends, people I knew or know, they don't talk to me properly anymore, kind of, they don't know what how to approach me, because they know what's happened (...) it's just kind of a hello and that's it ... no kind of dialogue really ..." (David, p. 11 – 12, lines 276 – 280).

"If somebody turns around to you and goes 'how you doing?' And you turn around and go 'well actually I'm thinking about suicide', they go,'

woooahh back off', and these are people that you've known for 15 years of your life …" (John, p. 1, line 10 – 11)

Participants also avoided others.

"… I kind of shut myself off again from people because I was sick of hearing 'you just need to cheer up, you need to chill out, you'll get over it you know you just need to get over it' and when you're feeling like that it's one of the worst things you could possibly hear off somebody …" (William, p. 10, lines 213 - 214)

"… if you begin to tell people that they begin to judge you, so don't tell people, or don't see people …" (John, p. 1, line 6 - 7)

Reconnecting with Oneself

This theme describes participants' experience of re-engaging with life and developing an awareness of themselves. Participants reflected a sense of reconnecting with themselves through being forced to reengage with life and through a process of self-development.

Forced Forward

Most participants described a lack of motivation and a need to be forced to reengage with life. This was experienced in three ways. Firstly, the act of attempting suicide forced participants to accept help from others.

> *"I think that was a turning point, that was when people kind of knew, they realised I wasn't going to ask, get the help, they needed to kind of step in, and so that was when the help was kind of forced on me, so it was a blessing in disguise* (…). *I've always been really independent since I was young, so it was understandable people didn't step in until that and you know it was kind of it was forced on them, like it was forced on me"* (William, p. 13, lines 287 - 296)

Secondly, participants forced themselves to reengage with life.

> *"… anxiety course coming up (…) I'm anxious about it, but I think it will, it will probably do me good to go (…) I will force myself to go."* (David, p. 13, lines 321 - 322)

Thirdly, participants were also forced by others to reengage with life.

> "*… I've got a dog, to force me to go out, because if I didn't have a dog I would not leave the house …"* (John, p. 23, line 415)

> *"When I play football on a Sunday, they [friends] kind of come down and kind of force me out"* (William, p. 2, line 30)

Significant others were a particularly important source of motivation.

"... I've got a picture of my kids everywhere in my flat every room I go into that helps, I done that for mental health, so, yeah I've always got a reminder of, there is, there are people who depend on me as well." (William, p. 13, lines 285 - 286)

Self-development

Participants described an experience of "soul searching" and developing a sense of self-awareness. This was described in three ways. Firstly, participants developed a greater awareness of their thought processes.

"... I don't look at the bigger picture. (...) I've kind of gone from one end to the other, not caring to caring too much about everything ...' (William, p. 15, lines 328 - 331)

'... I constantly battle with an inner critical voice which criticises everything I do." (David, p. 1, line 15)

Secondly, participants became more aware of their emotional experience.

"To recognise when I'm, slipping down, (...) I'm more aware now of how I'm feeling, how yesterday wasn't a great day, today seems okay so I'm aware of what's going on" (David, p. 10, lines 251 - 252)

Connecting with their emotional experience, participants developed an appreciation of others in their life.

*"... I'm lucky to have, to be able to have children because some people can't have children, lucky to be in a relationship ..." (*David, p. 12, line 301*)*

*"If it weren't for them, I don't know where I'd be ..." (*Robert, p. 1, line 18 - 19)

Thirdly, through this self-awareness participants developed a sense of control over their reactions.

"... I'm probably in more control than I was this time last year ..." (David, p. 5, lines 113 - 114)

*"... I've just grown up a bit I think, I don't go in all guns blazing anymore, I think I sit back a little bit more than I used to ..." (*Robert, p. 9, line 176)

This provided a sense of hope for their future.

"... I'm not saying my mental health has ... dramatically improved as such but it's the outlook and the fact that (...) it is going to get better at some point ..." (William, p. 11, lines 233 - 234)

> *"… you'll never be that person who your partner met all them years ago. But maybe that's a good thing. I don't know, time will tell."* (David, p. 11, lines 273 - 274)

Discussion

This study aimed to explore young men's interpersonal experiences following a suicide attempt. Using an IPA approach, interviews with four young men revealed three main themes; 1) sense of self, which involves a loss of identity and the acceptance and understanding of oneself as a person with mental health difficulties; 2) fear of self, which relates to a fear of reattempting and being stigmatised; and 3) reconnecting with oneself, which describes a process of re-engaging with life and self-development.

Sense of Self

This theme corresponds with findings from previous research (Reading & Bowen, 2014). In this study young men reflected on traumatic childhood experiences in order to make sense of who they are. This is consistent with the findings of Biong and Ravndal (2007) and is supported by research showing an association between traumatic childhood experiences and suicide attempts in young men (Mandelli, Carli, Roy, Serretti & Sarchiapone, 2011). Previous research also supports the finding that young men go through a process of understanding and accepting themselves (Reading & Bowen, 2014) and accepting that they need help from others (Meissner & Bantjes, 2017). The finding that young men find it helpful to talk to others with similar experiences is also indicated by previous research (Reading & Bowen 2014; Jordan et al., 2012).

A unique finding from this study is that young men experience a loss of identity after attempting suicide. There are three parts to this. Firstly, a loss of personal qualities leaves young men feeling as though they are a "different person" demonstrating how a suicide attempt can change one's sense of self. Secondly, there is an existential, metaphysical loss of their "soul" in the sense that part of them "has died" emphasising the intensity of losing one's identity. Thirdly, there is a loss of a role within their family, such as being a father or a partner. This emphasises the importance of having a role in one's family to their sense of self. This is supported by a sociological autopsy of suicide which found that male suicide is often triggered by a relationship breakdown involving a separation from children (Shiner, Scourfield, Fincham & Langer, 2009). Reading and Bowen (2014) highlight how a father role provides a sense of purpose and meaning in young men's lives.

The concept of identity has only been mentioned in previous research in terms of young men developing a new identity following a suicide attempt (Meissner & Bantjes, 2017). This raises the question of; how do young men go from losing their identity to re-establishing their identity?

Fear of Self

This theme is partly reflected in the existing literature. The findings of this research suggest that suicide stigma is complicated by stereotypes of masculinity, deeming seeking help a shameful experience. Previous studies have also described the fear of being stigmatised to be due to the belief that expressing emotions and seeking help are un-masculine (Cleary, 2012; Cleary 2017; Jordan et al., 2012; Meissner & Bantjes, 2017). This research further highlights the need

to address the harmful impact that hegemonic models of masculinity can have on help seeking in young men following a suicide attempt.

Other parts of this theme are unique to this research. The young men expressed shock about their capability to attempt suicide and an awareness of being at risk of reattempting suicide. Whilst this could provide an "option to escape", a common motive for suicide in young men (Meissner et al., 2016), it was experienced as a frightening possibility. This research suggests that a fear of reattempting suicide can provide young men with a motive for living and lead to the use of adaptive strategies to reduce their risk of reattempting. For example, this research found that a slow pace of re-engaging with life was important. Reading and Bowen (2014) interpret this as "present focus". It is important for those providing postvention support to be aware of this.

This research showed that young men may avoid talking or thinking about their experience due to the belief that it could lead to distress and increase their risk of suicide. This is a commonly held belief among professionals and patients (Bajaj et al ., 2008; Dazzi, Gribble, Wessley & Fear, 2014) despite evidence to the contrary (Biddle et al., 2013). This belief may act as a barrier to young men seeking help and therefore needs to be considered in suicide prevention initiatives.

Another important finding is that others' reactions to their suicide attempt can affect their ongoing suicidality. This suggests that those who have a positive experience may be more protected from repeated suicide attempts, whereas, those who do not are more at risk of reattempting. This is key in understanding the factors that increase the risk of young men reattempting suicide.

In addition to this, this study shows that young men believe others cannot understand their experience unless they have been through it themselves. This raises another potential barrier to seeking help in this population. Furthermore, it reiterates the importance of hearing from those who have a lived experience of surviving a suicide attempt in order to improve others understanding.

Reconnecting with Oneself

In line with this theme, a study by Reading and Bowen (2014) describes young men being motivated by themselves and others to reengage with life following a suicide attempt. In terms of self-development, previous research supports the finding that young men develop an awareness and control over their thoughts, emotional and behaviours (Reading & Bowen, 2014) as well as a sense of appreciation for others (Meissner & Bantjes, 2017; Reading & Bowen, 2014). Being hopeful about the future was also a key finding of Biong and Ravndal's (2007) research.

Building on this knowledge, this research highlights that, due to a lack of motivation following a suicide attempt, re-engaging with life and accepting help from others requires a degree of 'force'. The findings demonstrate that young men often know what they need to do to improve their wellbeing, such as leaving the house or attending a course about anxiety, but require an internal or external energy to push through a barrier of fear.

The Interpersonal Psychological Theory of Suicide

These themes reflect the interpersonal difficulties experienced by young men which are in line with the IPTS (Van Orden et al., 2010). This theory proposes that there are two principle constructs which lead to a desire to attempt suicide; 1) thwarted belongingness, which is the perceived lack of social

connections and supportive relationships leading to social isolation and feelings of loneliness; 2) perceived burdensomeness, characterised by a sense of worthlessness and self-hatred with feelings of shame and guilt, as well as beliefs of being a burden on others and that others would be better off if they were dead. This theory suggests that in order to have an active desire to attempt suicide, there must be a sense of hopelessness that thwarted belongingness and perceived burdensomeness will not change. Furthermore, in order for a person to act on this suicidal desire, there must also be an 'acquired capability' described as a desensitisation to physical pain and reduced fear of death.

In terms of thwarted belongingness, the current study found that young men experience a loss of a role in their family. Furthermore, they do not feel understood by others and experience others as avoiding them. This suggests that young men perceive a lack of social connection and support following a suicide attempt. However, the findings also suggest solutions to this. This research found that young men regain social connection through talking to others with similar mental health difficulties and experience supportive relationships through being forced to reengage with life.

In relation to perceived burdensomeness, this study found that young men experienced a sense of shame about needing help and a fear of not meeting the masculine stereotype of supporting others in their family. Perceived burdensomeness appears to be relieved through understanding and accepting oneself as having mental health difficulties which enables young men to accept help from others.

With regards to acquired capability, this research found that young men have an awareness of their capability to, and risk of, reattempting suicide. A fear

of capability could lead to the use of strategies to reduce the risk of reattempting, such as pacing oneself and reflecting on memories of others' reactions to their suicide attempt.

Clinical Implications

In order to reduce the risk of reattempting suicide it is important to address the ongoing difficulties of thwarted belongingness and perceived burdensomeness following a suicide attempt. This research highlighted that in order to accept help from others it is important for young men to understand and accept themselves as having mental health difficulties. Henriques, Beck and Brown (2003) propose that young adults "tell their story" about their suicide attempt as part of a specialised cognitive therapy intervention. Most of the men who participated in this research shared that they had not spoken in depth about their experience of attempting suicide prior to the interview and described the interview as a positive experience. This highlights the need for policies on postvention to incorporate guidance on how to support young men to share their experience of attempting suicide.

In clinical practice, this can be implemented in two ways. Firstly, this research found that talking to others with similar experiences can be helpful. This can be facilitated through peer support groups. Clinical Psychologists are equipped with skills in service development and evaluation, and understand the ethical practice of involving service users and carers in this process (Hurcom, Parnham, Horler, Horn & Davis, 2008; Sheldon & Harding, 2010). This may help provide young men with a role as well as an opportunity to connect with others with similar experiences.

Secondly, formulation can provide a framework for understanding one's experiences and developing self-awareness based on psychological theory and research (Division of Clinical Psychology, 2011; Johnstone & Dallos, 2013). Formulation is unique to the skill set of Clinical Psychologists and can be carried out either directly with young men who have attempted suicide or indirectly with mental health professionals working with this group (Hollingworth & Johnstone, 2014; Hurcom et al., 2008). The use of cognitive behavioural therapy formulation tools can be useful in developing an awareness of thoughts, feelings and behaviours.

Conclusion

Strengths and Limitations

This research fills a gap in the literature on young men who have attempted suicide by focusing on their interpersonal experiences following a suicide attempt. Research on this particularly high risk group is crucial for the development of interventions to reduce suicide rates and improve the quality of life for young male suicide survivors.

This research contributes to research into young men's experiences following a suicide attempt by providing new knowledge including: a loss of identity; a fear of reattempting suicide; the importance of how others' reactions to their suicide attempt is remembered; and a sense of being 'forced' by oneself and others to reengage in life. In the context of the IPTS, this research highlights that whilst young men may experience thwarted belongingness, perceived burdensomeness and acquired capability following a suicide attempt there are also ways in which these can be overcome.

This research is limited in three ways. Firstly, whilst interviewing four young men provided an in-depth insight into experiences following a suicide attempt, a broader sample size may have provided a richer understanding of the breadth and variation in their experiences (Levitt, Motulsky, Wertz, Morrow & Ponterotto, 2017). Discrepant case analysis could have been conducted on a larger sample size to identify experiences which disconfirm the findings and provide a more accurate insight into the complexity of this experience (Morrow, 2005).

Secondly, the validity of the findings are limited since they were not confirmed with the participants. Whilst participants were invited to provide feedback on whether the findings reflected their experiences, none responded. Furthermore, whilst the researcher's biases were bracketed and considered during the analysis process, only the researcher read and analysed the full data set. If the transcripts were read by other members of the research team, the interpretations may have been different.

Thirdly, the applicability of the findings is limited to those receiving NHS care from a CMHT. Those living in the community without this support may have had a different experience following a suicide attempt.

Future Directions

This research highlighted that young men who have attempted suicide experience a loss of identity. One possible area for future research is to gain a greater understanding of how sense of identity is lost and then re-established. A grounded theory approach would allow for the generation of a theory to understand the concept of identity in male suicide attempt survivors (Noble & Mitchell, 2016).

The development of postvention guidelines requires further research to evaluate the effectiveness of interventions, such as peer support groups and psychological formulation, in reducing the incidence of young men reattempting suicide. A study by Pien et al. (2015) indicates that improved quality of life three months following a suicide attempt, as measured by the World Health Organisation Quality-Of-Life assessment (Group, 1998), is associated with a reduced rates of suicide reattempts. Using this measure in a randomised control trial would establish whether an intervention is effective in improving the quality of life of young men who have attempted suicide.

References

Bajaj, P., Borreani, E., Ghosh, P., Methuen, C., Patel, M., & Joseph, M. (2008). Screening for suicidal thoughts in primary care: the views of patients and general practitioners. *Mental Health in Family Medicine, 5*(4), 229-235. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777583/

Barroso Martínez, A. A. (2018). Male suicide as a silent epidemic. *Psychiatria Danubina, 30*(3), 374-374. Retrieved from http://www.psychiatria-danubina.com/UserDocsImages/pdf/dnb_vol30_no3/dnb_vol30_no3_374.pdf

Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., Kapur, N., Donovan, J., & Gunnell, D. (2013). Qualitative interviewing with vulnerable populations: individuals' experiences of participating in suicide and self-harm based research. *Journal of Affective Disorders*, *145*(3), 356-362. doi:10.1016/j.jad.2012.08.024.

Biong, S., & Ravndal, E. (2007). Young men's experiences of living with substance abuse and suicidal behaviour: between death as an escape from pain and the hope of a life. *International Journal of Qualitative Studies on Health and Well-being*, *2*(4), 246-259. doi:10.1080/17482620701547008

Biong, S., & Ravndal, E. (2009). Living in a maze: health, well-being and coping in young non-western men in Scandinavia experiencing substance abuse and suicidal behaviour. *International Journal of Qualitative Studies on Health and Well-being*, *4*(1), 4-16. doi:10.1080/17482620802239869

Chi, M. T., Long, A., Jeang, S. R., Ku, Y. C., Lu, T., & Sun, F. K. (2014). Healing and recovering after a suicide attempt: a grounded theory study.

Journal of Clinical Nursing, *23*(11-12), 1751-1759. doi:10.1111/jocn.12328

Christiansen, E., & Jensen, B.F. (2007). Risk of repetition of suicide attempt, suicide or all deaths after an episode of attempted suicide: a register-based survival analysis. *Australian & New Zealand Journal of Psychiatry*, *41*(3), 257-265. doi:10.1080/00048670601172749

Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Science & Medicine*, *74*(4), 498-505. doi:10.1016/j.socscimed.2011.08.002

Cleary, A. (2017). Help-seeking patterns and attitudes to treatment amongst men who attempted suicide. *Journal of Mental Health*, *26*(3), 220-224. doi:10.3109/09638237.2016.1149800.

Colarusso, C. A. (1992). *Young Adulthood (Ages 20–40).* In Child and Adult Development (pp. 133-161). Springer, Boston, MA. doi:10.1007/978-1-4757-9673-5_10

Crona, L., Stenmarker, M., Öjehagen, A., Hallberg, U., & Brådvik, L. (2017). Taking care of oneself by regaining control-a key to continue living four to five decades after a suicide attempt in severe depression. *BMC Psychiatry*, *17*(69), 1-10. doi:10.1186/s12888-017-1223-4

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine, 44*(16), 3361-3363. doi:10.1017/S0033291714001299

Deshpande, G., Baxi, M., Witte, T., & Robinson, J. L. (2016). A neural basis for the acquired capability for suicide. *Frontiers in Psychiatry, 7*(125), 1-19. doi:10.3389/fpsyt.2016.00125

Division of Clinical Psychology (2011). *Good practice guidelines on the use of psychological formulation.* Leicester, UK: BPS. Retrieved from http://www.sisdca.it/public/pdf/DCP-Guidelines-for-Formulation-2011.pdf

Granato, S. L., Smith, P. N., & Selwyn, C. N. (2015). Acquired capability and masculine gender norm adherence: potential pathways to higher rates of male suicide. *Psychology of Men & Masculinity*, *16*(3), 246-253. doi:10.1037/a0038181

Group, T. W. (1998). The World Health Organization quality of life assessment (WHOQOL): development and general psychometric properties. *Social Science & Medicine*, *46*(12), 1569-1585. Retrieved from http://www.psychology.hku.hk/ftbcstudies/refbase/docs/thewhoqolgroup/1998/71_TheWHOQOLGroup1998.pdf

Hamza, C. A., Stewart, S. L., & Willoughby, T. (2012). Examining the link between nonsuicidal self-injury and suicidal behavior: A review of the literature and an integrated model. *Clinical Psychology Review*, *32*(6), 482-495. doi:10.1016/j.cpr.2012.05.003

Henriques, G., Beck, A. T., & Brown, G. K. (2003). Cognitive therapy for adolescent and young adult suicide attempters. *American Behavioral Scientist, 46*(9), 1258-1268. Retrieved from https://journals.sagepub.com/doi/pdf/10.1177/0002764202250668?casa_t

oken=9wfreQlvM5cAAAAA:ZSFsKn2AcEpvAvmla7__pNsGmwcFXpzSSgBhkCAkhcGxi3fTMIxENq2d4Zw1xygV9j1ONLZTgS6o1g

Hollingworth, P., & Johnstone, L. (2014). Team formulation: what are the staff views. *Clinical Psychology Forum*. *257*(5), 28-34.

Hurcom, C., Parnham, L., Horler, M., Horn, N. & Davis, F. (2008). *Briefing paper: The role of psychologists working in crisis resolution home treatment (CRHT) Teams.* The British Psychological Society, Leicester, UK. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Divisions/DCP/The%20role%20of%20psychologists%20in%20Crisis%20Resolution%20Home%20Treatment%20%28CRHT%29%20Teams.pdf

Information Commissioner's Office. (2018) Guide to the general data protection regulation (GDPR). Retrieved from https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation

Johnstone, L., & Dallos, R. (2014). *Formulation in psychology and psychotherapy: Making sense of people's problems.* New York, NY: Routledge.

Jordan,. J., McKenna, H., Keeney, S., Cutcliffe, J., Stevenson, C., Slater, P., & McGowan, I. (2012). Providing meaningful care: Learning from the experiences of suicidal young men. *Qualitative Health Research, 22*(9), 1207–1219. doi:10.1177/1049732312450367

Levitt, H. M., Motulsky, S. L., Wertz, F. J., Morrow, S. L., & Ponterotto, J. G. (2017). Recommendations for designing and reviewing qualitative

research in psychology: Promoting methodological integrity. *Qualitative Psychology*, *4*(1), 2-22. doi:10.1037/qup0000082

Lynch, L., Long, M., & Moorhead, A. (2018). Young men, help-seeking, and mental health services: exploring barriers and solutions. *American Journal of Men's Health*, *12*(1), 138-149. doi:10.1177/1557988315619469

Mandelli, L., Carli, V., Roy, A., Serretti, A., & Sarchiapone, M. (2011). The influence of childhood trauma on the onset and repetition of suicidal behavior: An investigation in a high risk sample of male prisoners. *Journal of Psychiatric Research*, *45*(6), 742-747. doi:10.1016/j.jpsychires.2010.11.005

Meissner, B. L., & Bantjes, J. (2017). Disconnection, reconnection and autonomy: four young South African men's experience of attempting suicide. *Journal of Youth Studies*, *20*(7), 781-797. doi:10.1080/13676261.2016.1273512

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 250-260. doi:10.1037/0022-0167.52.2.250

Naghavi, M. (2019). Global, regional, and national burden of suicide mortality 1990 to 2016: systematic analysis for the Global Burden of Disease Research 2016. *bmj*, *364*(l94). doi:10.1136/bmj.l94

National Institute for Health and Care Excellence (2018). *Preventing suicide in community and custodial settings: Postvention.* Guideline version (draft). Retrieved from https://www.nice.org.uk/guidance/ng105/documents/evidence-review-5

Noble, H., & Mitchell, G. (2016). What is grounded theory? *Evidence-based Nursing*, *19*(2), 34-35. doi:10.1136/eb-2016-102306

Nordström, P., Samuelsson, M., & Åsberg, M. (1995). Survival analysis of suicide risk after attempted suicide. *Acta Psychiatrica Scandinavica*, *91*(5), 336-340. doi:10.1111/j.1600-0447.1995.tb09791.x

O'Connor, R. C., & Portzky, G. (2018). Looking to the future: a synthesis of new developments and challenges in suicide research and prevention. *Frontiers in Psychology*, *9*(2139), 1-14. doi:10.3389/fpsyg.2018.02139

Office for National Statistics (2017). Suicides in Great Britain: 2016 registrations. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registration

Pien, F. C., Chang, Y. C., Feng, H. P., Hung, P. W., Huang, S. Y., & Tzeng, W. C. (2016). Changes in quality of life after a suicide attempt. *Western Journal of Nursing Research*, *38*(6), 721-737. doi:10.1177/0193945915620306

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7-14. doi:10.14691/CPPJ.20.1.7

Rasmussen, M. L., Hjelmeland, H., & Dieserud, G. (2018). Barriers toward help-seeking among young men prior to suicide. *Death Studies*, *42*(2), 96-103. doi:10.1080/07481187.2017.1328468

Reading, L., & Bowen, E. (2014). A thematic analysis of how prisoners overcome suicidality. *International Journal of Prisoner Health, 10*(4), 212-227. doi:10.1108/IJPH-05-2014-0014

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(1), 20-23. Retrieved from https://thepsychologist.bps.org.uk/volume-18/edition-1/exploring-lived-experience

Rimkeviciene, J., O'Gorman, J., Hawgood, J., & De Leo, D. (2016). Timelines for difficult times: use of visual timelines in interviewing suicide attempters. *Qualitative Research in Psychology, 13*(3), 231-245. doi:10.1080/14780887.2016.1170913

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching, 5*(9), 9-16. doi:10.5539/elt.v5n9p9

Sheldon, K., & Harding, E. (2010, May). *Good practice guidelines to support the involvement of service users and carers in Clinical Psychology services.* British Psychological Society. Leicester, UK. Retrieved from https://consaludmental.org/publicaciones/Goodpracticeinvolvementservic euserscarersclinicalpsychologyservices.pdf

Shiner, M., Scourfield, J., Fincham, B., & Langer, S. (2009). When things fall apart: gender and suicide across the life-course. *Social Science & Medicine, 69*(5), 738-746. doi:10.1016/j.socscimed.2009.06.014

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive Phenomenological Analysis: Theory, Method and Research.* London: Sage.

Struszczyk, S., Galdas, P. M., & Tiffin, P. A. (2019). Men and suicide prevention: a scoping review. *Journal of Mental Health, 28*(1), 80-88. doi:10.1080/09638237.2017.1370638

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80-96. doi:10.1177/1473325010368316

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological Review, 117*(2), 575. doi: 10.1037/a0018697

World Health Organization. (2014). *Preventing suicide: A global imperative*. Retrieved from http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf

World Health Organisation (2018). *National suicide prevention strategies. Progress, examples and indicators.* Retrieved from https://apps.who.int/iris/bitstream/handle/10665/279765/9789241515016-eng.pdf?ua=1

Wolford-Clevenger, C., Febres, J., Zapor, H., Elmquist, J., Bliton, C., & Stuart, G. L. (2015). Interpersonal violence, alcohol use, and acquired capability for suicide. *Death Studies, 39*(4), 234-241. doi:10.1080/07481187.2014.985405

Chapter III: Reflective paper

The Challenges of Conducting Qualitative Research on Suicide: Reflections of a Trainee Clinical Psychologist

Overall chapter word count (excluding figures and references):
3,872 (at submission)

Introduction

This paper presents my reflections on conducting qualitative research on suicide as a Trainee Clinical Psychologist. Reflection is a process of learning through experience (Boud, Keogh & Walker, 2013; Kolb, 1984) which has been found to support Clinical Psychologists to develop personally and professionally (Fisher, Chew & Leow, 2015; Sheikh, Milne & MacGregor, 2007). Qualitative research is a method of developing an understanding of a phenomenon from an individual's perspective (Merriam & Grenier, 2019). Suicide is an action with the intention to end one's life (Nock et al., 2008).

Background Literature

Existing literature highlights that conducting qualitative research on a sensitive topic can be ethically, professionally and emotionally challenging for researchers (Dickson-Swift, James, Kippen & Liamputtong, 2008; Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). A study by Johnson and Clarke (2003) found that researchers collecting sensitive qualitative data experience challenges in relation to maintaining confidentiality, concerns about the impact on the participant, and feelings of isolation. Conducting qualitative research on sensitive topics, including suicide, has also been found to lead to feelings of guilt, vulnerability and exhaustion (Dickson-Swift et al., 2008). Another study by Beale, Cole, Hillege, McMaster and Nagy (2004) reported that completing in-depth interviews can evoke emotions including shock, surprise, sadness, anger, and a sense of hopelessness. Conducting two interviews in one day was found to be detrimental to the researcher's wellbeing. Furthermore, the researcher "cut off" from the experience to manage this impact. Interviewing participants who have experienced mental health problems has also been found to

bring challenges (Mitchell & Irvine, 2009) . These include difficulties related to: negotiating informed consent; responding "appropriately" to participants when they express emotion; using self-disclosure to build rapport; and providing participants with follow up support.

Clinical Psychologists are clinicians who are also trained to conduct research. Having this dual researcher-clinician role when conducting qualitative research can bring an additional challenge of role confusion. This is when a psychologist experiences a conflict between their role as a clinician and a researcher, or when a participant is confused about which role the psychologist is taking (Thompson & Russo, 2012). A systematic review by Hay-Smith, Brown, Anderson and Treharne (2016) found that this is due to two reasons; 1) there are patterns of behaviour that are similar across the roles of a researcher and a clinician, such as wanting to help the participant or a participant asking a clinical question; 2) the researcher and participant both have an experience of the clinician-patient relationship which can lead to assumptions or actions, such as the researcher experiencing pressure to act clinically on information shared by the participant or the participant assuming the researcher's clinical understanding of a topic.

Rationale and Aim

The current literature on the challenges of conducting qualitative research is limited in two ways. Firstly, whilst some studies describe the experiences of researching a sensitive topic, there is limited literature on the experiences of researching suicide. Secondly, literature on the experiences of Clinical Psychologists, particularly those in training is lacking.

Since a significant part of Clinical Psychology training involves conducting an empirical research project, there is a key opportunity for Trainee Clinical Psychologists to contribute to research on suicide. However, the unknown challenges of researching suicide in this role may be off putting. The aim of this reflective paper is, therefore, to describe and discuss the challenges that I faced when conducting qualitative research on suicide. My reflections are based on my experience of completing a research study on 'young men's interpersonal experiences following a suicide attempt'. This involved interviewing four young males who had made a suicide attempt up to three years ago and analysing their responses using Interpretative Phenomenological Analysis (IPA).

In this paper I reflect on my experiences at various stages throughout the research journey, from designing the research to reporting the findings. Although this research focused on young males who have attempted suicide, the reflections are focused on my general experience of conducting research into suicide. My prior experience of conducting research has mainly involved quantitative research methods apart from one service evaluation for which I collected qualitative data via a survey. My reflections in this paper, therefore, represent a novice experience of IPA and using interviews to collect data.

The purpose of this paper is to provide readers with insight into how the challenges of conducting suicide research are experienced by a Trainee Clinical Psychologist. It is hoped that this will help others considering research on suicide to have an understanding of these challenges so that they can be overcome early in the research process.

Reflections

As a qualified Clinical Psychologist it is likely that I will be working with people who are suicidal. Having had limited training to prepare me for this, I took the opportunity to learn through my role as a researcher. Using a qualitative methodology I have gained an in depth understanding of personal and professional experiences of suicide. However, as described in the current literature, conducting qualitative research on a sensitive topic has its challenges.

Throughout my research journey there have been three main challenges; 1) my sense of responsibility for participants' wellbeing; 2) emotional labour; and 3) a fear of suicide. My reflections on these challenges will be structured using the six stage model of reflection (Gibbs, 1988) displayed in Figure 1. Following this model, I will describe my experience of each challenge and reflect on my thoughts and feelings at the different stages of the research. I will also evaluate what went well and what did not go well, and analyse the factors contributing to this. For each challenge I will then conclude what I could have done differently and the skills I need to develop. These reflections will be discussed in the context of previous literature before presenting an action plan for how I can further develop my skills as a Clinical Psychologist.

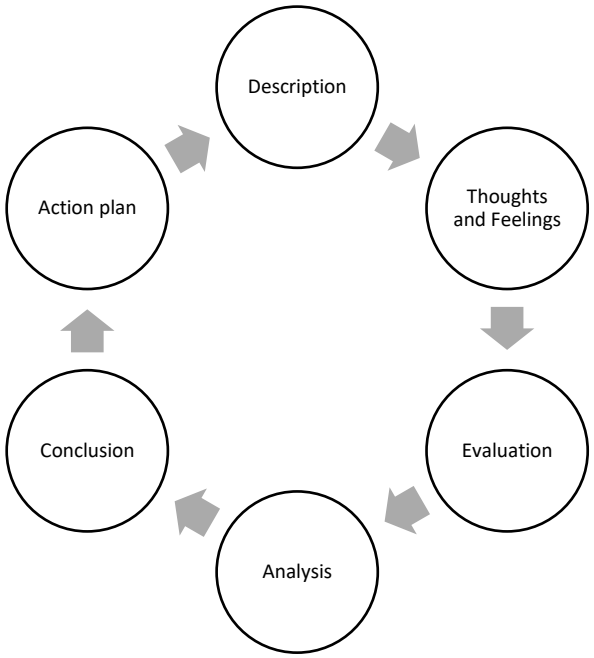


Figure 1. Six stage model of reflection (Gibbs, 1988)

Responsibility

Researchers have a number of responsibilities to manage when conducting research, one of which is to minimise the potential for the research to cause harm to the participants (British Psychological Society, 2014; Sanjari et al., 2014). The research I conducted involved interviewing young men who had attempted suicide; a group who are at particularly high risk of reattempting suicide (Cleary, 2017). The risk of causing harm to this group of participants is therefore potentially lethal. With this in mind, I felt a huge sense of responsibility to ensure that the research did not have an adverse impact on the participants' wellbeing. I carried this burden of responsibility from the early stages of designing the research to the final stage of reporting the findings.

Firstly, when developing the materials for the research, such as the Participant Information Sheet, I was cautious about the wording I used and how

this would be received by participants. For example, I was particularly sensitive to using the term 'failed suicide' as this may have negative connotations of 'failure'. Secondly, when seeking ethical approval for the study, I was required to provide a comprehensive plan of how I would manage the risk of potential harm to participants. When putting my name against the title of 'Chief Investigator' I experienced a fear of being blamed if a participant were to complete suicide following their participation in the research. Thirdly, when making contact with participants, either via telephone, over email or in person, I was self-conscious of how my written/verbal and non-verbal responses would be received. After completing each interview I had ruminative thoughts about whether I had done or said the right thing and whether the participant would be OK. Finally, during the data analysis phase and when reporting the results, I was mindful of how my interpretations may be received by the participants if they were to read them.

My reflections show that I was highly cautious of my actions at every step of the research journey. This was due to the sense of responsibility I held for participants' wellbeing along with a perception of participants' mental health being fragile. Whilst, as far as I am aware, the research did not cause participants distress, the ongoing anxiety I experienced was physically exhausting for me as a researcher.

As part of my thesis for Clinical Psychology Training I also conducted a systematic literature review into the psychological impact of client suicide on mental health professionals. From this I found that it is common for mental health professionals to feel responsible and to fear being blamed by others in the event of a client suicide. The findings of this review also highlighted that mental health professionals manage their sense of responsibility by acknowledging their

professional limitations and accepting that suicide is ultimately the clients' choice.

I have since incorporated this new understanding into my own sense of responsibility for participants' wellbeing. I now have a more balanced view that participants hold a part of the responsibility for managing their own wellbeing and accessing support if they need it. I have also come to appreciate that the role of managing the risk of suicide in participants is shared with other professionals, including the research supervision team. Furthermore, by recognising my limitations as a researcher, I now see more clearly that I can only truly be responsible for ensuring that participants are aware of the potential risks of the research, so that they can make their own informed choice about whether to participate, and providing them with information about how to access support should they need it. Whilst it is important to be mindful of how I communicate with participants, their responses are not within my control.

Having a more balanced and realistic view of my responsibilities as a researcher of suicide, I now feel more comfortable with the risk of suicide and confident that if such an event were to occur I would not necessarily be subject to blame. I am also reassured that the young men that I interviewed all shared that they had a positive experience of participating in the research.

Emotional Labour

Emotional labour describes the extent to which an occupation is emotionally demanding (Brotheridge & Grandey, 2002). A study by Dickson-Swift, James, Kippen and Liamputtong (2009) demonstrated that conducting qualitative research requires emotional labour. Here I will describe three ways

that emotional labour was challenging for me when carrying out research into suicide.

Firstly, when interviewing participants I found myself actively managing my emotional expression. There were times during the interviews when I felt emotionally connected to the participants. On one occasion I noticed the sensation of being on the verge of tears, however, I felt a need to hold this back. I was concerned that if I expressed my emotion, the participant would not believe that I was robust enough to hear their experience and may therefore hold back information. However, conversely, I was concerned that, by holding back my feelings, I would come across as unempathetic and robotic. Therefore, I had to find a balance between the two responses, showing enough emotion to demonstrate my empathy whilst demonstrating that I was capable of hearing the details of their experience. This emotional labour was experienced as emotionally exhausting.

Secondly, after holding back my emotions during the interview, I experienced a wave of powerful feelings over the following days. In response to this I became avoidant of completing other research tasks. For example, whilst I had planned to transcribe audio recordings within a few days of an interview, I found myself prioritising other tasks and finding other things to do. Whilst some of this behaviour was justified, part of me knew I was avoiding listening back to the participants experiences. When I did listen to the interviews I was also emotionally detached from the content.

Thirdly, the emotional labour of each interview made it very challenging to complete two interviews in one day. Balancing my role as a researcher and clinician, I had limited time available to meet with participants, therefore, I

arranged two interviews to be conducted on the same day. In my clinical role it was normal to see two clients in one day. Having not had previous experience of conducting qualitative research, I did not foresee this to be problematic. However, I soon learnt that interviewing a participant as a researcher is very different to a therapy session with a client. The emotional labour involved in the first interview, left me feeling emotionally depleted ahead of the second interview, later that day. Whilst I allowed a few hours in between each experience this was not enough time to recover. This had an impact on how I conducted the second interview. When listening to the audio recording of this interview I noticed that I asked fewer follow up questions than in other interviews and the duration was the shortest of all four interviews. This interview experience may have been different if it was not my second interview of the day.

My experiences demonstrate the emotional labour involved in qualitative research on suicide and the ways in which this can be challenging. In addition to this, I was performing a clinical role on placement which required me to engage emotionally with individuals who had complex needs, some of whom were suicidal. Carrying out two emotionally demanding roles at the same time meant that there was limited space to recover my emotional resources.

In order to fully engage with the research process I needed to be in a certain state of mind. However, the time pressures of completing research during Clinical Psychology Training made this even more challenging. Self-care has therefore been essential in order to complete this work. For me, this involved incorporating activities into my schedule which allowed me to relax and switch off from work, such as going for walks and spending time with friends. This gave me the emotional strength to then complete research tasks, such as transcribing an

interview. Furthermore, it was important for me to space out research tasks to allow time to process the emotions it evoked in me and reduce the risk of emotional exhaustion. This involved making the conscious choice to complete all other interviews on separate days.

Fear of Suicide

It is a commonly held belief that talking about suicide will increase the risk of suicide (Bajaj et al., 2008). However, research has shown that this is not the case (Biddle et al., 2013). In fact, research has indicated that talking about suicide may reduce suicidal ideation and improve mental health (Dazzi, Gribble, Wessely & Fear, 2014). Although suicide has not been a crime in the UK since 1961 (Neeleman, 1996) the term 'committed suicide' is still commonly used and the legal system remain involved in investigations following a death by suicide (Maple et al., 2010). These factors contribute to a social stigma around suicide that can make it difficult for those affected by suicide to talk openly about their experiences (Maple et al., 2010). Here, I will reflect on my own experience of the challenges related to a fear of suicide.

Firstly, I experienced a sense of fear when talking about suicide. When people would ask me about my research I noticed myself being hesitant to talk about the topic and would often start with a disclaimer of "it's very morbid " to prepare people. I also noticed that others would talk quietly when they said the word "suicide". Attending an event held by the charity 'Silence of Suicide' highlighted to me, that by doing this, I was reinforcing the stigma and public avoidance of suicide. Following this I made a conscious effort to speak openly to others about my research, however, I was often faced with silence and have noticed myself avoiding eye contact with other people when saying the word

"suicide". This highlighted the powerful effect of stigma. I even noticed in my interviews with participants that I would hesitate before saying "suicide attempt" and that participants also avoided using the word "suicide".

Secondly, I experienced a fear that participants would re-attempt suicide after the interview. After an interview with one participant, who had spoken about ongoing suicidal thinking, I had an urge to contact them to check they were OK. However, through discussing this with my clinical supervisor soon after the interview, I was able to recognise that whilst there was a high risk of suicide, as there is generally in this population, the participant had told me that they did not have any plans to act on these thoughts and there was, therefore, no need to take further action. This showed me how my fear of suicide had impacted my judgement of suicide risk which may have also been influenced by a lack of confidence in my ability to assess suicide risk. This challenge also raised the ethical dilemma of whether I should follow-up with all participants if I did decide to follow-up with one. Whilst one participant spoke about their experiences of suicidal thoughts, others may have also had this experience but may not have shared this in the interview. However, since I had not planned to follow up participants after the interview I did not have consent for this. The experiences they shared with me were, therefore, based on the understanding that they would not be seeing me again. Making contact with participants after the interview would be breaking this boundary and could negatively impact upon their trust in the research.

These experiences highlight how a fear of suicide made it difficult for me to talk about the topic of my research and impacted my ability to assess suicide risk. This demonstrates how powerful stigma is and highlights my assumption

about the fragility of participants' psychological wellbeing. In order to address these challenges, I made a conscious effort to talk about suicide more openly with others and discussed my concerns about suicide risk with my supervisor.

Discussion

In this reflective paper I have described and discussed the challenges that I faced as a Trainee Clinical Psychologist conducting research into suicide. This is based on my novice experience of conducting an IPA study on 'young men's experiences following a suicide attempt'. My reflections highlighted three main challenges which I faced throughout this research journey; 1) a sense of responsibility for participants' wellbeing; 2) emotional labour; and 3) a fear of suicide. I will now discuss how these challenges compare to the previous literature before outlining an action plan on how I can further develop as a clinician and research practitioner.

Conducting research with a sample that is at high risk of suicide came with a great sense of responsibility. My concern about causing harm to participants is shared by other researchers using qualitative methods to explore sensitive topics (Johnson & Clarke, 2003). Previous literature, however, has not described how this sense of responsibility can lead a researcher to be over cautious at every stage of the research and fear that they will be blamed if their participant were to die. This may be unique to the experience of conducting research into suicide due to the risk of harm having a potentially lethal outcome. My reflections on this experience have led me to have a more balanced view that my responsibility for participants' wellbeing is shared with others, including the participant themselves.

The emotional labour involved in suicide research was found to be challenging in three ways. Firstly, I found myself managing my expression of emotion during interviews. The appropriateness of researchers expressing emotion has previously been described as a challenge by Dickson-Swift et al. (2009). My experience of this being emotionally exhausting is also supported by Brotheridge and Grandey (2002). Secondly, my experience of emotionally detaching from the research process is consistent with previous literature (Beale et al., 2004; Dickson-Swift et al., 2009). Avoidance, however, has not previously been discussed in the literature on researcher's experiences of conducting qualitative research. This may be another challenge which is unique to the experience of researching suicide or an experience that is unique to me. Thirdly, the challenge of conducting two interviews in one day is supported by Beale et al. (2004). My reflections also add to this an insight into how a dual clinician-researcher role may find this particularly challenging due to an assumption that interviewing *clients* is similar to interviewing *research participants*. This is in line with the findings of Hay-Smith et al. (2016).

The challenges of emotional labour that I have described indicate that I may have been at risk of burnout. The three states that can lead to burnout are: emotional exhaustion; depersonalisation; and a lack of personal achievement (Maslach, Jackson, Leiter, Schaufeli & Schwab, 1986). Emotional exhaustion was experienced through managing my emotions during the interviews. The detachment and avoidance I experienced is a low level of depersonalisation. My difficulty with conducting two interviews in one day also impacted my sense of achievement.. Previous literature has highlighted the importance of self-care (Bahn & Weatherill, 2012), supervision (Dickson-Swift et al., 2008) and

debriefing (Beale et al., 2004) in managing the challenges of qualitative research. Engaging in self-care and accessing support from my supervision team may have prevented me from experiencing burnout.

My reflections also highlight that the stigma of suicide can create a fear which makes it difficult to talk to others, including participants, about the research. I also experienced a fear that participants may re-attempt suicide. This raised ethical issues of whether to follow-up with participants after their interview. This dilemma has previously been raised by Mitchell and Irvine, (2008). Furthermore, the findings of Hay-Smith et al (2016) suggest that my dual clinician-researcher role may have added a pressure to respond to the participant's expression of suicidal ideation.

Action Plan

Reflecting on my experiences of conducting research into suicide I have developed numerous strategies to address the challenges that I faced. These strategies form my action plan for how I can continue to develop as a clinician and research practitioner. These include: recognising my professional limitations to understand what I can reasonably be responsible for both in my role as a clinician and a researcher; incorporating self-care into my routine to prevent the risk of burnout; openly talking about suicide to address stigma; and recognising the influence of my assumptions and fears on my clinical judgement of suicide risk.

Conclusion

This reflective paper provides insight into the challenges of conducting qualitative research on suicide as a Trainee Clinical Psychologist. Some of these challenges may be unique to me, some may be unique to researching suicide,

whereas others apply more generally to conducting qualitative research on a sensitive topic. It is hoped that by providing an insight into these challenges, and how they can be overcome, other researchers will be more willing to consider conducting research into suicide.

I will end this reflective paper by describing how I liken the experience of conducting research into suicide to a surgeon carrying out heart surgery. Like the surgeon, a researcher interviewing people about their experiences of suicide has the potential to cause harm, which could be lethal. On the other hand it also has the potential to save lives and if the research or heart surgery is not carried out, the risk may not change. So, whilst there may be challenges when conducting research into suicide, it is important to remember that suicide research contributes to suicide prevention and therefore saves lives.

References

Bahn, S., & Weatherill, P. (2012). Qualitative social research: a risky business when it comes to collecting 'sensitive' data. *Qualitative Research, 13*(1), 19-35. doi:10.1177/1468794112439016

Bajaj, P., Borreani, E., Ghosh, P., Methuen, C., Patel, M., & Joseph, M. (2008). Screening for suicidal thoughts in primary care: the views of patients and general practitioners. *Mental Health in Family Medicine, 5*(4), 229-235. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777583/

Beale, B., Cole, R., Hillege, S., McMaster, R., & Nagy, S. (2004). Impact of in-depth interviews on the interviewer: Roller coaster ride. *Nursing & Health Sciences, 6*(2), 141-147. doi:10.1111/j.1442-2018.2004.00185.x

Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., Kapur, N., Donovan, J., & Gunnell, D. (2013). Qualitative interviewing with vulnerable populations: individuals' experiences of participating in suicide and self-harm based research. *Journal of Affective Disorders, 145*(3), 356-362. doi:10.1016/j.jad.2012.08.024

Boud, D., Keogh, R., & Walker, D. (2013). *Reflection: Turning experience into learning*. Routledge: Oxton, UK.

British Psychological Society (2014). Code of human research ethics. Leicester, UK. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Brotheridge, C. M., & Grandey, A. A. (2002). Emotional labor and burnout: Comparing two perspectives of "people work". *Journal of Vocational Behavior, 60*(1), 17-39. doi:10.1006/jvbe.2001.1815

Cleary, A. (2017). Help-seeking patterns and attitudes to treatment amongst men who attempted suicide. *Journal of Mental Health, 26*(3), 220-224. doi:10.3109/09638237.2016.1149800.

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence?. *Psychological Medicine, 44*(16), 3361-3363. doi:10.1017/S0033291714001299

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2008). Risk to researchers in qualitative research on sensitive topics: Issues and strategies. *Qualitative Health Research, 18*(1), 133-144. doi:10.1177/1049732307309007.

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2009). Researching sensitive topics: qualitative research as emotion work. *Qualitative Research, 9*(1), 61-79. doi:10.1177/1468794108098031

Fisher, P., Chew, K., & Leow, Y. J. (2015). Clinical psychologists' use of reflection and reflective practice within clinical work. *Reflective Practice, 16*(6), 731-743. doi:10.1080/14623943.2015.1095724

Gibbs, G. (1988). *Learning by doing: A guide to teaching and learning methods*. Oxford, UK: Oxford Brookes University, Further Education Unit.

Hay-Smith, E. J. C., Brown, M., Anderson, L., & Treharne, G. J. (2016). Once a clinician, always a clinician: a systematic review to develop a typology of clinician-researcher dual-role experiences in health research with patient-participants. *BMC Medical Research Methodology, 16*(95), 1-17. doi:10.1186/s12874-016-0203-6

Johnson, B., & Clarke, J. M. (2003). Collecting sensitive data: The impact on researchers. *Qualitative Health Research, 13*(3), 421-434. doi:10.1177/1049732302250340

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development*. Engelwood Cliffs, NJ: Prentice Hall. Retrieved from https://s3.amazonaws.com/academia.edu.documents/34850950/Kolb.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1556757806&Signature=Ak4euNTWsojbocVwBwJ5UiIlQnA%3D&response-content-disposition=inline%3B%20filename%3DKolb.pdf

Maple, M., Edwards, H., Plummer, D., & Minichiello, V. (2010). Silenced voices: hearing the stories of parents bereaved through the suicide death of a young adult child. *Health & Social Care in the Community, 18*(3), 241-248. doi:10.1111/j.1365-2524.2009.00886.x

Maslach, C., Jackson, S. E., Leiter, M. P., Schaufeli, W. B., & Schwab, R. L. (1986). *Maslach burnout inventory* (Vol. 21, pp. 3463-3464). Palo Alto, CA: Consulting Psychologists Press.

Merriam, S. B., & Grenier, R. S. (Eds.). (2019). *Qualitative research in practice: Examples for discussion and analysis*. Jossey-Bass: CA, USA.

Mitchell, W., & Irvine, A. (2008). I'm okay, you're okay?: Reflections on the well-being and ethical requirements of researchers and research participants in conducting qualitative fieldwork interviews. *International Journal of Qualitative Methods, 7*(4), 31-44. doi:10.1177/160940690800700403

Neeleman, J. (1996). Suicide as a crime in the UK: legal history, international comparisons and present implications. *Acta Psychiatrica Scandinavica*, *94*(4), 252-257. doi: 10.1111/j.1600-0447.1996.tb09857.x

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic Reviews*, *30*(1), 133-154. doi:10.1093/epirev/mxn002.

Sanjari, M., Bahramnezhad, F., Fomani, F. K., Shoghi, M., & Cheraghi, M. A. (2014). Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline. *Journal of Medical Ethics and History of Medicine, 7*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4263394/pdf/jmehm-7-14.pdf

Sheikh, A. I., Milne, D. L., & MacGregor, B. V. (2007). A model of personal professional development in the systematic training of clinical psychologists. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *14*(4), 278-287. doi: 10.1002/cpp.540

Thompson, A. R., & Russo, K. (2012). Ethical dilemmas for clinical psychologists in conducting qualitative research. *Qualitative Research in Psychology*, *9*(1), 32-46. doi: 10.1080/14780887.2012.630636

Appendices

Appendix A : Author Guidelines for the Journal of Suicide and Life-Threatening Behaviour

Submissions
As of December 1, 2010 all manuscript submissions to Suicide and Life-Threatening Behavior can be made online via **Manuscript Central**, the web-based submission, tracking and peer review system.
Suicide and Life-Threatening Behavior is devoted to emergent theoretical, scientific, clinical, and public health approaches related to violent, self-destructive, and life-threatening behaviors. It is multidisciplinary and concerned with a broad range of related topics including, but not limited to, suicide, suicide prevention, death, accidents, biology of suicide, epidemiology, crisis intervention, postvention with survivors, nomenclature, standards of care, clinical training and interventions, violence.
Brief Summary. Manuscripts should be submitted with a 200-word abstract. The entire manuscript, including references, quotations, text, and tables, and be double-spaced. American Psychological Association (APA) standard style should be used. Manuscript length, except under unusual circumstances, should not be over 20 double-spaced pages, and, ordinarily, should be shorter.

Original Contributions. Authors should only submit manuscripts that have not been published elsewhere, and are not under review by another publication. Cover Letter. With your submission include a cover letter designating one author as correspondent for the review process, and provide a complete address, including phone and fax. In this letter please attest that neither the manuscript nor any other substantially similar paper has been published, except as described in the letter. The corresponding author should also attest that in the case of several authors, each one has studied the manuscript in the form submitted, agreed to be cited as a coauthor, and has accepted the order of authorship. If author affiliations are given with regard to academic, hospital, or institutional affiliations, it is the author[s] responsibility to obtain any required permissions from the proper authorities to utilize such affiliations.

Editing. Manuscripts will be copyedited, and page proofs will be sent to the authors for review. Authors are responsible for all statements made in their work. Manuscripts should not only be well written in the sense of organization and clarity, but should be explained in a manner that is interesting and engaging to readers with a wide range of backgrounds. All manuscripts should begin with an abstract of the paper.

Manuscript Preparation. Your paper should be double spaced and submitted in Microsoft Word. On the title page list the full names, affiliations, and professional degrees of all the authors. Abbreviations should not be used in the title or abstract, and should be very limited in the text.
Abstracts. An abstract of up to 200 words must include the following sections and headings: Objective: a brief statement of the purpose of the research; Method: a summary of research participants (sample size, age, gender, ethnicity), and

descriptions of the research design and procedures; Results: a summary of the primary findings; Conclusions: a statement regarding the implications of the findings. Below the abstract, supply up to five keywords or short phrases.

References. Reference lists should be prepared according to the style illustrated in the articles in this issue of the journal. This approach minimizes punctuation in the specific references, but utilizes the author and date in the text of the articles, to provide maximum information quickly to the reader.
Illustrations. Graphics should be executed in Microsoft Excel in either Mac or IBM formats for making graphs. If this is not possible, please submit camera ready copy. In all cases indicate the correct positioning of the item in the text. Illustrations should be cited in order in the text using Arabic numerals. A legend should accompany each illustration, and not exceed 40 words. Please include reproductions of all illustrations. As the author you are ultimately responsible for any required permissions regarding material quoted in your text, tables, or illustrations of any kind.

Tables. Tables should be cited in order in the text using Arabic numerals. Each Table should be displayed on a separate page, and each must have a title.

Reviews and Decisions. Manuscripts are generally sent to outside reviewers, and you will be informed of the editorial decision as soon as possible. Ordinarily a decision will be reached in about 3 months after submission is acknowledged. A request for revising the manuscript along the lines suggested by the Editor and reviewers does not constitute a decision to publish. All revised manuscripts will be re-evaluated, and the Editors reserve the right to reject a paper at any point during the revision process.

Author Services. Free access to the final PDF offprint or your article will be available via author services only. Please therefore sign up for author services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers. Visit **http://authorservices.wiley.com/bauthor/** to sign up for author services.

Copyright Transfer Agreement
If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services; where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

For authors signing the copyright transfer agreement
If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and Conditions **https://authorservices.wiley.com/author-resources/Journal-Authors/licensing-open-access/licensing/licensing-info-faqs.html**

For authors choosing OnlineOpen
If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

Creative Commons Attribution License OAA

Creative Commons Attribution Non-Commercial License OAA

Creative Commons Attribution Non-Commercial -NoDerivs License OAA

To preview the terms and conditions of these open access agreements please visit the Copyright FAQs hosted on Wiley Author Services http://authorservices.wiley.com/bauthor/faqs_copyright.asp and visit**https://authorservices.wiley.com/author-resources/Journal-Authors/licensing-open-access/licensing/open-access-agreements.html**.

If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with Wellcome Trust and Research Councils UK requirements. For more information on this policy and the Journal's compliant self-archiving policy please visit: **http://www.wiley.com/go/funderstatement**.
OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. Please see the full list of **terms and conditions**.

Prior to acceptance there is no requirement to inform an Editorial Office that you intend to publish your paper OnlineOpen if you do not wish to. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

Membership. Information about membership in the American Association of Suicidology can be obtained by writing to:
Amy J. Kulp
Interim Executive Director
American Association of Suicidology
5221 Wisconsin Ave., NW
Washington, DC 20015
telephone: (202) 237-2280
fax: (202) 237-2282
email: [redacted]

Appendix B: Search Strategies

MEDLINE Search

# ▼	Searches	Results
6	limit 5 to "qualitative (best balance of sensitivity and specificity)"	433
5	3 and 4	962
4	1 and 2	1581
3	(health professional* or Psychologist* or Nurse* or Staff or Counsellor* or Counselor* or Psychiatr* or Clinician* or Worker* or Therapist* or general practitioner*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	1249628
2	(Impact* or Response* or Experience* or Effect* or Reaction*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	11946788
1	((Service user* or Client* or in-patient* or Inpatient* or patient*) adj2 suicid*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	3873

Scopus Search

7	((TITLE-ABS-KEY ((("Service user*" OR client* OR in-patient* OR inpatient* OR patient*) W/2 (suicid*)) AND (impact* OR response* OR experience* OR effect* OR reaction*))) AND (TITLE-ABS-KEY ((health AND professional* OR psychologist* OR nurse* OR staff OR counsellor* OR counselor* OR psychiatr* OR clinician* OR worker* OR therapist* OR "general practitioner")))) AND (ALL (qualitative)) View Less	171 document results
6	ALL (qualitative)	1,591,604 document results
5	(TITLE-ABS-KEY ((("Service user*" OR client* OR in-patient* OR inpatient* OR patient*) W/2 (suicid*)) AND (impact* OR response* OR experience* OR effect* OR reaction*))) AND (TITLE-ABS-KEY ((health AND professional* OR psychologist* OR nurse* OR staff OR counsellor* OR counselor* OR psychiatr* OR clinician* OR worker* OR therapist* OR "general practitioner")))	855 document results
4	TITLE-ABS-KEY ((health AND professional* OR psychologist* OR nurse* OR staff OR counsellor* OR counselor* OR psychiatr* OR clinician* OR worker* OR therapist* OR "general practitioner"))	936,214 document results

PsycINFO search

☐	6	limit 5 to "qualitative (best balance of sensitivity and specificity)"	349	Advanced
☐	5	3 and 4	1383	Advanced
☐	4	1 and 2	2055	Advanced
☐	3	(health professional* or Psychologist* or Nurse* or Staff or Counsellor* or Counselor* or Psychiatr* or Clinician* or Worker* or Therapist* or general practitioner*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	740096	Advanced
☐	2	(Impact* or Response* or Experience* or Effect* or Reaction*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	2274900	Advanced
☐	1	((Service user* or Client* or in-patient* or Inpatient* or patient*) adj2 suicid*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	4711	Advanced

CINAHL Search

S15	S12 OR S14	**Search modes** - Find all my search terms	View Results (106) | View Details | Edit
S14	S11 AND S13	**Search modes** - Find all my search terms	View Results (86) | View Details | Edit
S13	(MH "Qualitative Studies+") OR "qualitative"	**Search modes** - Find all my search terms	View Results (164,933) | View Details | Edit
S12	S7 AND S10	**Limiters** - Clinical Queries: Qualitative - Best Balance **Search modes** - Find all my search terms	View Results (64) | View Details | Edit
S11	S7 AND S10	**Search modes** - Find all my search terms	View Results (533) | View Details | Edit
S10	S8 OR S9	**Search modes** - Find all my search terms	View Results (633,718) | View Details | Edit
S9	TI (MH "Health Personnel") OR "health professional* OR Psychologist* OR Nurse* OR Staff OR Counsellor* OR Counselor* OR Psychiatr* OR Clinician* OR Worker* OR Therapist* OR general practitioner	**Search modes** - Find all my search terms	View Results (275,601) | View Details | Edit
S8	AB (MH "Health Personnel") OR "health professional* OR Psychologist* OR Nurse* OR Staff OR Counsellor* OR Counselor* OR Psychiatr* OR Clinician* OR Worker* OR Therapist* OR general practitioner	**Search modes** - Find all my search terms	View Results (484,120) | View Details | Edit
S7	S5 AND S6	**Search modes** - Find all my search terms	View Results (887) | View Details | Edit
S6	S2 OR S3	**Search modes** - Find all my search terms	View Results (1,479,214) | View Details | Edit
S5	S1 OR S4	**Search modes** - Find all my search terms	View Results (2,303) | View Details | Edit
S4	TI (Service user* OR Client* OR in-patient* OR Inpatient* OR patient*) n2 suicid*	**Search modes** - Find all my search terms	View Results (993) | View Details | Edit
S3	TI Impact* OR Response* OR Experience* OR Effect* OR Reaction*	**Search modes** - Find all my search terms	View Results (509,675) | View Details | Edit
S2	AB Impact* OR Response* OR Experience* OR Effect* OR Reaction*	**Search modes** - Find all my search terms	View Results (1,225,943) | View Details | Edit
S1	AB (Service user* OR Client* OR in-patient* OR Inpatient* OR patient*) n2 suicid*	**Search modes** - Find all my search terms	View Results (1,715) | View Details | Edit

Appendix C: Quality Assessment Framework (Caldwell, Henshaw & Taylor, 2011)

Criterion	Guidance
1.Does the title reflect the content?	The title should be informative and indicate the focus of the research. It should allow the reader to easily interpret the content of the research. An inaccurate or misleading title can confuse the reader.
2.Are the authors credible?	Researchers should hold appropriate academic qualifications and be linked to a professional field relevant to the research.
3.Does the abstract summarize the key components?	The abstract should provide a short summary of the research. It should include the aim of the research, outline of the methodology and the main findings. The purpose of the abstract is to allow the reader to decide if the research is of interest to them.
4.Is the rationale for undertaking the research clearly outlined?	The author should present a clear rationale for the research, setting it in context of any current issues and knowledge of the topic to date.
5.Is the literature review comprehensive and up-to-date?	The literature review should reflect the current state of knowledge relevant to the research and identify any gaps or conflicts. It should include key or classic studies on the topic as well as up to date literature. There should be a balance of primary and secondary sources.
6.Is the aim of the research clearly stated?	The aim of the research should be clearly stated and should convey what the researcher is setting out to achieve.
7.Are all ethical issues identified and addressed?	Ethical issues pertinent to the research should be discussed. The researcher should identify how the rights of informants have been protected and informed consent obtained. If the research is conducted within the NHS then there should be indication of Local Research Ethics committee approval.
8.Is the methodology identified and justified?	The researcher should make clear which research strategy they are adopting, i.e. qualitative or quantitative. A clear rationale for the choice should also be provided, so that the reader can judge whether the chosen strategy is appropriate for the research.
9. Are the philosophical background and research design identified and the rationale of choice of design evident?	The design of the research, e.g. phenomenology, ethnography, should be identified and the philosophical background and rationale discussed. The reader needs to consider if it is appropriate to meet the aims of the research.
10. Are the major concepts identified?	The researcher should make clear what the major concepts are, but they might not define them. The purpose of the research is to explore the concepts from the perspective of

	the participants.
11. Is the context of the research outlined?	The population is the total number of units from which the researcher can gather data. It maybe individuals, organisations or documentation. Whatever the unit, it must be clearly identified.
12. Is the selection of participants described and the sampling method identified?	Informants are selected for their relevant knowledge or experience. Representativeness is not a criteria and purposive sampling is often used. Sample size may be determined through saturation.
13. Is the method of data collection auditable?	Data collection methods should be described, and be appropriate to the aims of the research. The researcher should describe how they have assured that the method is auditable.
14.Is the method of data analysis credible and confirmable?	The method of data analysis must be described and justified. Any statistical test used should be appropriate for the data involved.
15.Are the results presented in a way that is appropriate and clear?	Presentation of data should be clear, easily interpreted and consistent.
16.Is the discussion comprehensive?	In quantitative studies the results and discussion are presented separately. In qualitative studies these maybe integrated. Whatever the mode of presentation the researcher should compare and contrast the findings with that of previous research on the topic. The discussion should be balanced and avoid subjectivity.
17. Are the results transferable?	There may also be recommendations for further research, or if appropriate, implications for practice in the relevant field.
18. Is the conclusion comprehensive?	Conclusions must be supported by the findings. The researcher should identify any limitations to the research.

Appendix D: Quality Assessment Scores

	Aveyard et al., 2016	Christiansson & Everall, 2009	Darden & Rutter, 2011	Finlayson & Simmonds, 2019	Harris, 2007	Hendin et al., 2000	Kimball, 2015	Meadams & Foster, 2002	Moody, 2010	Morrissey & Higgins, 2018	Murphy et al., 2019	Overfelt, 2015	Sanders et al., 2005	Silverthorn, 2005	Talseth & Gilje, 2007	Tilman, 2006	Ting et al., 2006
Title	2	2	2	2	2	2	1	1	2	2	2	1	2	1	2	1	2
Authors credible	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Abstract	2	2	1	2	2	2	2	1	2	2	2	1	2	2	2	2	2
Rationale	2	2	2	2	2	1	2	1	2	2	1	2	2	2	2	1	2
Literature	1	2	1	2	2	0	2	1	2	2	2	2	2	2	2	1	2
Aim	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	1	2
Ethical issues	1	1	1	2	1	0	2	0	2	2	1	2	1	2	1	1	1
Methodology	1	2	2	2	2	1	2	1	2	1	2	2	2	2	2	2	2
Design	0	2	2	1	2	0	2	0	2	2	1	2	1	2	2	2	2
Major concepts	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Context	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Sampling	2	2	2	2	2	2	2	1	2	2	2	2	2	2	1	1	2
Data collection	2	1	2	2	2	1	2	2	2	2	1	2	2	2	1	2	1
Analysis	2	2	2	2	2	0	1	0	2	2	2	2	2	2	2	2	1
Results	2	2	2	2	2	1	2	1	2	2	2	2	2	2	1	2	2
Discussion	2	2	2	2	2	0	2	1	2	2	2	2	2	1	2	1	2
Transferability	2	1	2	2	2	1	2	2	2	2	2	2	2	2	2	1	2
Conclusion	2	2	2	2	2	1	2	1	2	2	2	2	1	1	2	2	1
Total Score	31	33	33	35	35	19	34	21	36	35	32	34	33	33	32	28	32

Appendix E: Ethical Approval for Systematic Literature Review

Certificate of Ethical Approval

Applicant:

Amanda Haines

Project Title:

Exploring Mental Health Professionals' Experiences Following a Client Suicide: A Meta-Ethnographic Synthesis

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

02 April 2019

Project Reference Number:

P89814

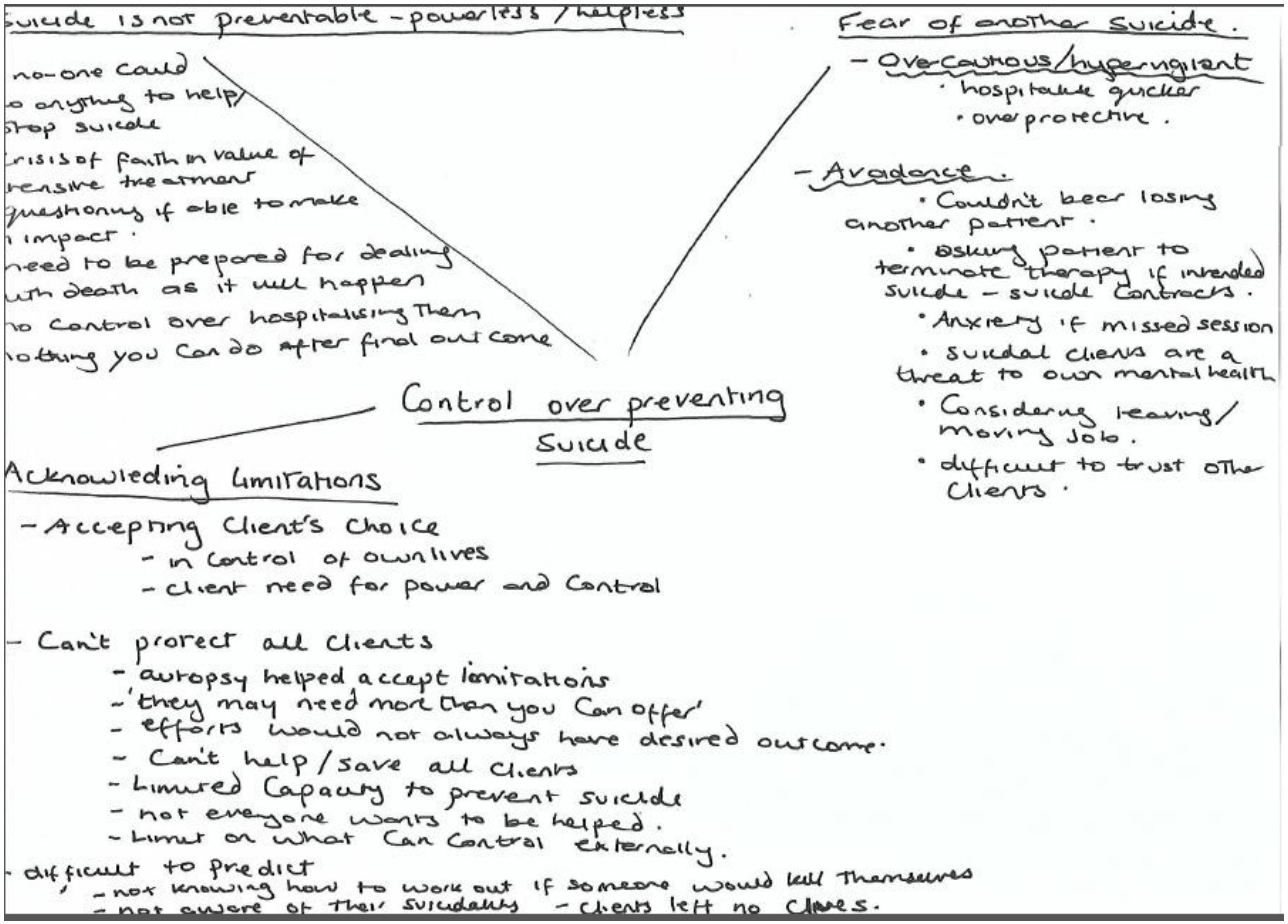
Appendix F: Phase 4 of Meta-ethnography

Table of Concepts for Awenat et al (2017) and Christianson and Everall (2009)

	Awenat et al., 2017	Christianson & Everall, 2009
CONTEXT: Sample Data collection Setting	- Nurses, support workers, psychiatrists, clinical psychologists, social workers, occupational therapists - Semi-structured interviews – thematic analysis - Inpatient suicide - Northern England	- School counsellors - Interviews – grounded theory - Canada
CONCEPT 1: Blame and responsibility	A defensiveness and fear about being blamed and losing career with service prioritising blame over personal reactions. Reflection on what went wrong and what was missed	Fear of litigation due to being accountable and fear of others responses. Feeling more responsible to protect young people due to their age. Questioning competence.
CONCEPT 2: Control over preventing suicide	Change in attitude that suicide is not preventable.	Challenged perception of being able to help young people whilst feeling vulnerable and powerless. Going from effecting change to being at the whim of external factors.
CONCEPT 3: Emotional impact	Upsetting when have known a client for years. Ongoing extensive investigation with prolonged distress for entire clinical team, changing the ward atmosphere. Colleagues off sick with anxiety and depression before coroners court. It never leaves you.	Intensity of grief experience depends on individual personal and professional circumstances. Some found it impossible to contain personal horror and experienced nightmares. Living with after effects whilst often being swept back into loss. There is a desire to move on

		without ignoring the experience.
CONCEPT 4: Experience of support	Varied experiences of support. Some found it helpful to talk in supervision, knowing manager is there and having access to formal support. However, some felt they had little to no support with personal and professional impact not being recognised. They were not debriefed, asked about what they thought or felt or about improvements. Being excluded from the investigation meant there was less opportunity to process the event and consequences. Having to find out through electronic record system. There was no time to pause to reflect and make sense of what has happened. Participants had to support patients effects, and senior staff had to support junior staff.	Some able to reach out and receive help, however most felt devalued, disempowered and isolated from other mental health professionals feeling that colleagues were not able to understand, or know how to respond or support them. There was a frustration and anger with the system. Participants either felt obliged or chose to serve the organisation as their primary responsibility. Assuming a leadership position gave a sense of control and Prioritising others needs provided a temporary relief from own feelings. Greif was forced underground and experience was compartmentalised in order to focus on work. Participants felt they had to project an aura of strength to support others. Attending funerals and engaging in spiritual practices
CONCEPT 5: Personal and professional growth	-	Recognising their strength in managing their distress, participants hoped they could continue to work in a high risk setting. Participants accepted the personal impact of loss and released themselves from responsibility. In future, participants learnt that they would access support quicker and involve others in clients care.

Appendix G: Phase 5 of Meta-Ethnography: Image of a Concept Map



Appendix H: Sample Inclusion and Exclusion Criteria

Criteria	Include	Exclude
Gender	Male	Female or transgender
Age	20 to 40	<19 or >40
Language	Can communicate and understand the English language	Requires an interpreter
Capacity	Has capacity to consent	Lacks capacity to consent
Time since suicide attempt	Attempted suicide between 6 - 36 months prior to the interview using any method of lethal self-injury with the intention to die	Has attempted suicide within six months of the interview or over three years ago
Suicidal ideation	Do not have active plans to end their life	Have active plans to end their life with the intent to act on them
Stage of treatment	Currently engaged in Community Mental Health Services (Secondary care)	Not currently an inpatient

Appendix I: Advert

Version 3 (10/07/2018)

IRAS ID: 241368

Young Men's Experiences of Life Following a Suicide Attempt

My name is Amanda Beavan and I am a Trainee Clinical Psychologist conducting a research study as part of a Clinical Psychology Doctorate.

I am looking to interview young men, aged between 20 and 40, who have attempted suicide between 6 months to 3 years ago.

It is hoped that the findings from this study will help develop a better understanding of how to support young men who have attempted suicide.

If you would like more information about this study, please ask your Mental Health Team for a Participant Information Sheet or contact the Lead Researcher, Amanda Beavan, on:

E-mail [redacted]

If you are interested in taking part, please complete the form below.

EXPRESSION OF INTEREST FORM

Name: _____

Contact Tel no. :_____

E-mail: _____

Location of Mental Health Team: *(Please circle)*

Coventry / Stratford-upon-Avon / Rugby / Leamington / Warwick / Nuneaton

Date completed: _____

Thank you for completing this form.

Please return in the envelope provided to:

Amanda Beavan (Lead Researcher)
Clinical Psychology Doctorate Programme,
Coventry University,
Coventry, CV1 5FB

Your data will be held securely, treated confidentially and will only be used to contact you about this study. Once I have received your form, I will contact you within 10 working days. You will then have up to 2 weeks to decide whether or not you wish to take part.

R&I RESEARCH & INNOVATION

Coventry University

WARWICK THE UNIVERSITY OF WARWICK

NHS Coventry and Warwickshire Partnership NHS Trust

Appendix J: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Research Study Title: Young men's experiences of life following a suicide attempt
Name of the Researcher: Amanda Beavan

You are being invited to take part in a research study exploring young men's experiences of life following a suicide attempt. This research is led by Amanda Beavan who is a Trainee Clinical Psychologist at Coventry University.

Before you decide whether to take part in this study it is important for you to understand why the research is being undertaken and what it will involve. Please take the time to read the following information carefully and discuss with others if you wish. The Mental Health Professional who has provided you with this information sheet is only involved in supporting the recruitment of participants for this study and is not part of the research team.

What is the purpose of this research?

It is known that men are three times more at risk of suicide compared to women and this is the leading cause of death in young men. For every suicide, it is estimated that more than 20 others attempt to end their life. However, there is little known about how young men experience life after a suicide attempt. This research study is attempting to better understand this experience.

One helpful approach to understanding more about this is to speak to young men who have attempted suicide. It is hoped that this study will provide new ways of understanding how best to help young men who have attempted suicide to reduce the risk of further attempts.

Who can take part in this study?

You will be able to take part if you are male, aged between 20 and 40 years, and have attempted suicide sometime between 6 months to 3 years ago.

What does taking part in this research study involve?

Taking part in this research will involve meeting with the Lead Researcher, Amanda Beavan, for an interview. During the interview you will be asked a range of questions about your last suicide attempt and your experiences (thoughts and feelings) following this. The interview will be audio recorded so that your responses can be transcribed.

Your participation in this study will start when the interview begins, and will end when the interview finishes. The interview will last up to 90 minutes and will take place in a private room in the NHS building where you attend your appointments with the Mental Health Team. Once the interview has ended, Amanda Beavan will provide you with a debrief sheet thanking you for your participation and providing information about

receiving a copy of the results, how to withdraw from the study if you wish to do so, and contact details for services that can support you if you are worried about acting on suicidal thoughts or plans.

What are the benefits of taking part?

We cannot promise that the study will help you personally, however, we hope that your interview responses will contribute to developing a better understanding of young men's experiences of life following a suicide attempt. Research suggests that talking about experiences of suicide can be helpful, however, the interview may impact each participant differently.

Are there any risks associated with taking part?

There are no significant risks associated with participating in this study. Every effort will be made to ensure that your wellbeing is considered before, during and after your involvement in this study. Your Mental Health Team will be informed when you have participated in the study so that they can support you.

Some people may find it difficult to talk about their experiences of suicide and this may cause distress. If you become distressed at any point during the interview, you will be offered a break and the Lead Researcher will discuss with you how best to continue. This may involve discontinuing the interview and contacting a member of your Mental Health Team to support you.

Do I have to take part?

No – it is entirely up to you. The Lead Researcher, Amanda Beavan, will contact you within 10 working days of receiving your Expression of Interest Form. You will then have up to 2 weeks to decide whether to take part. If you do decide to take part, please keep this Participant Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate.

What if I decide that I no longer wish to take part?

Please note down your participant number (which is on the Informed Consent Form) and provide this to the Lead Researcher if you wish to withdraw from the study. You are free to withdraw your information from the project within 2 weeks from the date of the interview. After this time, the data from your interview will be fully anonymised in our records and so it will no longer be possible to identify which data belongs to each participant.

Your data may be used in formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study.

To withdraw your data from this study, please contact the Lead Researcher, Amanda Beavan (E-mail: beavana@uni.coventry.ac.uk). Please also contact the Faculty Research Support Office (E-mail: researchproservices.fbl@coventry.ac.uk; Tel: +44(0)2477658461) so that your request can be dealt with promptly in the event of the Lead Researcher's absence. You do not need to give a reason. A decision to withdraw, or to not take part, will not affect you in any way.

Data Protection and Confidentiality

Your data will be processed in accordance with the General Data Protection Regulation (GDPR). All information collected about you will be held securely and treated as strictly confidential which means that it will not be shared with anyone outside of the research team. Your Mental Health Team will only be made aware that you are participating in the study and they will not have access to your interview responses. However, if the researcher is made aware of a risk of harm to yourself or someone else then they have a duty of care to share this information with the appropriate person (e.g. your Mental Health Team). You will be made aware of this where possible.

Your data will be referred to by a unique participant number rather than by name. In the publication of any direct quotes for this study you will be referred to by a false name and any identifiable information will be removed. The audio recording of your interview will be transcribed by the Lead Researcher, Amanda Beavan, into a password protected document. Once your interview responses have been transcribed, Amanda Beavan will destroy the audio recording of your interview. The transcript of your data will be fully anonymised by removing any identifiable information.

All electronic data, including your transcript, will be stored on a password protected storage drive called OneDrive that is only accessible by the Lead Researcher, Amanda Beavan. All paper records will be stored in a locked filing cabinet within the Coventry and Warwickshire Partnership NHS Trust (CWPT). Your Informed Consent Form will be kept, securely in a locked cabinet, separately from your responses in order to minimise risk in the event of a data breach. The Clinical Psychology Department at Coventry University will take responsibility for destroying all collected data (i.e. your interview transcript) on or before 27th September 2024.

CWPT will collect information from you for this research study in accordance with our instructions. CWPT will use your name and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from Coventry

University and regulatory organisations may look at your medical and research records to check the accuracy of the research study. CWPT will pass these details to Coventry University along with the information collected from you. The only people in Coventry University who will have access to information that identifies you will be people who need to contact you to arrange an interview to carry out the research or audit the data collection process. Coventry University will keep identifiable information about you (I.e. your consent form) until 27th September 2024.

Data Protection Rights

Coventry University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting the University Data Protection Officer via email enquiry.ipu@coventry.ac.uk or you can write to 1st Floor, Portal House, New Union Street, Coventry, CV1 2NT. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if there is a problem?

If you are unhappy with any aspect of this research, please first contact the Lead Researcher, Amanda Beavan (Email: [redacted])

If you still have concerns and wish to make a formal complaint, please write to:

Name: Dr Anthony Colombo (Academic Research Supervisor)
Address: Clinical Psychology, Coventry University, Priory Street, Coventry CV1 5FB
Email: [redacted]

In your letter please provide information about the research project, specify the name of the researcher and detail the nature of your complaint.

For any problems not resolved by the research team, please contact:

The Patient Advice & Liaison Service (PALS)
Address: PALS and Complaints, CWPT,
Wayside House, Wilsons Lane, Coventry, CV6 6NY

Freephone Number: 0800 212445 **Tel:** 024 7653 6804 / Fax: 024 7653 6896
Email: PALS.complaints@covwarkpt.nhs.uk

Alternatively, you can contact:

Name: Professor Olivier Sparagano (Associate Pro-Vice-Chancellor)
Address: University Applied Research Committee, Coventry University, Priory Street, Coventry, CV1 5FB
Email: [redacted]

What will happen to the results of the study?

The results of this study will be written as part of a Clinical Psychology Doctorate thesis at Coventry University and The University of Warwick. This will be presented at conferences and written for publication. No identifiable information about you will be published.

If you indicate on the Informed Consent Form that you would like to receive a copy of the results of this study, this will be E-mailed to you in plain English once the data has been analysed. When you receive a copy of the results, you will be offered the opportunity to provide feedback on whether the study findings represent your experiences; this is entirely optional.

Who is organising and funding the study?

This research study is organised by Amanda Beavan, who is a student from the Coventry University Clinical Psychology Department. The research is sponsored by Coventry University and is not externally funded.

Who has reviewed the study?

This study has been reviewed and approved through the formal research ethics procedures of Coventry University and the Health Research Authority.

Who can I contact for further information?

If you have any questions about this study, please contact the research team who will do their best to answer your questions:

Name (and role)	Contact details
Amanda Beavan (Lead Researcher)	**Address:** Clinical Psychology, Coventry University, Priory Street, Coventry CV1 5FB **Email:** [redacted]

Dr Anthony Colombo (Academic Research Supervisor)	**Address:** Clinical Psychology, Coventry University, Priory Street, Coventry CV1 5FB **Email:** [redacted]
Dr Marianna Perdikouri (Clinical Research Supervisor)	**Address**: IPU 3-8, CWPT, St Marys Lodge, 12 St Mary's Rd, Leamington Spa, CV31 1JN **Email:** [redacted]

Who can I contact if I am experiencing suicidal distress?

The following services can support you if you are worried about acting on suicidal thoughts or plans.

Location of Community Mental Health Team	Duty worker contact no. Monday - Friday 9am – 5pm	Out of hours crisis team no.
Stratford-upon-Avon	01789 415440	01926 406741
Leamington Spa	01926 339261	01926 406741
Coventry	02476 472662	02476 932800
Rugby	01788 513700	02476 322744
Nuneaton	0300 2002008	02476 322744

Samaritans:	**Tel:** 116 123 (free to call) **Website:** www.samaritans.org **Email:** [redacted] **Address:** Samaritans Coventry, 57 Moor Street, Earlsdon, Coventry, CV5 6ER
Mental Health Matters:	**Tel:** 0800 616 171 **Website:** www.mentalhealthmatters.com
CALM	**Helpline:** 0800 58 58 58 (5am – midnight) **Webchat:** www.thecalmzone.net

Thank you for reading this information sheet.

Appendix K: Interview Guide

Semi-structured Interview Guide

Study Title: Young men's experiences of life following a suicide attempt
Name of Researcher: Amanda Beavan

The purpose of this interview is to explore your experiences following a suicide attempt in the last 3 years. I encourage you to be as open as you can during the interview. Although I will be asking you some questions, I hope this to be led by you and your experiences. At times I may ask you what you mean by something or for further details. This is to ensure that I am able to understand your experiences in as much detail as you are comfortable to share. We will use a timeline which will start from the period immediately before you attempted suicide, to now. The purpose of this is to support your memory recall of the events in this time period. We have up to 90 minutes for this interview; however, we can end the interview at any time you wish. You are also free to take a break at any time. Do you have any questions before we begin?

1) Can you talk me through a typical day for you?
a) What contact, if any, do you have with other people on a typical day? (Work, hobbies, family, neighbours, friends)
b) Does anyone rely or depend on you for anything?
c) Do you rely or depend on anyone for anything?

2) How do you view yourself?
a) What words would you use to describe yourself?
b) What type of person do you think you are?
c) What makes you think this?
d) Have you always thought this?
e) How does this view of yourself make you feel?
f) Do you think others see you this way?

3) Who is most important to you in your life?
a) How often do you see them?
b) How do you feel when you are around them?
c) How do you think they view you?
d) How long have you known them?

4) Can you tell me about your last suicide attempt?
a) When was this?
b) What happened? (What method did you use, where did it take place, did you receive any medical intervention)
c) Was this the only time you have attempted suicide or have there been other attempts? (if yes, when did these occur, were they similar to your last attempt?)

5) What led you to attempt suicide?
a) What was happening in your life at the time?
b) When did you decide to do this? (Planned or impulsive)
c) For how long had you spent thinking about suicide before you attempted? (Urges, thoughts or plans)
d) How often did these thoughts occur over this period? (did the frequency remain constant or change over time?)

6) What was your experience in the period after you attempted suicide?
a) What happened in the first few hours / days / and weeks after?
b) How did you make sense of this at the time?
c) What did you do?
d) What were you thinking during this period?
e) What emotions did you notice?
f) How did others respond? (Friends, family, services)

7) What were the effects of this experience on your life?
a) How did this experience affect your life (social/ family /work / personal)?
b) How did you manage this?
c) How did these effects change and evolve over time?

8) Looking back, what are your thoughts and feelings about this suicide attempt now?
a) How do you view your suicide attempt now?
b) How does this make you feel?
c) How do others view your suicide attempt now?
d) How do you feel about their view of your suicide attempt?

9) How is life for you now compared to before you attempted suicide?
a) What has life been like for you since attempting suicide?
b) Have you noticed any changes in:
Yourself?
How you view others?
Your relationships with others?
Your view of the world?
Any other changes in your circumstances?

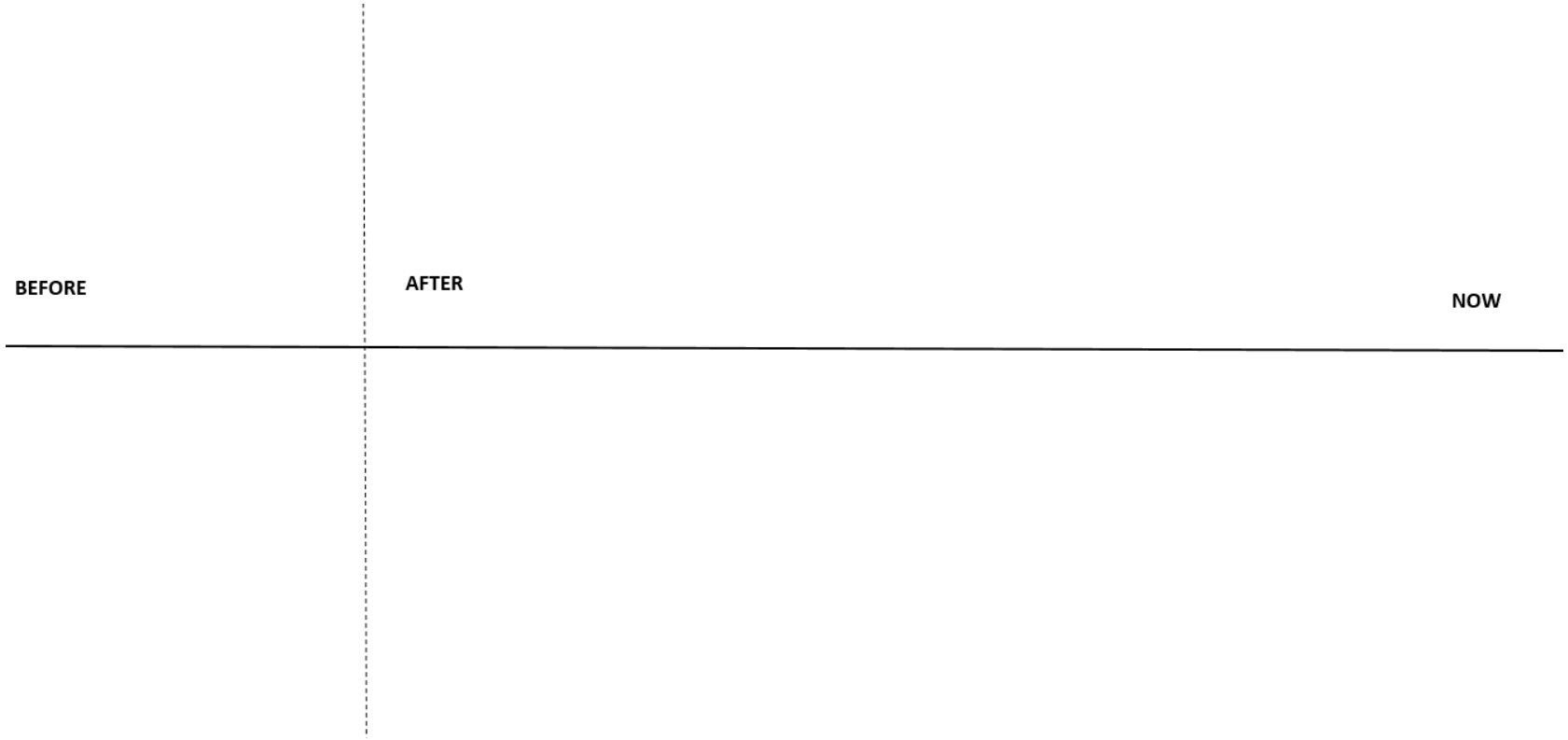
10) How do you feel about the future?
a) What are your hopes and fears about the future?
b) How does this compare to how you felt prior to the suicide attempt?

11) What matters most to you now?
a) What makes this important?
b) How do you feel about this?

12) Thank you for taking part in this interview. Would you like to add anything or comment on any areas we haven't covered?

General prompts:
- *Can you explain what you mean by that?*
- *Could you tell me more about that?*
- *What did that mean to you?*
- *How did that leave you feeling?*
- *Has this always been the case?*
- *What do you understand by that?*
- *What was that like for you?*

Appendix L: Timeline



Appendix M: HRA Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Amanda Beavan
Trainee Clinical Psychologist
Coventry and Warwickshire NHS partnership trust
St Michaels Hospital
St Michaels Road
Warwick
CV34 5QW

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

17 July 2018

Dear Miss Beavan

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Young men's interpersonal experiences following a suicide attempt**
IRAS project ID:	**241368**
Protocol number:	**n/a**
REC reference:	**18/WM/0182**
Sponsor	**University Applied Research Committee, Coventry University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Dr Anthony Colombo (Clinical Psychology Doctorate Programme, Coventry University)
Tel:
Email: [redacted]

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **241368**. Please quote this on all correspondence.

IRAS project ID	241368

Yours sincerely

Andrea Bell
Assessor

Email: hra.approval@nhs.net

Copy to: *Dr Anthony Colombo, Clinical Psychology Doctorate Programme, Coventry University- Sponsor contact*
Kay Wright, Coventry & Warwickshire Partnership NHS Trust – Lead NHS R&D contact

IRAS project ID	241368

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Coventry-University-ethics-certificate]	1	29 May 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [CU_Ethics_Review]	1	29 May 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [CU_ethics_Application]	1	29 May 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [R&I_Approval_20.04.18]		20 April 2018
Copies of advertisement materials for research participants [Advert_V2]	3	10 July 2018
Copies of advertisement materials for research participants [Advert_V3_Tracked_changes]	3	10 July 2018
Covering letter on headed paper [Covering letter]	1	10 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity_Insurance]		31 July 2017
GP/consultant information sheets or letters [email_template_to_Clinician_V1]	1	11 April 2018
GP/consultant information sheets or letters [email_template_to_gatekeepers_V1]	1	11 April 2018
HRA Schedule of Events [IRAS 241368 SoE]	2	17 July 2018
HRA Statement of Activities [IRAS 241368 SoA]	2.0	17 July 2018
Interview schedules or topic guides for participants [Interview_guide_V1]	1	11 April 2018
IRAS Application Form [IRAS_Form_01062018]		01 June 2018
IRAS Checklist XML [Checklist_12072018]		12 July 2018
Letter from sponsor [Sponsor Letter]	1	29 May 2018
Letters of invitation to participant [Feedback_form_V2]	3	10 July 2018
Letters of invitation to participant [Feedback_form_V3_tracked_changes]	3	10 July 2018
Participant consent form [Consent_Form_V2]	3	10 July 2018
Participant consent form [Consent_form_V3_Tracked_changes]	3	10 July 2018
Participant consent form [Debrief_sheet_V2]	3	10 July 2018
Participant consent form [Debrief_sheet_V3_tracked changes]	3	10 July 2018
Participant information sheet (PIS) [PIS_V2]	3	10 July 2018
Participant information sheet (PIS) [PIS_V3_Tracked_changes]	3	10 July 2018
Referee's report or other scientific critique report [Research_Proposal_Critique]	1	13 October 2017
Research protocol or project proposal [Research_Protocol_V2]	3	10 July 2018
Summary CV for Chief Investigator (CI) [Chief_Investigator_CV_V1]	1	25 May 2018
Summary CV for student [chief_investigator_CV_V1]	1	25 May 2018
Summary CV for supervisor (student research) [Academic_supervisor_CV_V1]	1	25 May 2018
Summary CV for supervisor (student research) [Clinical_Supervisor_CV_V1]	1	25 May 2018

Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [liability_Insurance]		01 August 2017

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	
4.2	Insurance/indemnity arrangements assessed	Yes	
4.3	Financial arrangements assessed	Yes	
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion	Yes	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
	received for applicable studies		
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
There is one site type. All organisations will undertake the activities as detailed in the IRAS application and protocol. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
The CI will be responsible for all of the research activities undertaken at site. A Local Collaborator will be required to arrange access to rooms at the participating NHS site to undertake the interviews. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

IRAS project ID	241368

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix N: REC Approval

Health Research Authority

West Midlands - Edgbaston Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

17 July 2018

Miss Amanda Beavan
Coventry and Warwickshire NHS partnership trust
St Michaels Hospital
St Michaels Road
Warwick
CV34 5QW

Dear Miss Beavan,

Study title:	**Young men's interpersonal experiences following a suicide attempt**
REC reference:	**18/WM/0182**
Protocol number:	**n/a**
IRAS project ID:	**241368**

Thank you for your letter of 12 July 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will

be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Coventry-University-ethics-certificate]	1	29 May 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [CU_Ethics_Review]	1	29 May 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [CU_ethics_Application]	1	29 May 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [R&I_Approval_20.04.18]		20 April 2018
Copies of advertisement materials for research participants [Advert_V2]	3	10 July 2018
Copies of advertisement materials for research participants [Advert_V3_Tracked_changes]	3	10 July 2018
Covering letter on headed paper [Covering letter]	1	10 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity_Insurance]		31 July 2017
GP/consultant information sheets or letters [email_template_to_Clinician_V1]	1	11 April 2018
GP/consultant information sheets or letters [email_template_to_gatekeepers_V1]	1	11 April 2018
Interview schedules or topic guides for participants [Interview_guide_V1]	1	11 April 2018
IRAS Application Form [IRAS_Form_01062018]		01 June 2018
IRAS Checklist XML [Checklist_12072018]		12 July 2018
Letter from sponsor [Sponsor Letter]	1	29 May 2018
Letters of invitation to participant [Feedback_form_V2]	3	10 July 2018
Letters of invitation to participant [Feedback_form_V3_tracked_changes]	3	10 July 2018
Participant consent form [Consent_Form_V2]	3	10 July 2018
Participant consent form [Consent_form_V3_Tracked_changes]	3	10 July 2018
Participant consent form [Debrief_sheet_V2]	3	10 July 2018
Participant consent form [Debrief_sheet_V3_tracked changes]	3	10 July 2018
Participant information sheet (PIS) [PIS_V2]	3	10 July 2018
Participant information sheet (PIS) [PIS_V3_Tracked_changes]	3	10 July 2018

Referee's report or other scientific critique report [Research_Proposal_Critique]	1	13 October 2017
Research protocol or project proposal [Research_Protocol_V2]	3	10 July 2018
Summary CV for Chief Investigator (CI) [Chief_Investigator_CV_V1]	1	25 May 2018
Summary CV for student [chief_investigator_CV_V1]	1	25 May 2018
Summary CV for supervisor (student research) [Academic_supervisor_CV_V1]	1	25 May 2018
Summary CV for supervisor (student research) [Clinical_Supervisor_CV_V1]	1	25 May 2018
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [liability_Insurance]		01 August 2017

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

18/WM/0182	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely,

Mr Paul Hamilton
Chair

Email:NRESCommittee.WestMidlands-Edgbaston@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr Anthony Colombo , Clinical Psychology Doctorate Programme, Coventry University*
Kay Wright, Coventry & Warwickshire Partnership NHS Trust

Appendix O: NHS Local R&I Approval

Local R&I Approval

Dear Amanda
Study Title: Young Men's Experiences Following a Suicide Attempt
IRAS Number: 241368

I am pleased to inform you that the R&I review of the above project is complete. Therefore NHS permission has been granted for the study at Coventry and Warwickshire Partnership NHS Trust. The details of your study have now been entered onto the Trust's database.

The permission has been granted on the basis described in the application form, protocol, supporting documentation **pending** REC & HRA Approval letters.

As previously discussed, once you are in receipt of HRA and REC approval letters formal approval will be confirmed.

Congratulations and good luck with your research.

Best wishes

Liz

Best wishes & kind regards
Elizabeth Vassell
Research Support Facilitator

[redacted]

R&I RESEARCH & INNOVATION
Research and Innovation Department
1st Floor, Caludon Centre
Clifford Bridge Road, Coventry CV2 2TE
Email: researchteam@covwarkpt.nhs.uk
Tel: 024 7693 2430
www.covwarkpt.nhs.uk/research-innovation

Appendix P: Coventry University Approval

Certificate of Ethical Approval

Applicant:

Amanda Beavan

Project Title:

Young men's interpersonal experiences following a suicide attempt

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

29 May 2018

Project Reference Number:

P62406

Appendix Q: Consent Form

Version 3 (10/07/2018) IRAS ID: 241368

INFORMED CONSENT FORM

Research Study Title: Young men's experiences of life following a suicide attempt
Name of Researcher: Amanda Beavan

You are invited to take part in this research study for the purpose of collecting data on young men's experiences of life following a suicide attempt.

Before you decide to take part, it is important for you to **read the accompanying Participant Information Sheet.**

Please do not hesitate to ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

If you are happy to participate, please confirm your consent by initialling each box against the below statements and then signing and dating the form as the participant.

		Initials
1	I confirm that I have read and understood the Participant Information Sheet (10/07/2018) for the above study and have had the opportunity to ask questions.	
2	I understand that my participation is voluntary and that I am free to withdraw my research data within 2 weeks of the interview date, without giving a reason or my treatment being affected, by contacting the Lead Researcher and the Faculty Research Support Office.	
3	I am aware that my research data will be referred to by a unique participant number (bottom right of this Informed Consent Form) rather than by name and that this may be required by the lead researcher if I wish to withdraw from the study.	
4	I understand that any identifiable information will be removed from my data and I will be referred to by a false name in any publication of this study.	
5	I give permission for direct quotes from the interview to be used in publications, in academic papers and other formal research outputs.	
6	I understand that all the information I provide will be held securely and treated confidentially and I am aware that confidentiality will only be broken if there is a risk of harm to myself or someone else.	
7	I am happy for the interview to be audio recorded.	

Page **1** of **2** When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

8	I understand that the data collected during this study may be looked at by the named research team and I give permission for these individuals to access my research data.		
9	I understand that the data collected for this study will be stored securely for 5 years after the research study is completed before being destroyed on or before 27/09/2024.		
10	I understand that this research study has been reviewed and approved by Coventry University Research Ethics Committee and The Health Research Authority.		
11	I understand that I may contact the researchers if I would like more information about the study (contact details on the Participant Information Sheet).		
12	I agree to my Mental Health Team being informed of my participation in this study.		
13	I agree to take part in the above named research study.		
14	I would like to receive a copy of the results of the study via my E-mail address that I provided on the Expression of Interest Form from the study advert.	YES	NO

Participant's Name	Date	Signature
Researcher's Name	Date	Signature

Participant No.

Appendix R: Participant Debrief Sheet

Version 3 (10/07/2018) IRAS ID: 241368

PARTICIPANT DEBRIEF SHEET

Study Title: Young men's experiences of life following a suicide attempt
Name of Researcher: Amanda Beavan

Thank you for taking part in this study and taking time to share your experiences. Your participation in this research is extremely valuable in helping to improve our understanding of young men's experiences after a suicide attempt.

If you indicated on the Informed Consent Form that you would like to receive a copy of the results of this study, this will be E-mailed to you once the data has been analysed. When you receive a copy of the results, you will be offered the opportunity to provide feedback on whether the study findings represent your experiences; this is entirely optional.

Talking about your experiences may have brought up difficult emotions. Contact details are provided for the following services that can support you if you are worried about acting on suicidal thoughts or plans.

Location of Community Mental Health Team	Duty worker Monday - Friday 9am – 5pm	Out of hours Crisis Team
Stratford-upon-Avon	01789 415440	01926 406741
Leamington Spa	01926 339261	01926 406741
Coventry	02476 472662	02476932800
Rugby	01788 513700	02476 322744
Nuneaton	0300 2002008	02476 322744

Samaritans	**Tel:** 116 123 (free to call) **Website:** www.samaritans.org **Email:** [redacted] **Address:** Samaritans Coventry, 57 Moor Street, Earlsdon, Coventry, CV5 6ER
Mental Health Matters	**Tel:** 0800 616 171 **Website:** www.mentalhealthmatters.com
CALM	**Helpline:** 0800 58 58 58 (5am – midnight) **Webchat:** www.thecalmzone.net

R&I RESEARCH & INNOVATION Coventry University WARWICK THE UNIVERSITY OF WARWICK NHS Coventry and Warwickshire Partnership NHS Trust

What if I decide that I no longer wish to participate?

Please note down your participant number (which is on the Informed Consent Form) and provide this to the Lead Researcher if you wish to withdraw from the study. You are free to withdraw your information from the project within 2 weeks from the date of your interview. After this time, the data from your interview will be fully anonymised in our records and so it will no longer be possible to identify which data belongs to each participant.

Your data may be used in formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study.

To withdraw your data from this study, please contact the Lead Researcher, Amanda Beavan (E-mail: [redacted]. Please also contact the Faculty Research Support Office (E-mail: researchproservices.fbl@coventry.ac.uk; Tel: +44(0)2477658461) so that your request can be dealt with promptly in the event of the Lead Researcher's absence. You do not need to give a reason. A decision to withdraw, or to not take part, will not affect you in any way.

If you have any questions about this study, please contact the lead researcher Amanda Beavan [redacted] who will do their best to answer your questions.

Thank you for participating in this study.

Appendix S: Example of IPA stage 2

Emergent themes	Original transcript	Exploratory comments (Descriptive / *Linguistic* / **Conceptual)**
Social withdrawal Lack of drive Loss of self Stigma Fear of new self	P: … normally get up at about half past 10…err I take the dog for a walk, and err that's it, I don't really do anything else, I don't go out, I don't see friends, I don't watch TV, I just sit there, all the time, I: has that always been the case? P: no, no, I got, after the suicide attempt, it did not (unintelligible) really, I have become a different person and err, yeah I find socially, I don't feel I've got the skills anymore, because people annoy me. So I, people are very opinionated so, I tend, I find that, (unintelligible)…my life, if you begin to tell people that they begin to judge you, so don't tell people, or, don't see people, so I don't see people, and that's a bad way of dealing with my emotions, but that's generally what happens every day really	Walking dog as part of routine to leave house *Doing much less than he used to (later talks about seeing friends and watching comedy)* Stagnation **Lack of drive** *Denies it was always the case twice 'no, no'* **Shame of being seen this way** Becoming a different person Loss of social skills Annoyed by people **less tolerant of others** Others as judgemental *'Begin' – not having the chance to explain – being judged by the suicide attempt as if this defines him – moves to second person tense as if they are not judging the real him* Social withdrawal – avoidance **Stigma – hiding new self** *judging self 'bad way of dealing with my emotions'* **avoidance driven by fear of own response to others**

Appendix T: Example of IPA Stage 4