Life after loss to suicide: understanding social network interactions and their impact

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I, Hannah Rachel Scott, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

[signature redacted]

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Abstract

Conservative estimates suggest that globally, 5 million people are impacted by suicide each year, making it a prevalent stressful life event, and one that has the potential to impact considerably on wellbeing. In England, professional support specifically focused on the needs of people bereaved by suicide is limited and so informal social support, the help available from family and friends, is particularly important. Little is known about the mechanisms of social support after a suicide loss, particularly its reciprocal aspect.

The aim of this thesis is to explore how the social networks of friends and family bereaved by suicide informally support one another after their loss.

The first project in this thesis is a systematic review and narrative synthesis of 16 studies, which showed that higher levels of social support are at least partially associated with improved wellbeing after sudden or traumatic deaths. Social support is therefore worth working to improve.

A qualitative study followed this, in which 26 participants from 13 different social networks were interviewed about their experiences of support and social interactions after their loss. A novel method of analysis (based on dyadic analysis) was used to examine the similarities and differences in perspectives of participants from within the same social networks. Results showed that social networks tend to naturally adapt to cope with a loss, but can face barriers to communication which hinder supportive efforts, and relationships can be negatively impacted by mismatches of narratives of the loss and support style.

Finally, a public resource aimed at social networks bereaved by suicide underwent initial development. Using findings from the qualitative study, draft material for a text-based resource intended to inform and normalise experiences, and a plan for its further development was created.

Impact Statement

Suicide is something that impacts a significant proportion of the UK population, with data indicating that roughly 6000 people die by suicide in the UK every year (Samaritans, 2018), each leaving behind a group of family and friends. There is a lack of professional support specifically for people who have been bereaved by suicide in the UK, and so the social support that takes place between family and friends is particularly important to improve wellbeing outcomes after people have experienced a loss to suicide.

This project provides a better understanding of the impact of suicide bereavement on friend and family groups, and the support that takes place within them then has previously existed in academic literature. The findings of this research have the capacity to influence the focus of suicide bereavement services and directly help people who have experience a loss to suicide cope with their bereavement.

The systematic review (chapter 2) presented in this thesis has been published in a peer reviewed journal, and papers related to the qualitative study are in preparation for submission. I have also presented the qualitative methodology at a national conference and the results of the qualitative study at an international academic conference. In particular, the published thesis and published peer-reviewed papers can serve as a guide for other qualitative researchers looking to carry out analysis of their data at multiple levels (individual, within and across group-levels) as there is currently a lack of published literature that describes the methodological process of multi-level qualitative analysis.

During my PhD, I have given several oral presentations both about my research and broader suicide prevention research to non-academic audiences, using my learnt expertise about the subject area in general as well as my own project. Audiences include charity volunteers at the Survivors of Bereavement by Suicide AGM and the Central London Samaritans AGM, and charity donors and supporters at the Mental Health Research UK's Scholar's Day. These talks have hopefully encouraged audiences to engage further with research in the future.

A significant part of my project has been the initial development of a public resource based on the results of the qualitative study, and the work that has been carried out so far and future plans for work are described in chapter 7. In brief, the resource is intended to be an informational booklet or web page aimed at people who have recently been bereaved by suicide, or know somebody supporting somebody bereaved by suicide. It will use vignettes to normalise the social changes that can take place within family and friend groups and provide advice about how to cope with these changes. Whilst this resource could not be fully developed within the timescale of this project, initial development and consultation has been carried out and potential supporters for ongoing work on this project have been identified. By partnering with a known suicide prevention or bereavement charity to disseminate the resource, there is the potential to reach and therefore help a large number of people.

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List of abbreviations

DPM	Dual Process Model
HMT	Hierarchical Mapping Technique
NOS	Newcastle-Ottawa Scale
PPI	Public and Patient Involvement

Chapter 1: Background

In this chapter I will summarise existing literature regarding bereavement, social support, and the relationship between the two. First, I will discuss bereavement, focusing on suicide bereavement and what makes it unique to other types of bereavement. Section 1.2 describes how social support can be conceptualised and measured and considers how it relates to formal support. Finally, section 1.3. considers the relationship between suicide bereavement and social support, identifying existing gaps in the literature and providing a justification for this thesis. The aims of the thesis are summarised in section 1.4.

1.1 Bereavement

1.1.1 Overview of bereavement

Bereavement is the "physiological, psychological, behavioural, and social response patterns displayed by an individual following a loss (usually through death) of a significant person or thing" (Dunne, McIntosh, & Dunne-Maxim, 1987) and is an integral human experience, impacting almost all of us, often multiple times over a lifetime.

Defining who is bereaved after a loss is complex, as a judgement must be made about whether somebody is impacted enough by a loss to count as being bereaved, and intensity and length of bereavement varies on a number of individual factors (Sidney, Zisook & Shear, 2009); researchers generally rely on those impacted by a loss to self-identify as being bereaved. The term bereavement is also often used interchangeably with grief and mourning, however there are key distinctions between each. Bereavement is the state of experiencing loss, whereas grief is the reaction to a loss and mourning is the outward expression of this grief (Buglass, 2010).

Bereavement is seen as a temporary state: on average, the acute bereavement period lasts 18 months (Horowitz et al., 2003) while an individual adapts to a loss. Beyond the bereavement period where grief is at its most intense and an individual has not yet adapted to their loss, the death of a loved one can have an extensive long-term impact (Stroebe, Schut, & Stroebe, 2007) depending on the context of the loss and a range of individual and interpersonal variables such as social support, which will be considered later in the chapter. Research reports that bereavement has a significant impact on a wide range of health and social outcomes including risks of affective, cognitive, behavioural, physiological-somatic and immunological dysfunction (Berardo, 1970; Kristensen, Weisæth, & Heir, 2012; Stroebe et al., 2007).

In addition to the expected lasting impact, if a person's state of bereavement lasts beyond an expected length, it can reach a threshold such that it is regarded as "complicated grief" (Shear et al., 2011). Complicated grief, or prolonged grief disorder has gained recognition as a diagnosable disorder included in the ICD-11 (World Health Organization, 2018a). It is characterised by intense

grief responses such as longing for or preoccupation with the deceased that impair an individual's functioning that lasts for more than 6 months (Killikelly & Maercker, 2017).

Bereavement involves the cognitive processing of loss; coming to an understanding and acceptance of what happened (meaning-making), which determines the emotions that bereaved individuals have (Stroebe & Schut, 2004). There are several theories that explain how people cope with loss. Traditionally, theories have been based on the idea that grief can be worked through in stages, such as the popular five stages model (denial, anger, bargaining, depression and acceptance) (Kübler-Ross, 1973). However, this and similar other models are not well supported empirically (Maciejewski, Zhang, Block, & Prigerson, 2007) and over-simplify the process of adapting to a loss by suggesting that it falls into linear stages. These models also fail to account for individual differences in bereavement, and the stressors that are indirectly related to loss such as finances, workload etc. A theory that may better explain bereavement is the Dual Process Model (DPM; Schut, Stroebe, 1999), which accounts for the individuality of bereavement and its far-reaching impact on an individual's life.

1.1.2 The dual process model as a way to understand coping with bereavement

Meaning-making after a loss can be conceptualised using the dual process model of coping with bereavement (Schut, Stroebe, 1999) that expands on the idea of meaning-making after a loss. Unlike the popular Kübler-Ross (1973) model of grief which suggests those who are bereaved experience five stages of coping with their grief, the DPM has been substantiated by a body of research in the two decades since it was first proposed (Carr, 2010). The bereavement experience has also been understood through attachment theory (Bowlby, 1977), suggesting that central to an individual's adaptation to a loss was an individual's attachment style and their attachment with the person who died. This concept of adjustment after bereavement is limited, as it suggests that confronting the lost relationship and reassigning the role the person who died played for them is the only way of working through a bereavement. Attachment theory was also conceptualised with a focus on short-term stressors and attachments with a single figure and so fails to take into account the complexity of the social world (Field, 1996).

Compared to attachment-based models, the DPM allows for the use of different coping styles by proposing that there are two types of stressor that need to be dealt with to successfully adapt to a bereavement: "loss-oriented (focusing on the deceased and death events; confronting and dwelling on loss) and restoration-oriented (dealing with secondary stressors, such as coping with finances or learning to run a household, that come about as a result of the death)." (Stroebe, 2002). This way of framing bereavement is more suited to the varied types of loss people can experience, including suicide loss, and the different coping styles that people have. For example, it can account for avoidance as a healthy coping mechanism to some extent through enhancing someone's capacity to deal with restoration-oriented stressors (Shear, 2010).

As well as theoretical evaluations of the model, some empirical research has been carried out to establish the existence and importance of restoration and loss-oriented stressors. Generally, studies have found support for methods of coping with each of these types of stressors being

associated with better adjustment to the loss, although most of this research has been carried out on older widows (Bennett, Gibbons & MacKenzie-Smith, 2010). A key issue within the DPM is that of the balance between the two types of stressors, and how much should be invested in coping with each. It has been suggested that this balance changes over the course of bereavement (Richardson, 2007), but further empirical research is needed to confirm this.

The DPM does clearly allow for the concept of interpersonal coping and the idea that one person's way of grieving can impact on another's (Gilbert, 1989; Stroebe & Schut, 2010). Others can reduce the load of restoration-oriented stressors and facilitate coping with loss-oriented stress in that talking through narratives and getting others' perspectives on the event can facilitate or impede working through a loss (Park, 2010). Empirical research focusing on parental bereavement, where interpersonal coping is particularly relevant, indicates that couples' approach to dealing with loss and restoration stressors impacted on their partner's ability to cope (Wijngaards-de Meij et al., 2008). This model therefore allows for the influence of reciprocal social support in coping with loss, which will be discussed further in the next section.

This approach to loss may explain the lack of empirical evidence that supports the buffering hypothesis of social support in relation to bereavement. The hypothesis specifies that social support works by negating the stressful deficits caused by a loss, whereas DPM accounts for the unique relationship an individual will have had with a person who died that cannot easily be compensated for by others in a network (Stroebe & Schut, 1996). It suggests that social support can help after bereavement by specifically alleviating feelings of social isolation, rather than replacing what was provided by the person who died. This may explain why research consistently finds that stigma sets suicide bereavement apart from other losses, as these feelings of social isolation will be compounded by perceived stigma.

1.1.3 The interpersonal context of bereavement

While bereavement impacts on a number of aspects of an individual's life, other factors also influence the impact and severity of bereavement; particularly the social environment (Sanders, 1988; Stroebe & Schut, 2001; van der Houwen et al., 2010). There is a significant body of literature that focuses on the interpersonal dimension of bereavement, highlighting that any individual's grief is embedded within their core relationships and the dynamics of their social network (also referred to as social group) (Shapiro, 2004).

Meaning-making is a social process as well as a personal one. When an individual's perception of reality is challenged, they often turn to others in their social network to help confirm their reality. In the case of bereavement, it may be helpful for social network members to have a shared view about what happened and therefore confirm each other's realities. If network member's realities differ, this could present challenges to the way the group functions (Gilbert, 1996).

Research also shows that there are social norms for the expression of bereavement; both the way in which individuals express their grief and when they grieve are influenced in some part by what their social network expects and how it responds to them (Robson & Walter, 2013).

At a broad level, different cultures have different processes for marking a death and different beliefs about what happens after life, both of which can help or hinder an individual's adjustment to loss and alter how they are treated by those around them in relation to their loss (Cacciatore & DeFrain, 2015). Worldwide, there are 25 countries where suicide is still illegal (Mishara & Weisstub, 2016) and each of the major world religions have groups within them who view suicide negatively (Bhugra, 2010). Whilst very little cross-cultural research exists looking at the social aspects of grief and bereavement after loss to suicide, it is likely that communities in these countries and sects are more likely to stigmatise those who take their own life and those who were close to them.

At the social network level, it is understood that the loss of a network member has an impact on the remaining relationships within that group; for example widowhood has been found to negatively impact on friendships (Zisook, Shuchter, Sledge, Paulus & Judd, 1994) and the loss of a child makes partners more likely to break up, potentially if they found that they were unable to adequately support one another (Lehman, Lang, Wortman & Sorenson, 1989). Several quantitative assessment tools have been developed specifically to capture how family relationships are impacted by losses (Hooghe, De Mol, Baetens & Zech, 2013). Other studies use network characteristics or more general measures of relationships to examine the relationship between loss and family dynamics. For example, a systematic review of the impact on partners' relationships after the death of their child found that their loss could have positive and negative effects depending on situational factors such as the cause of death and relationship factors such as congruence of grieving. Marital quality and interdependence influenced each partner's individual adjustment (Albuquerque, Pereira, & Narciso, 2016).

1.1.4 Suicide bereavement

Mode of death is another factor that influences the bereavement experience. Deaths can be categorised into unexpected (e.g. a natural disaster) or expected deaths (e.g. terminal illness) and/or violent (e.g. homicide) or non-violent (e.g. heart attack). Whilst these categorisations are broad, there are distinctions in bereavement outcomes according to type of loss. Studies show that lack of preparedness for death and perception of violent death are associated with an increased risk of the bereaved developing a psychiatric disorder (Barry, Kasl, & Prigerson, 2002; Kaltman & Bonanno, 2003) compared to more expected and less violent deaths.

Being able to expect death in some sense enables a person to begin the bereavement process before a person dies and makes dealing with loss and restoration-oriented stressors easier. It allows a person to begin to come to terms with a loss more slowly, to reassign the roles that the person gave to them for other people, and to have cognitive closure (Van Hiel & Mervielde, 2003).

Suicide is commonly categorised as a violent and unexpected loss (although it can sometimes be anticipated), and is uniquely distinct from other types of death, given that it involves the deliberate act to end one's own life. The World Health Organization (World Health Organization, 2018b) estimates that 800,000 people die by suicide each year; whilst suicide rates in England have been in decline since the 1980s, suicide is still the leading cause of death in adults under fifty with roughly 6000 deaths in England and Wales each year (Office for National Statistics, 2020). Broken down by age and gender, males aged between 45 and 49 and females aged between 50 and 54 have particularly high rates of suicide in England and Wales, with males having a higher suicide rate overall (Office for National Statistics, 2020). Also particularly at risk are low-skilled workers, divorcees, those who live in deprived areas and those who have been bereaved by suicide (Office for National Statistics, 2017b).

Individuals who are bereaved by suicide experience a greater risk of a range of negative wellbeing outcomes compared to those who are bereaved through other means. The extent of these risks are dependent on kinship with the person who died (Pitman, Osborn, King, & Erlangsen, 2014), but individual studies have shown that for those bereaved by suicide the risk of attempting suicide themselves is increased by 65% compared to the non-bereaved population (Pitman et al., 2017) and the risk of complicated grief is at 63% rather than 10-20% for other types of bereavement (Bellini et al., 2018).

It is difficult to make a binary distinction between who is and isn't bereaved. Cerel (Cerel, McIntosh, Neimeyer, Maple & Marshall, 2014) suggests that exposure to suicide loss on a continuum of the long term bereaved (those with a close personal relationship to the person who died who are impacted across a protracted period), the short term bereaved (those with a close personal relationship to the person who died), the affected (anyone who experienced distress) and the exposed (anyone who knew or identified with the person who died). The categories are not mutually exclusive, so those who might technically fall into one category might self-identify as being in another, and the length of time before somebody is classified as long term bereaved is not specified. This conceptualisation is difficult to operationalise and is perhaps most useful in identifying target groups for interventions after a loss to suicide, however, it is the most comprehensive framework for categorising of the impact of suicide available. Using this continuum in research and practice also encourages recognition of the fact that a suicide loss impacts not just the close family and friends of the person who died. This is clearly documented in research about social diffusion of suicides, where several suicides occur in similar temporal and geographical spaces as a result of social connections (Abrutyn, Mueller, & Osborne, 2020; Haw, Hawton, Niedzwiedz, & Platt, 2013).

Estimates about how many people are impacted by loss to suicide vary considerably depending on how impact (or affect) and bereavement are defined. A long-standing estimate of suicide impact suggested that for every loss to suicide, six people were impacted, but this estimate was reportedly based on "common sense" rather than empirical research (Shneidman, 1969). Since then, research based on surveys has indicated that 135 individuals are exposed to each suicide and are therefore at increased risk of negative health outcomes (Cerel et al., 2018). However, as stated above, exposure is not necessarily bereavement. Population based studies estimate that the prevalence of suicide exposure in the past year is 4.3% and 21.8% over the lifetime (Andriessen,

Rahman, Draper, Dudley, & Mitchell, 2017). Based on a tighter definition, where impact that counted was defined as being "intimately and directly affected" by the loss, it was found that between 40 and 80 people were significantly impacted depending on the stage of life of the person who died (Berman, 2011). Even using this more conservative estimate implies that globally, 5 million people each year are impacted by a loss to suicide.

1.1.5 Quantitative research comparing suicide bereavement to other types of bereavement

Given that suicide is a unique type of death, it could be expected that the bereavement experience would also be unique and impact on health outcomes differently to other types of loss. The grief experienced after suicide bereavement is often described as disenfranchised grief, or "grief that is experienced when a loss cannot be openly acknowledged, socially sanctioned, or publicly mourned" (Doka, 1999), based on the idea that that suicide bereavement is distinct in terms of the stigma attached to it, as it can be seen as a failure, both on the part of the person who died and their social group, in dealing with life stress (Cvinar, 2005).

A systematic review of 41 quantitative studies (Sveen & Walby, 2008) found no difference between suicide bereavement and other types of bereavement for general mental health, depression, PTSD, anxiety and suicidal ideation in the majority of included studies that measured these outcomes. Those bereaved by suicide did, however, report increased feelings of shame, rejection and stigma. However, there were a number of methodological issues that were prevalent across included studies: samples of those bereaved by suicide were often demographically different from comparison samples and there was a sampling bias across a number of studies. Only 6 included studies were longitudinal and could indicate causality, and outcomes were measured inconsistently.

A more recent systematic review on the same topic found 57 studies for inclusion (Pitman et al., 2014). As well as updating the previous review, this study separated out reporting of results by relationship to the person who died, finding that rates of adverse outcomes depended on kinship (parents, partners, children and siblings). The review found that for those experiencing suicide bereavement compared to other types of loss, there is an increased risk of suicide in bereaved partners and mothers, depression in children and admission to psychiatric care for parents. There was some evidence for increased feelings of rejection and shame compared to bereavement through other violent causes of death, and increased stigma compared to non-violent deaths.

Pitman et al (2014) reported the same methodological issues across studies as those in Sveen and Walby's (2008) review, and neither review was able to carry out a meta-analysis given the heterogeneity in methods of included studies. Given that over half of the studies included in the first review were also included in the second, the difference in the findings regarding mental health outcomes are likely to be explained by the latter review considering findings according to kinship, which likely relates to the degree of closeness to the person who died. Although this

review did include some studies which assessed friends of somebody who had died by suicide, this subgroup was not mentioned in the synthesis, suggesting that there is a lack of evidence about the impact of bereavement on friends.

Reviews that focus on mental health outcomes are also unable to fully capture the impact of a loss to suicide on the social world of those who are bereaved. Both reviews find reasonably consistent support for increased feelings of shame and rejection for those who have been bereaved by suicide, but the number of studies measuring these outcomes were much lower than the measurement of mental health outcomes (twelve studies in the 2008 review and five studies in the 2014 review included these outcomes) so empirical support for these results are relatively limited. These outcomes closely relate to loneliness and social integration, and the 2008 review reported that for all six studies that measured social support as an outcome, those who were bereaved by suicide reported significantly less support than those bereaved through other types of loss; the 2014 review found only two studies on this with contradictory findings. There is a paucity of quantitative research that documents the experience of relations beyond immediate kin, and that focuses on social outcomes.

More recent studies confirm the findings of these reviews, finding that those bereaved by suicide have a higher risk of suicide and mental illness compared to other types of bereavement (Hamdan, Berkman, Lavi, Levy, & Brent, 2020; Spiwak et al., 2020). In addition, a longitudinal study found that feelings of stigmatization, guilt and rejection were higher in those bereaved by suicide than by other means (Kõlves et al., 2020).

As previously stated, the context of suicide bereavement is unique: it is the only death where somebody choses an action that ends their life, often unexpected and always classed as violent. As well as the methodological limitations in the quantitative literature highlighted in these quantitative reviews, this impact of the context of the death on bereavement is likely something that is difficult to capture through quantitative research that generally focuses on diagnosable mental health issues and employ brief psychiatric assessments as outcome measures (Kitson, 2000). The context of the social environment (Ali, 2015) and the impact of specific factors such as finding the body (Young et al., 2012) or learned suicidal behaviours (Mesoudi, 2009) often cannot be considered in general measurement tools.

1.1.6 Qualitative research comparing suicide bereavement to other types of bereavement

Whilst existing quantitative literature has methodological challenges, it indicates that suicide bereavement results in wellbeing outcomes distinct from other types of bereavement. Qualitative literature can be used to understand what it is about the bereavement experience that is unique and leads to these specific outcomes. As it is more explorative and produces a more nuanced understanding of phenomena, it can also be used to consider the social aspect of bereavement.

Out of the eleven studies included in a review of qualitative studies exploring suicide bereavement (Shields, Kavanagh, & Russo, 2017), seven explored the theme of meaning-making. The studies consistently reported that those who had been bereaved by suicide invested in understanding why the suicide happened and coming to terms with the deliberateness of it though finding a way to make it fit with their understanding of the world. Studies consistently reported perceptions of pressure from others to stop grieving before those who were bereaved felt ready to, and that talking with others about the loss was challenging. Included studies were generally of good quality, however the problems with selective samples found in quantitative research were mirrored in the studies included in this review. Samples were often recruited from support groups, were highly self-selective, and only consisted of family members, limiting the transferability of the research and, similar to the existing quantitative literature, fail to document the experience of the wider social network.

Given that this review only included studies with samples who had been bereaved by suicide, it doesn't directly confirm that suicide bereavement leads to a unique meaning-making experience. However, aspects of the bereavement process, such as understanding the deliberateness of the death are only relevant to suicide bereavement. No similar review for other types of bereavement exists, but individual studies report different qualitative aspects of meaning-making and the adjustment period (particularly finding positives and contemplating religious beliefs) and place less emphasis on meaning-making and adjustment than the studies included in Shields, Kavanagh and Russo's review (Holland, Currier, & Neimeyer, 2006; Steffen & Coyle, 2011; Wortmann & Park, 2009).

Shields and colleagues' review also suggests that social support can help facilitate the meaning-making process by helping those who are bereaved to construct a narrative of the loss that makes sense and negate any feelings of blame that they might be assigning to themselves. In a theoretical paper, Jordan (2001) suggests that suicide bereavement is distinct from other types of bereavement in three ways: "the thematic content of grief, the social processes surrounding the survivor [person bereaved by suicide], and the impact suicide has on the family systems". Finding some sort of understanding of a death through suicide can be challenging, as family and friends are often left with unanswerable questions, such as why the decision may have been made and why help was not sought (Begley & Quayle, 2007). These can be damaging to an individual's assumptive world-view, and coping with the loss is dependent on this world-view being altered to accommodate this new life experience (Gillies & Neimeyer, 2006). Failure to create an understanding of the loss is associated with distress and complicated grief (Castelli Dransart, 2013).

Both qualitative and quantitative studies have some support for the idea that suicide bereavement is different to other types of bereavement and causes unique social challenges. Qualitative research appears to find stronger support for the uniqueness of suicide bereavement and may be more suited to understanding the complexities of suicide bereavement (Jordan, 2001; Neimeyer, Baldwin, & Gillies, 2006; Shields et al., 2017).

1.1.7 Section summary

Bereavement has a lasting impact on wellbeing and in order to adapt to a loss, individuals must come to terms with their bereavement cognitively by finding meaning in what happened, as well as dealing with the practical and emotional stresses that come with a loss. This process can best be understood through the dual process model, which allows for different individual coping styles and for the interpersonal element of bereavement. Suicide bereavement requires a uniquely demanding meaning-making process compared to other types of loss, as it is the only type of loss in which the person who died has chosen to end their life. It also results in less perceived support and greater experience of shame and rejection. It is therefore worth studying suicide bereavement separately to other types of bereavement, and focusing on the interpersonal impact of a loss to suicide.

1.2 Social support

1.2.1 Overview of social support

Social support can be defined as the help available from an individual's social group (Langford, Bowsher, Maloney, & Lillis, 1997). The phenomenon of social support is well-studied and has consistently been shown to reduce the severity of a broad range of negative outcomes after stressful life events and to have an overall positive effect on mental health and wellbeing (Cohen & Wills, 1985; Kawachi & Berkman, 2001; Santini, Koyanagi, Tyrovolas, Mason, & Haro, 2015).

Social support can be categorised in different ways: the most common operational distinctions are for it to be broken down into four distinct categories: emotional (empathy and caring), tangible (physical resources), informational (advice and guidance) and companionship (sense of belonging) (Wills, 1991). Social support can also be broken down into informal social support and formal social support, where informal support is that which naturally occurs within family and friend groups and community, and formal support is structured in some way, usually through organised peer groups (Kelman, Thomas, & Tanaka, 1994).

1.2.2 Models of social support, wellbeing and loss

Several competing explanations of the mechanism by which social support impacts on an individual's experience of a stressful life event have been explored: the most influential being the buffering hypothesis (Cohen & Wills, 1985) which states that social support has a buffering (protective) effect against the negative impact of stressful life events by moderating the relationship between stress and wellbeing, rather than an overall positive effect on individuals regardless of the situation (the main effects model; Cohen & Lynn, 2000). Figure 1 illustrates these two models.

Figure 1: Diagram to show differences between the buffering and main effects models of social support

Buffering model

Main effects model
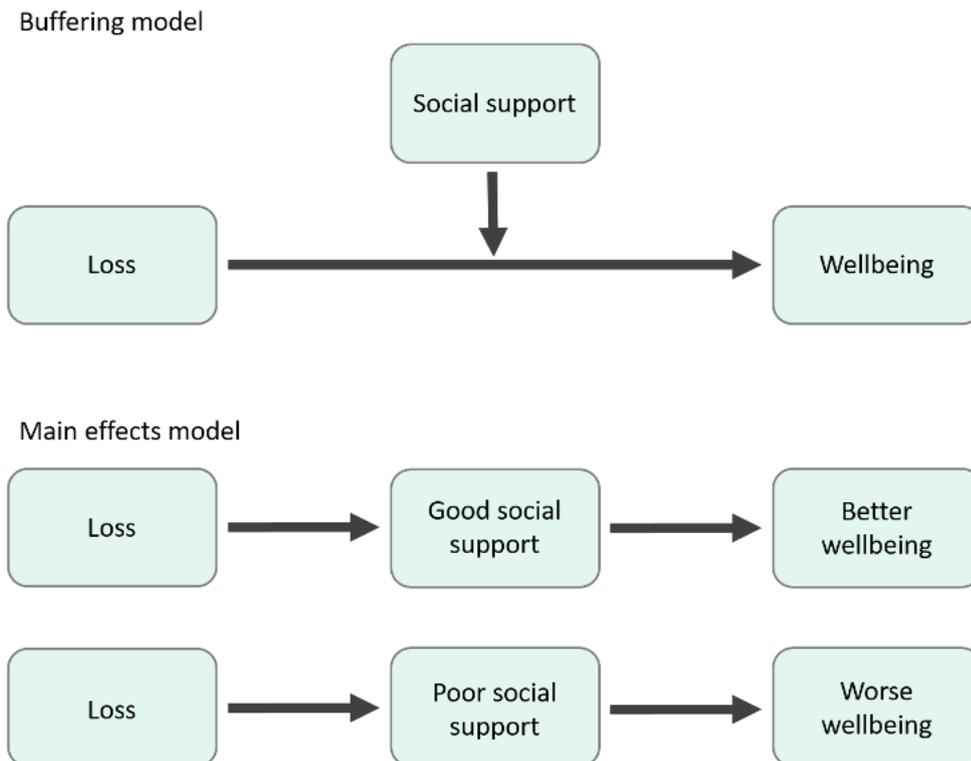
Whilst this hypothesis remains popular to this day, there are some crucial flaws to it. If social support were to have an effect only at high levels of stress (during a stressful life event), then its impact would be seen in recovery rates, where those with good social support have improved rates of wellbeing sooner than those without. Cross-sectional studies including participant groups with high and low levels of support and with and without a bereavement can be used to test for this effect. However, Thoits (1982) suggests that cross-sectional studies testing for a buffering effect may allow for confounding effects of stressful life events: these events may impact on support available and conversely, support may decrease the likelihood of some stressful events, biasing results towards supporting a buffering effect. A review of support after bereavement including longitudinal studies contradicted the hypothesis of a buffering effect at high levels of distress, but found some evidence for social support having a main effect and decreasing distress overall for those with high support (Stroebe, Zech, Stroebe, & Abakoumkin, 2005).

Since this review, a limited number of longitudinal studies that may be able to examine this relationship and the validity of the buffering hypothesis have been published. One study

examining stressful bereavements and divorces found a trend but no significant relationship between the amount of social support received and the rate of increase in biological markers of stress and anxiety (Ironson, Henry, & Gonzalez, 2017). Another longitudinal study of bereavement did not include statistical analyses of rates of recovery with social support as a mediating variable (Bottomley, Burke, & Neimeyer, 2017) so could not test for a buffering effect. Studies outside the topic of bereavement have also found more support for a main effect than a buffering effect of social support (Paterson, Robertson, & Nabi, 2015; Zhou et al., 2010). Social support is more likely, then, to have an overall benefit to well-being irrespective of levels of stress, as evidenced in both cross-sectional and longitudinal studies, rather than just act as a buffer in a stress situation.

1.2.3 Conceptualisation and measurement of informal social support

Throughout published literature there is substantial variation in how social support is conceptualised: a recent review of mental health research found eleven different conceptualisations of social support (Wang et al., 2017) across included studies. This is reflected in the inconsistency of social support measurement used by studies and the large number of validated assessment tools available. The two most common conceptualisations use categorisation of perceived (subjective judgement of support from others) and received support (actual supportive actions from others; Barrera, 1986), and structural (integration with the social network) and functional support (specific functions that others can provide; Cohen, Mermelstein, Kamarck, & Hoberman, 1985).

Studies typically measure one or both of these categories using self-report questionnaires. No one measure is consistently used across quantitative studies of social support, and global measures of support that produce a single total support score are common, likely because more detailed measures can be time-consuming. The issue of global measurement of support has been commented on as early as the 1980s, when it was highlighted that some assessment tools that include different aspects of support that do not reliably correlate with each other (Barrera, 1986). However quantitative measurement of social support has not become notably more sophisticated since then (Cleary, 2017). Given how all-encompassing a definition of social support may be, global measures of support may not be precise enough to accurately capture all of the variations in social support that exist. They also typically do not establish whether low social support scores reflect the absence of support or the presence of negative support (Wang et al, 2017).

Conceptualisations of support that only distinguish between perceived and received support are particularly problematic: received support is not necessarily beneficial support, and self-reported perceived support may not be an accurate reflection of the support that has been offered. Conceptualising social support through functional and structural support may be more appropriate, as this more easily lends itself to identification of what categories of support are being offered and whether the network as a whole is being supportive or if help is being provided by a few key social connections.

Another key issue of existing social support measurement tools is that they cannot capture the social environment in which support takes place. Understanding the characteristics of the network providing support and the relationships between those giving and receiving support could provide important context to the assessment of the efficacy of support. This is particularly important in the case of bereavement, where it is likely that whole social networks need support to some extent, and that relationships are impacted.

1.2.4 The interpersonal context of social support

A theoretical paper by Shumaker and Brownwell (1984) discusses social support through the lens of relationships, explaining that support is a communicative exchange between two or more people, and so personal characteristics and the context of their relationship will influence the support between them. Therefore the structure of a network and the society that it is in will influence both its potential to offer support and which network members are able to offer support. It is therefore important to consider the factors that influence the make-up of a network and how they might relate to support.

Social network research quantifies groups of people through identifying individuals (nodes) in a target group and noting which other individuals in the group they are connected with (ties) (Scott, 2000) and can be useful in understanding social support. Given the current limitations with defining and measuring social support itself, traditional social network research may be a useful additional approach to understanding social support within a network, and in fact network ties are measured by some researchers through the extent of reciprocal support they have (Liu, Sidhu, Beacom, & Valente, 2017). Characteristics such as density (how interconnected nodes are), closeness of relationships (strength of ties) and degree of connection (the average number of relationships each network member has) can help to conceptualise social network structures and their variations (Mitchell & Trickett, 1980). It follows that these would be related to structural and functional elements of social support. In the context of mental health, the Social Network Schedule is a widely used tool in research and asks about frequency of contact and quality of contact with specified network members (Dunn, O'Driscoll, Dayson, Wills, & Leff, 1990).

The typical structure of an individual's social network is that they are dense in the middle, consisting of a personal network of family and close friends who are highly likely to have relationships with each other, and more loosely connected on the edges of the network with fewer and weaker ties (Granovetter, 1983). Individuals in the middle of a network are therefore most likely to support one another when support is needed, but a traumatic event such as a loss is likely to impact multiple people at the centre of a network, given its interconnectedness. The size of a social network can also have an impact, with bigger networks resulting in larger numbers of potential supporters.

One of the most significant and most universal factors influencing a person's social network, and therefore its functional and structural capacity, is age (McPherson, Smith-Lovin, & Cook, 2001). An individual's social network size typically increases until young adulthood and then decreases

across the rest of adulthood, with network members outside of the centre of the network important only at particular life stages (Wrzus, Hänel, Wagner, & Neyer, 2013). Events that typically occur at specific stages of life greatly influence networks: children and adolescents tend to have large networks of friends through school and clubs, and when they leave school many of these ties are lost and replaced with new colleagues or peers. In early adulthood, finding a spouse and transitioning to parenthood reduces the size of a network, as there is a need for an increased focus on the family unit (Bost, Cox, Burchinal, & Payne, 2002). During older adulthood, network size and quality often continues to decrease as individuals retire and lose their work network, become physically less able to participate in the community and are more likely to be bereaved (Grenade & Boldy, 2008).

Gender also influences networks: women often have larger, denser and more diverse social networks than men (Haines & Hurlbert, 1992) and therefore have better potential support (Walen & Lachman, 2000). Research comments on traditional gender roles, where women are seen to be more emotionally expressive than men, which may result in better access to emotional support (Barbee et al., 1993). However, it has been suggested that women are more sensitive to negative support attempts, as their social roles and embeddedness in their network typically expose them to more negative stressors, and so they are more likely to perceive bad social support after a trauma than men (Andrews, Brewin, & Rose, 2003).

Ethnic minority groups can be marginalised and may sometimes fail to be integrated into the wider community (Smith, 1985; Sommerlad & Berry, 1970; Vervoort, 2012), and can have communication barriers and lack of residential stability. As a result these groups may not have access to wider support networks and so become insular and have smaller and denser networks (Sampson, 1988). Evidence suggests that suicide suggestion (where an individuals' attempted or completed suicide increases the risk of suicide in others who know them) may be higher in minority communities, likely because of the interconnectedness of networks (Hanssens, 2008; Walker, 2008) as well as overall increased suicide rates due to the pressures of being a minority group (McKenzie, Serfaty, & Crawford, 2003).

Age, gender and minority status are therefore key factors in influencing the structure of a social network over the life course; research also finds that they are key factors in influencing social support (Adams, King, & King, 1996; Smith, 1985; Zimet, Dahlem, Zimet, & Farley, 1988), suggesting that they are operating under the same mechanisms.

Personal qualities of supporters are also important, with supporters' resourcefulness and lack of caring responsibilities improving supportive relationships (Hauken, Dyregrov, & Senneseth, 2019).

In one of the few papers written about network structure in the context of loss, Rubin (1990) discusses the impact of network density on mourning in light of finding that partners with many mutual friends relied on their friends more than each other for support, and those with few mutual friends relied more on each other. This highlights that received support during bereavement can be significantly impacted by network structure.

Stressful life events, such as job loss, relocation and divorce all have the potential to reduce the size of a network and diminish the number of people available to offer support. The death of a social network member, however, is distinct as it removes them from the network permanently and affects the whole network to some extent. As discussed in section 1.1.3, bereavement within a social network can have a demonstrable impact on the remaining relationships within that network, which inevitably will influence the support available within that network. This will be considered further in section 1.3.

1.2.5 Formal support for suicide bereavement

In contrast to informal social support, formal support for suicide bereavement is the organised help provided by professionals, such as GPs or counsellors, who do not have a personal relationship with the person they are supporting. Models for formal support for people bereaved by suicide (postvention services) vary internationally (Andriessen, Krysinska, Kõlves, & Reavley, 2019) and aren't always clearly grounded in evidence. Support groups, in which people bereaved by suicide share experiences with each other, are the most commonly available source of formal support and are often initiated by people with lived experience of suicide bereavement rather than professional services (Farberow, 2001). Peer support groups are not consistently categorised as being formal or informal support in academic literature, as they are not necessarily led by those with professional training, but is viewed in this thesis as being formal social support, as it is organised and facilitated by individuals with some degree of expertise or personal experience.

Supporting people who have been bereaved by suicide can present particular challenges to professionals. Occupational exposure to suicide and suicide bereavement can have a negative mental health impact (Aldrich & Cerel, 2020) and is something that healthcare staff are not necessarily trained well in or are provided with resources for (Foggin et al., 2016; Tiatia-Seath, Lay-Yee, & Von Randow, 2017).

There have been several systematic reviews that have examined the evidence of the effectiveness of formal interventions for those bereaved by suicide (Andriessen, Krysinska, Hill, et al., 2019; Linde, Treml, Steinig, Nagl, & Kersting, 2017; McDaid, Trowman, Golder, Hawton, & Sowden, 2008; Szumilas & Kutcher, 2011). One review focused specifically on interventions that included outcomes related to grief, and found mixed evidence for the effectiveness of formal interventions focused on reducing grief (Linde et al., 2017). Five out of seven included studies found that an intervention significantly reduced the intensity of grief. Two reviews considered a wider range of outcomes and included only controlled studies for a more reliable assessment of efficacy. The earliest found eight studies eligible for inclusion and six of these found that the assessed intervention significantly impacted the measured outcome, which for all studies was related to intensity of grief (McDaid et al., 2008). An updated review of interventions included eleven studies (five of which had been included in the 2008 review), with eight of these finding some significant reduction in negative outcomes.

Across the three reviews, the overall evidence of effectiveness was weak, given the small effect sizes and poor methodology consistently found in included studies. All of the reviews highlighted the poor methodology of the limited existing research and demonstrated that evaluation of bereavement interventions are often not conducted well (Wilson, Errasti-Ibarrondo, & Rodríguez-Prat, 2019). Interventions were mostly in the form of support groups and generally included participants who had been bereaved for under a year, suggesting that either only those who have been recently bereaved need formal support, or that only they are offered it. Very few of the included studies in any of the reviews had long follow-up periods, and so any lasting impact of interventions cannot be confirmed. Overall, studies also included a limited range of outcomes; whilst reduction of grief seemed to be the primary focus of interventions, this should be connected to a reduction in severity of mental health symptoms or improvements in other aspects of wellbeing, which could be measured as secondary outcomes and could help to confirm or refute effectiveness of formal support.

These reviews also highlight the lack of variation in the types of formal support which have been evaluated, as included studies either used bereavement groups, CBT-based therapy or writing therapy as an intervention. One review has taken a broader view of what constitutes an intervention, including a range of community based postvention programs, some of which included informational support (Szumilas & Kutcher, 2011). Results were separated out by target population, finding limited benefit of intervention programs for schools and some effectiveness for family-focused interventions. The review noted that there were no analyses of the benefits of broader community-based programs or of cost effectiveness of prevention programs. Crucially, there was no evidence of a reduction in suicidal behaviour, which is often the key aim of community-based postvention activity.

Therapy and counselling offer an opportunity to speak to somebody who will not be emotionally impacted and who is trained to help people cope with their loss, but may be suitable only for those whose mental health has been significantly impacted by their loss (Linde et al., 2017). This is reflected in research that indicates that the efficacy of current interventions to help people who have been bereaved is poor, with one review going as far as to suggest that interventions may interfere in most individuals' natural grieving processes and thus be detrimental (Schut & Stroebe, 2005). They concluded that interventions are more likely to be effective if designed for people with diagnosed complicated grief and crucially, conclude that formal support should not be proactively offered, instead provided to those who seek it and are therefore more likely to trust professionals and be motivated towards the particular type of help on offer. Qualitative explorations of formal support after loss to suicide report that participants have mixed views of the usefulness of support received, and feel that it can be hard to access (Andriessen, Lobb, et al., 2018; McKinnon & Chonody, 2014).

Evidence for the effectiveness of formal support is therefore limited in terms of the types of support shown to be somewhat effective, the aspects of wellbeing it may improve, and the individuals for whom it is effective. It may be valuable to widen the focus of interventions for suicide bereavement and explore the efficacy of interventions targeted at the social network or community level, for example by aiming to improve social support. Research into bereavement support must focus on broader and more consistent evidence for the effectiveness of formal

support, but also consider the potential of informal support with its applicability to the wider population.

1.2.6 The relationship between informal and formal support

In considering the benefits of both formal and informal support, it is useful to understand how they may relate to each other. Here, the potential overlaps and differences in their function are considered and in section 1.3, the evidence specifically relating to informal support after suicide bereavement will be reviewed.

In a survey of bereaved adults in the UK, (Pitman et al., 2014) found that 66% of the sample had received informal support related to their bereavement from family, friends or community leaders in relation to their loss, and 60% had received formal support in relation to their loss, but those bereaved by suicide were significantly less likely to receive informal support for their bereavement than those bereaved in other ways and experienced delays in receiving both types of support, potentially due to perceived stigma. Other studies also suggest that the receipt of formal support amongst those bereaved by suicide amongst those who want it is low, with one finding that 44% of their sample had received professional support, although 95% of the sample felt that they needed it (Wilson & Marshall, 2010). A different study found that half of the sample were contacted by professionals offering support, but this was primarily priests and undertakers as opposed to health professionals (Dyregrov, 2002).

There are several plausible reasons for this low uptake of formal support: access, motivation and suitability. Currently in most countries, support for those bereaved comes largely in the form of support groups and therapy, both emotional support. In its third annual report on suicide prevention (HM Government, 2017), the U.K. government acknowledged that it needed to progress further in the amount of support it offered to people bereaved by suicide. Beyond the generally available mental health support offered by the NHS, support from the state for those bereaved by suicide is lacking: it is only in recent years that the NHS has started to support the development of local services for people bereaved by suicide (Kendall, 2019) and independent charities provide the vast majority of services such as peer support groups, limiting access to these services, particularly in rural areas. A qualitative study of English participants indicates that there is a perception amongst people bereaved by suicide that accessing support from GPs can be difficult and that certain barriers discourage help-seeking (Wainwright et al., 2020).

Whilst informal support from social contacts can be immediately available and often doesn't require much proactive help-seeking, individuals' access to formal support relies on their motivation and capacity to seek help from professionals. There are an array of individual factors that reduce the likelihood of help-seeking, such as perceived stigma, being male, having minority status and having more severe mental health symptoms (Addis & Mahalik, 2003; Levy & Derby, 1992; Stanton-Salazar, 1997; Willging, Salvador, & Kano, 2006). Drapeau found that certain personality traits influence help-seeking, with one study finding that high neuroticism decreased help seeking in those bereaved by suicide by directly negatively influencing perceived ability to seek help increasing concern about experiencing stigma (Drapeau, Cerel, & Moore, 2016). More

recently, increased perception of stigma and feelings of guilt have been associated with seeking help after suicide loss (Geležėlytė et al., 2020). Certain groups, therefore, will be less likely to seek help and so will be less likely to have access to formal support. A secondary issue with this is that suicide bereavement studies that recruit samples exclusively through support groups generate results based on a specific help-seeking sub-group of the population.

Some individuals can and do access both types of support, suggesting that each may provide something the other does not (Pitman et al., 2014; Sharpe, 2008). Formal support available in the U.K. primarily consists of emotional help offered by somebody with a degree of professional training, whereas a social network has the potential to offer more immediate and a wider range of support from people who are less likely to have experience of the needs of those who have been bereaved.

At the same time, one type of support may impact on the effectiveness of the other, with peer support group members becoming valued friends (Caserta & Lund, 1996), and professionals advising and helping to enable support from family and friends (Hutti, 2005). Informal social support may impact on an individual's response to post-bereavement therapy by encouraging and reinforcing (or not) their attempts to get better (Ogrodniczuk, Piper, Joyce, McCallum, & Rosie, 2002) and conversely, therapy could influence psychiatric symptoms such as depression that may result in an individual perceiving their social support more positively (Ogrodniczuk, Joyce, & Piper, 2003).

For those bereaved by suicide, peer support is likely to be a good bridge between more therapeutic formal support and social support (Bartone, Bartone, Violanti, & Gileno, 2017), as it gives them the opportunity to have contact with others with a similar experience and decreases heightened feelings of social isolation. Peer support groups also have an element of reciprocity that may not be present in all the family and friend relationships of somebody who has been recently bereaved, as not all family and friends will be equally as impacted by the death. In peer support groups, however, everyone has been significantly impacted by their loss and so everybody both offers and receives support (Bartone et al., 2017).

Qualitative research consistently reports that those bereaved by suicide particularly value peer contact as it normalises the grief experience and is an opportunity to share coping skills (Ali & Lucock, 2020; Andriessen, Lobb, et al., 2018; Wilson & Marshall, 2010). This may be a contributor to the noticeable rise in the number of online forums that exist for people bereaved by suicide (Chapple & Ziebland, 2011) over the past decade. These forums also appear to be particularly important for people who live in rural areas and cannot access physical support groups, who may be isolated from their support network, or who do not receive good support from their network (Feigelman, Gorman, Beal, & Jordan, 2008). Using such forums may be an easier step in help-seeking than accessing professional services or physically going to a group, and can encourage people to do so subsequently (E. Bailey, Krysinska, O'Dea, & Robinson, 2017). However, quantitative evidence for the positive benefits of support groups is limited; studies evaluating support groups were included in the intervention reviews described above and recent reviews of general bereavement support groups suggests that there are weak quantifiable benefits over

control groups (Bartone, Bartone, Violanti, & Gileno, 2019; Maass, Hofmann, Perlinger, & Wagner, 2020).

1.2.7 Section summary

Social support can be understood as the help provided to an individual by their social network, which has an overall benefit to wellbeing. It is clear that social support is beneficial during stressful life events, although research that focuses on bereavement doesn't provide a clear consensus on impact. There are a large range of measurement tools available for the quantitative measurement of social support, but these tend to be over-simplistic and not capture the interpersonal element of social support, which is reliant on relationships between the providers and recipients of support and the overall supportive capacity of the social network.

Social support is more accessible than formal support for people who have been bereaved by suicide, and the efficacy of therapeutic interventions to improve wellbeing after suicide bereavement did not have strong empirical substantiation. Peer support, which is organised and can be led by professionals, but is more similar to the informal emotional and companionship support that would be provided by a social network has similarly limited empirical support, and may only be suitable for those who are willing to seek help. Therefore, there is value in seeking to better understand the impact of social support on the wellbeing of people bereaved by suicide; if it does have a beneficial effect, then it would be valuable to improve social support for those bereaved by suicide.

1.3 The impact of social support during bereavement

1.3.1 The relationship between social support and bereavement

Given the conflicting empirical data regarding the efficacy of formal interventions after loss, and the limited proportion of those bereaved who actually use them, it is important to better understand and hence improve informal social support as well as work towards better formal interventions. Even for those who do receive formal interventions, informal support may improve outcomes even further by helping in a different way. Whilst social support has the potential to be a very personalised and cost-effective intervention (Logan, Thornton, & Breen, 2018), there are limited documented efforts to promote and improve community social support for those who have been bereaved (Breen et al., 2017).

Bereavement in general is different to other types of stressful life events; as discussed earlier, key elements of adapting to a loss are meaning-making and adapting to new stressors. In the context of the social network, this translates to individuals coming to a collective understanding of the loss and filling roles that the person who died held within the group. For example, a parent may face

more responsibility if their partner dies, leaving them as the sole carer for their child. Conversely, if a child is lost, a parent will have to adapt to no longer having "carer" as part of their identity.

It is also crucial to acknowledge the fact that a bereavement regularly impacts on more than one member of a social network, meaning that network members will often simultaneously be givers and receivers of support. This creates complex relationships between network members as they experience the dual stress of the loss and need to be supportive and so the whole network must change to adapt to the loss and share the burden of support (Aoun et al., 2019). Network members who are perceived to be more distantly connected to the person who died, such as cousins or colleagues, may be expected to fulfil support provider roles if they are thought to be "less bereaved" and therefore less emotionally impacted than others in their network, and so may not get adequate support for their own grief whilst trying to help others (Rossetto, 2015). During this period of change in relationships and roles, social support is bound to be impacted, particularly within the close personal network.

In the case of suicide, support from the wider network and the wider community is likely to be lacking due to the suddenness of the death, as potential supporters are not able to prepare to offer support, and due to the stigma that can be associated with suicide. At the same time, bereavement through unexpected and violent causes in general has the capacity to prompt social withdrawal for fear that others will not understand their experience (Gall, Henneberry, & Eyre, 2014; Hannays-King, Bailey, & Akhtar, 2015); it is a relatively rare experience making it potentially hard for others to relate to and therefore know how to support. This can work as a self-fulfilling prophecy, where people may expect or wrongly perceive lack of understanding and so pre-emptively discourage offers of support or hide a desire for help (Bartik, Maple, Edwards, & Kiernan, 2013a). Social withdrawal can also be prompted by guilt, perceived uniqueness of experience or social discomfort (Azorina et al., 2019; Séguin, Lesage, & Kiely, 1995).

In studies examining what those who have been bereaved deem to be unhelpful responses from those around them, participants consistently cite that giving advice, encouragement to recover and avoiding talking about the person who died are unhelpful responses, but all are responses that a network member may instinctively employ as very natural reactions to the loss (Dyregrov, 2004; Lehman, Ellard, & Wortman, 1986). Given that these unhelpful responses may seem useful to those without professional knowledge or experience, the concept of "miscarried helping", developed to explore relationships between caregiver and receivers (Fales, Essner, Harris, & Palermo, 2014), may be applicable to informal support after bereavement. Here, the support giver may desire to help using whatever methods they think best, if these methods do not work then this can contribute to negative interactions between the two parties and result in conflict rather than support (Coyne, Wortman & Lehman, 1988; Harris et al., 2008).

1.3.2 Existing quantitative research into social support after loss to suicide

Whilst the implications of research findings are that social support could theoretically reduce the negative impact of bereavement by suicide, there has been no recent review of the empirical evidence for this. Stroebe et al (2005) reviewed social support for all bereavement types,

but could only find eight studies suitable for inclusion. However, this review was non-systematic and was carried out with the purpose of examining evidential support for the buffering hypothesis of social support, so only included studies with methodology suited to this. Of the eight included studies, one found no support for the association, one found an association for social embeddedness (which is conceptually similar), but not for support and one did not include reports of an analysis to assess a main effect of social support. The remaining five studies found at least some evidence for social support have a positive impact on wellbeing after a loss.

The conclusions of the review about the effectiveness of support were, however, somewhat negative, referring to evidence suggesting that talking about loss doesn't facilitate coping with loss. However, this fails to consider that social support can be many things other than emotional support. Inconsistency in findings may be a result of variation in study design (this review did not comment on quality of included studies) such as the use of non-validated social support measures by a number of the studies.

A number of recent quantitative studies (Levi-Belz, 2015; Levi-Belz & Lev-Ari, 2019; Oexle & Sheehan, 2019; Spino, Kameg, Cline, Terhorst, & Mitchell, 2016) have examined the relationship between wellbeing and informal social support after suicide loss using validated measurement tools. Several have found that reduced social support was associated with negative wellbeing outcomes, and one longitudinal study found that social support predicted post-traumatic growth. These studies, whilst offering limited evidence, do indicate that better social support improves outcomes for people bereaved by suicide.

An up-to-date and more comprehensive review and synthesis of this literature is needed. In chapter 2, quantitative studies exploring the impact of social support on violent and/or traumatic deaths will be systematically reviewed and the strengths and limitations of the evidence will be considered in detail.

1.3.3 Existing qualitative research into social support after loss to suicide

Quantitative research is useful in establishing a relationship between social support and bereavement, particularly in understanding the temporal aspect of this relationship. However, as discussed previously, quantitative measurement of social support lacks the nuance needed to account for all of the variables that impacted on the efficacy of support.

Despite the suitability of qualitative research for this topic of study, there are comparatively few qualitative studies that focus on the impact of sudden/unexpected bereavement on social groups with the view to understanding what kind of support is valuable and the challenges in offering and receiving support. Studies tend to explore the whole bereavement experience rather than focusing on specific areas (Shields et al., 2017) and so cannot make recommendations as to how to tackle specific issues in the bereavement experience. There are

very few studies that explore suicide bereavement alone, despite the uniqueness of the social experience.

In their overview of the impact of suicide on the family, (Cerel, Jordan, & Duberstein, 2008) comment on the overall impact on networks, focusing on communication impairments that can arise from the blame, shame and secrecy that may occur within networks after such a loss. This article acknowledges problems that may occur between close friends and family, but does not consider the benefits that a strong, functional support network may bring, or the potential positive impact that those on the outskirts of a network who are less emotionally involved may have.

Some research has focused on aspects of support and identified ways to improve them. One qualitative study explored help-seeking with a sample consisting of an even split between participants who had and hadn't been bereaved by suicide. There was a mixture of opinion amongst participants about whether loss-related social support was appropriate in the short or long-term, but consistently felt that acceptance and acknowledgement of the loss was important from others (Andriessen, Lobb, et al., 2018). Another focused particularly on support in the workplace for parents who had lost a child to suicide (Gibson, Gallagher, & Tracey, 2011). Practical and emotional support from colleagues was deemed to be particularly helpful, and training for managers was widely recommended, suggesting that organisations may not typically have guidance for management on how to support those bereaved by suicide.

One study that examined perspectives of informal social support after a sudden loss (Lehman et al., 1986) interviewed those who were bereaved about helpful and unhelpful support from those around them, then interviewed control participants about how they would offer support to someone bereaved by sudden loss to compare responses. This was a slightly artificial comparison between the two groups because those in the control group were asked to imagine how they would respond, rather than describe their support attempts from lived experience. It is not possible to know whether this would reflect their actual reactions in a real situation.

In 2006, a study (Dyregrov, 2006) held focus groups with 69 participants from 21 network groups impacted by a loss; at least one member of the group had been bereaved by either Sudden Infant Death Syndrome or suicide. Those in supportive roles felt it was important to offer support early and proactively but that they found offering support challenging (they did not know what to do, were worried about doing the wrong thing) and tended to only maintain it for a short period of time. The use of focus groups in this study could have made it difficult to be honest about poor support that may have occurred within groups. The participants themselves were all recruited through support organisations and were therefore help-seekers. Crucially, the overall impact on each social network was not considered in analysis.

Two relevant qualitative studies focus exclusively on suicide bereavement. A mixed methods study interviewed individuals who had been bereaved and a single nominated family member or friend (Wagner & Calhoun, 1992). Almost all of the bereaved individuals reported negative experiences

of social support and most believed their relationships with particular network members had become closer since the loss. The individuals giving support all noted that they had seen support from others made available to the person who was bereaved and that they had responded to an expressed need to talk. They perceived their friend/family member as being recovered sooner or more than the individual themself did. Social support, however, was not discussed in depth, as other parts of the bereavement experience were covered in the interviews.

More recently, (Peters, Cunningham, Murphy, & Jackson, 2016) explored what those bereaved by suicide felt to be helpful and unhelpful responses from their network. The ten participants discussed the importan0ce of different types of support: help from others who had been through the same experience, informational help immediately after the loss, as well as a desire for empathy and sensitivity from the professionals they encountered in the aftermath. Only one member of a network was interviewed, and so competing accounts of the same bereavement could not be compared. Similarly, in a study interviewing parents bereaved through sudden deaths, Dyregrov (2004) states the importance of understanding "the communicative relationship between the receiver and provider of support". Participants were asked about positive and negative aspects of support, as well as the barriers for accepting it. However, although some of the participants were couples, data from each participant was treated individually, thus only considering one side of a typically important and supportive relationship.

Another recent study interviewed participants in focus groups about their experiences of formal and informal support during their bereavement (Ross, Kõlves, & De Leo, 2019). Whilst the expected support from peers and professional services were clearer than those from friends and family, people often had negative experiences when returning to the workplace through avoidance and stigma. They found that social interactions could be challenging and generally felt that there was a loss of social contact and support.

1.3.4 Limitations of current research

A paper written 30 years ago summarises the key issues in the relationship between social support and bereavement, highlighting the need of those bereaved to have suitable social support from their network beyond professional help, the lack of diversity in study samples and the impact of a loss on a whole network rather than just a few individuals (Vachon & Stylianos, 1988). In light of research carried out since this publication, these issues remain relevant to this day, yet surprisingly little progress has been made in addressing them.

Recruitment of participants for any study relating to suicide bereavement is challenging, given the sensitivity of the topic. Studies often use convenience sampling, recruiting from bereavement services. As a result, samples often include participants who are help-seeking and predominantly white, female and over 40 years old (Heeke, Stammel, Heinrich, & Knaevelsrud, 2017; Kristensen, Weisæth, & Heir, 2010; Spino et al., 2016; Xu, Wang, & Sun, 2017). Help-seeking, gender, ethnicity and age all influence the social support people have access to, and so such samples are not representative of the wider population.

The majority of studies in this area assume that family units prior to bereavement are cohesive and are influenced by a response bias of participants with strong family ties. Partners facing a loss has been a particular focus in research (Stroebe, 2002), likely because a romantic relationship is seen as a particularly important social network tie. There is a general lack of literature about the effect of bereavement on other types of ties, such as friendships (Bartik, Maple, Edwards, & Kiernan, 2013b) and sibling relationships (Dyregrov & Dyregrov, 2005).

Studies will often recruit only family members, which makes the assumption that networks are homogenous and that family units are united in bereavement. A particular consideration is "fictive kin": friends who are not biologically related to a participant, but who are close enough to have been considered part of their family. Relationships of this type are likely to be common across young adults are participants from collectivist cultures (Burke, Neimeyer, & McDevitt-Murphy, 2010; Rae, 1992), but having stronger friendship ties than family ties is likely something that is common across all groups of participants. One study that acknowledges this makes reference to ties of "obligation", finding that for older women who had been widowed, ties with children were not as affected as ties with other family members that had been maintained more through social expectation than through choice (Anderson, 1984).

 A better approach may be to allow participants to self-identify as being bereaved and include anyone, regardless of relationship, who feels as though they have been significantly impacted by their loss, in line with Cerel's continuum of impact (Cerel et al., 2014). This is particularly advantageous in research about social support after bereavement, as it is likely that the friends of somebody who is bereaved of a family member do not have close relationships with the person who died and are therefore more available for support.

Of the two qualitative studies that interviewed groups of friends and family, Dyregrov (2006) did not focus on one type of death and so was not able to identify specific support and communication issues; and Wagner and Calhoun (1992) included social support as only one part of their topic guide. Neither study analysed data within groups to understand the differences and similarities in perspectives that may exist within networks. This research makes the assumption that the experience of one group member represents the experience of the whole group, whereas it is possible that individuals within the same network have different bereavement experiences depending on how they deal with stressors and make meaning from the death.

A key limitation of existing qualitative research is that it tends to focus on a single member of a social network who is primarily receiving support, rather than considering the whole social group as a network of reciprocal supportive relationships. Whilst it is crucial to understand what kinds of support those bereaved by suicide want, it is equally as important to understand what the challenges are for those in a supportive role in providing that support, and to understand how structural and functional support is influenced by relationships.

1.3.5 Section summary

Existing quantitative research provides some evidence that social support positively influences wellbeing after a loss, although limitations exist in quantitative measurement of social support. Existing qualitative research creates a clearer picture of social support, but has failed to capture the experiences of both giving and receiving support, as well as the overall impact of a suicide loss on supportive relationships within a social network.

1.4 Focus and aims of the project

Suicide is a type of death which results in a bereavement experience similar to other violent or sudden losses, but presents additional challenges to wellbeing and meaning-making in bereavement over and above losses that are not self-inflicted (section 1.1.5). Wider research on bereavement suggests that formal and informal support are important in reducing this negative impact (sections 1.2.5 and 1.3.2). Whilst some formal support for suicide bereavement in the U.K. is available, social support from family and friends is more accessible, and may bring further benefits beyond those which formal support can confer. However, informal social support is highly dependent on the context in which it is given and received within a group; individual characteristics (such as life stage) and existing relationships impact on the availability and quality of support from one's group (section 1.2.4). The current literature on social support after a loss to suicide is very limited. It is therefore important to understand how informal social support can work best for people bereaved by suicide and to make recommendations for best practice; this work must encompass the social landscape within which the support takes place.

I have chosen primarily to view the bereavement experience in the context of the theoretical dual process model (Schut & Stroebe, 1999), which places importance in people who are bereaved working through both loss and restoration-oriented stressors. This model accounts for different individual coping methods and styles, and allows for an interpersonal impact of grieving and coping within groups. As such, I will explore different categories of support focused on both loss and restoration, and ensure that I draw out individual support preferences in relation to individual coping styles to avoid drawing conclusions that assume that bereavement is a homogenous experience. Beyond this, I will also explore how social networks adapt to loss, and how support takes place between individuals in networks.

 The thesis comprises three sequential projects; with the main work of the thesis being a qualitative study to explore experiences of social support within social networks who have been bereaved by suicide loss. This work is preceded by a systematic review evaluating existing quantitative literature of social support after loss, and followed by the initial development of a public resource for those bereaved by suicide. The aims for the thesis are as follows:

Main aim:

To explore how social networks of friends and family bereaved by suicide informally support one another after their loss.

Objectives:

1. To better understand the possible association between social support and wellbeing after a sudden or violent loss by reviewing existing quantitative research (chapter 2).
2. To explore the informal support that takes place within a friend and family network after a loss to suicide (chapters 3, 4 and 5).
3. To understand the social impact of a suicide loss on individual relationships between friends and family members, as well as the whole network (chapters 3, 4 and 5).
4. To use the findings of the research within this thesis to inform the preliminary development of a public resource aimed at supporting friend and family networks bereaved by suicide (chapter 6).

Chapter 2: A systematic review of studies describing the influence of informal social support on psychological wellbeing in people bereaved by sudden or violent causes of death

This systematic review was published in a peer reviewed journal (BMC Psychiatry) in May 2020 (full text attached in Appendix 1). This chapter presents the work with some additional detail, including a section highlighting relevant studies that have been published since the publication of this review.

2.1 Aims

Whilst any type of bereavement can be traumatic, bereavement through violent or sudden causes is associated with more severe negative health and wellbeing outcomes compared to other types of loss. Chapter 1 set out an argument for social support having a protective effect against the negative influence of stressful life events. However, this association appears to be less consistently demonstrated in studies that focus on bereavement, and the literature in this area has not yet been systematically reviewed. Although a review of social support literature has previously been carried out, it was not systematic and is over a decade old (Stroebe et al., 2005).

The literature in chapter 1 also indicated that suicide bereavement is a unique type of bereavement in that it is the only one where the death has been self-inflicted. This chapter described elements and outcomes that were unique to suicide bereavement (such as increased feelings of guilt or stigma), but also recognised that other aspects overlapped with other types of loss, particularly those that violate the worldview of those bereaved (typically violent losses) or are unexpected and don't allow for a chance to prepare for a loss (typically sudden losses).

Therefore, a decision was made to review all types of sudden and/or violent loss because of some shared characteristics these types of loss, and because initial scoping indicated there is currently a very limited body of literature exploring the specific relationship between social support and suicide bereavement. The intention of the review was to examine literature on the categories of

death within which suicide sits (sudden, violent), and to do a separate analysis of the papers focused on suicide loss within the review.

This study aimed to systematically review the international quantitative literature to examine whether there is an association between informal social support from family and friends after bereavement through sudden and/or violent causes, and post-bereavement wellbeing.

2.2 Introduction

According to the dual process model (Schut, Stroebe, 1999), adapting to a loss requires dealing with both loss and restoration oriented stressors; dealing with the changes and feelings that relate to the death itself as well as the changes in roles and responsibilities it brings.

This model is compatible with the idea that certain types of loss are more challenging to adapt to than others (Kaltman & Bonanno, 2003). Losses that are sudden (such as those arising from natural disasters, transport accidents) do not allow those left behind the chance to prepare: either for the loss of their relationship with the deceased or for any additional role they may take on, such as financial or caregiving duties. Violent losses (such as homicide or suicide) are also generally sudden, but are primarily challenging in terms of loss-oriented stressors as they can violate the assumption that human life must be protected (Currier, Holland, & Neimeyer, 2006). A systematic review (Kristensen et al., 2012) found consistent evidential support that losses that are both sudden and violent are distinct from other form of loss, being associated with slower recovery and an increased risk or prevalence of mental health disorders such as PTSD and depression compared to bereavement from natural deaths.

Social support has been proposed as being protective against the negative effects of stressful life events (Peirce, Frone, Russell, Cooper, & Mudar, 2000). Whilst the definition and conceptualisation of social support in research varies (Wang et al., 2017), informal social support describes the help provided by the individual's existing social network, whereas formal social support describes organised help from individuals who may be professionals (such as trained therapists, case workers or peer group facilitators) or non-professionals (such as members of organised peer support groups) (Solomon, 2004). As described in chapter 1, there are two models through which this effect is proposed to work; the main effects model and the buffering model. The buffering model (Cohen & Wills, 1985) suggests that social support has a protective effect on the negative impact of stressful life events by moderating the relationship between stress and wellbeing, rather than an overall positive effect on individuals regardless of their situation, as proposed in the main effects model (Cohen & Lynn, 2000)=. In the wider literature, there is support for both models, but more consistent evidence for social support having an overall impact on wellbeing irrespective of levels of stress (Paterson et al., 2015; Zhou et al., 2010). The main effects model also takes into account the potential positive benefits of social

support beyond negating stressors (Feeney & Collins, 2015). In particular, better social support is associated with a lower level of depressive and PTSD symptoms (Peirce et al., 2000; Vranceanu, Hobfoll, & Johnson, 2007).

There is limited empirical support for the effectiveness of formal social support interventions following sudden and violent loss (Currier et al., 2006), findings mirrored by evidence regarding those who have experience any kind of loss (Currier, Neimeyer, & Berman, 2008). The same is true for more specific groups, such as those bereaved by suicide, where a recent systematic review has found that a diverse range of different interventions have been assessed for effectiveness using a range of outcomes measures, leading to inconclusive evidence for best practice (Andriessen, Krysinska, Hill, et al., 2019). Interventions based on peer support services, where individuals use shared experience to support one another, have a more consistent positive benefit (Bartone et al., 2019). However, formal sources of social support, including as peer support, must be sought out proactively and can be limited in scope, timing or affordibility. Research, however, shows that those bereaved by sudden causes are more likely to access informal social support (Dyregrov, 2002), described as the provision of help from other people not provided through any organised helping agency, typically emotional, tangible, informational and companionship support (Wills, 1991). Informal social support is therefore the most accessible and personalisable type of support available to those bereaved through violent and/or sudden causes (Logan et al., 2018): interventions to improve access to informal social support for people in this situation could therefore be valuable if its relationship to higher levels of wellbeing is established in this context.

The most recent review of the impact of informal social support on wellbeing outcomes after bereavement was carried out 14 years ago (Stroebe et al., 2005). However, this was a non-systematic review that focussed on studies with a primary aim of testing the buffering hypothesis of social support but instead finding support for the main effects model. The eight included studies found mixed evidence to support social support after bereavement as having a significant impact on wellbeing. Given the specific nature of the inclusion criteria for interventions in that review, it is likely that a number of relevant papers examining the impact of social support after a loss were not included. Additionally, the mixed findings could be explained by the inclusion of heterogeneous samples bereaved by all types of loss.

To address an identified gap in current knowledge, this review sought to understand whether informal social support is associated with wellbeing after a loss through sudden and/or violent causes, by synthesising evidence from studies that compared measures of psychological wellbeing in those who received varying levels of informal support after bereavement.

2.3 Methods

2.3.1 Study Inclusion

I included peer-reviewed primary observational (cross-sectional or longitudinal) research studies published as a full paper rather than solely an abstract, which used quantitative methods to investigate the association between social support and wellbeing of adults (18 years old or over) following bereavement through violent and/or sudden death. Samples including children were excluded as children and adults typically have different experiences of loss and consequently, different support experiences (Saldinger, Peterfield & Cain, 2004). Violent deaths were defined as those that were unnatural and caused by human action (Paulozzi, 2004), whereas sudden deaths were those that were unexpected and occurred instantly or rapidly (Morentin, 2000). It was a requirement that study participants identified as having had a personal relationship (friend or family member) with the deceased.

Exposure was defined as participants' first-hand experience of any form of social support, provided by family or friends outside a formal setting (excluding peer mentoring groups or care-giving agencies) after their loss. Only studies in which social support measures had been psychometrically validated using content, criterion or construct validity were included. I included studies that assess the outcomes of i) psychological wellbeing, defined as positive psychological adjustment, measured using validated indicators of psychological adjustment (such as measures of social involvement, life satisfaction or sense of purpose); or ii) psychiatric symptoms (such as a clinical diagnosis of a mental health problem or a measure of mental health symptom severity assessed using a psychometrically validated assessment tool); or iii) a measure of service use in relation to mental health problems.

The exclusion criteria were: studies that solely analysed data qualitatively, that did not distinguish between formal and informal support in measurement of support, or did not specify cause of death. Qualitative literature was excluded from this review as the focus was to establish whether there was a consistently quantifiable effect of social support on wellbeing. There were no exclusions by date of publication or language.

2.3.2 Study selection

I registered the protocol for this review prospectively with PROSPERO: registration number CRD42018093704. Throughout the review I followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2015; checklist included as appendix 2). Our search terms combined terms for: sudden or violent bereavement; and informal social support; and mental health or wellbeing (appendix 3). The protocol was reviewed by members of the Public and Patient Involvement (PPI) group for the project who confirmed that the review question was of value and commented on the search terms, and also by a university librarian.

I conducted a systematic search of five online databases: IBSS, CINAHL, PsycINFO, MEDLINE and the Cochrane library. Inclusion criteria were observational studies published from database inception up to 26th April 2018 without language or date limits. The search was updated a year later, with records searched up to 10th May 2019.

In addition to the database searches, I hand-searched from journal inception three relevant journals, *Bereavement Care*, *Death Studies* and *OMEGA- The Journal of Death and Dying*. I also hand-searched conference abstracts from all available online records of key relevant conferences (International Death, Grief and Bereavement conference; European Symposium on Suicide and Suicidal Behaviour) as well as grey literature sources (OpenGrey, OpenDOAR, EThOS and OATD databases searched). For each study identified for inclusion in the review, I hand-searched the reference list and used forward citation tracking to seek other relevant studies. I extracted and managed references using Endnote software.

For 29 studies that reported they had recorded death type but not distinguished between types of death in statistical analyses, authors were contacted to request further information.

I screened articles in two stages; first titles and abstracts of all articles returned by the search, excluding those that did not meet inclusion criteria, and then screened full texts of potentially eligible studies. A colleague (PK) independently reviewed 15% of study abstracts and 15% of full text studies along with all of the included studies, with any disagreements discussed between authors.

2.3.3 Data Extraction

I developed a standardised schedule to extract data (attached as appendix 4)
and summarise details of the study setting, sample, measures of intervention and outcome and results. PK independently extracted data from 15% of the included papers, with any disagreements discussed between both of us.

2.3.4 Quality appraisal

Following data extraction, I used the Newcastle-Ottawa Scale for evaluating the quality of non-randomised studies [NOS; Wells, Shea, O'Connell, & Peterson, 2000] to assess the quality of the included longitudinal studies three domains: selection, comparability and outcome. Discounting the criteria covering the selection of a non-exposed cohort that would not be applicable to single-group studies, a maximum score of 8 was possible. As the NOS has been designed primarily for cohort and case control studies, a pre-established adapted version of the NOS (Herzog et al., 2013) was used to assess the quality of the included cross-sectional studies. A maximum score of 10 was possible for this scale. Appendix 5 lists the questions included in both scales.

PK and I independently reviewed each of the included studies according to the criteria set out in the tool, and where disagreements arose over assessment of bias, these were discussed with my primary supervisor.

To be rated as good quality, studies had to score 3 or 4 points in the selection domain, 1 or 2 points in the comparability domain and 2 or 3 points in the outcome/exposure domain. For fair quality, studies had to score 2 points in selection domain, 1 or 2 points in the comparability domain and 2 or 3 points in the outcome/exposure domain. Studies were deemed to be poor quality if they scored 0 or 1 point in the selection domain, 0 points in comparability domain or 0 or 1 points in the outcome/exposure domain. Scoring for the cohort study was the same, except for the selection domain, where good qualities studies must score 2 or 3 points, fair studies 1 or 2 points, poor studies 0 points.

2.3.5 Analysis

As I expected that included studies would be heterogeneous in terms of conceptualisations of social support, study settings, participant characteristics and the measures and statistical analyses used, I did not plan to conduct a meta-analysis but instead planned to use the approach of narrative synthesis, grouping findings by outcome. For this I referred to an existing framework (Popay et al., 2006) to ensure a systematic approach. This framework starts by developing a theory of how the exposure works, why and for whom, before developing a preliminary synthesis of findings, exploring relationships in the data, and assessing robustness of the synthesis. When discussing study results, I used "positive association" if all measured social support variables had a significant positive association with the reduced severity of, or reduced likelihood for meeting the threshold of diagnosis for a measured outcome regardless of whether models were adjusted or unadjusted. I used "partial positive association" if some but not all of the included social support variables had a significant positive association with reduced severity of, or reduced likelihood for meeting the threshold of diagnosis for the measured outcome, and the remaining included variables were not significantly associated with the outcome.

I planned for results to initially be grouped by outcome, with results synthesised according to the most common wellbeing outcomes assessed by studies, and less common but conceptually similar outcomes. The robustness of results was considered according to study quality and number of studies. Based on theoretical knowledge about the uniqueness of suicide bereavement and categorisations of support, I considered exploration of relationships, with specific sub-group analyses planned based on type of loss and type of social support measurement where these were possible.

2.4 Results

2.4.1 Included studies

Using electronic database searches I identified 6,556 records for title and abstract screening after removing duplicates (figure 2). I conducted a full text review of 263 records, of which 16 met all the inclusion criteria and were included in the narrative synthesis. Foreign language full text articles were translated (seven in Japanese, two in Spanish, two in German, two in Chinese (simplified) and one in French). No additional studies were found through grey literature searching, or hand searches of journal contents of included studies' reference lists.

Initial rates of agreement between the two reviewers were 97% for screening (where reviewers made the same decision about including or excluding a study), 98% for data extraction (where reviewers had the same data extracted for each criteria on the schedule) and 98% for the quality assessment (where reviewers had the same scores for the NOS). All disagreements were resolved through discussion between us.

Figure 2: Flow diagram of included studies
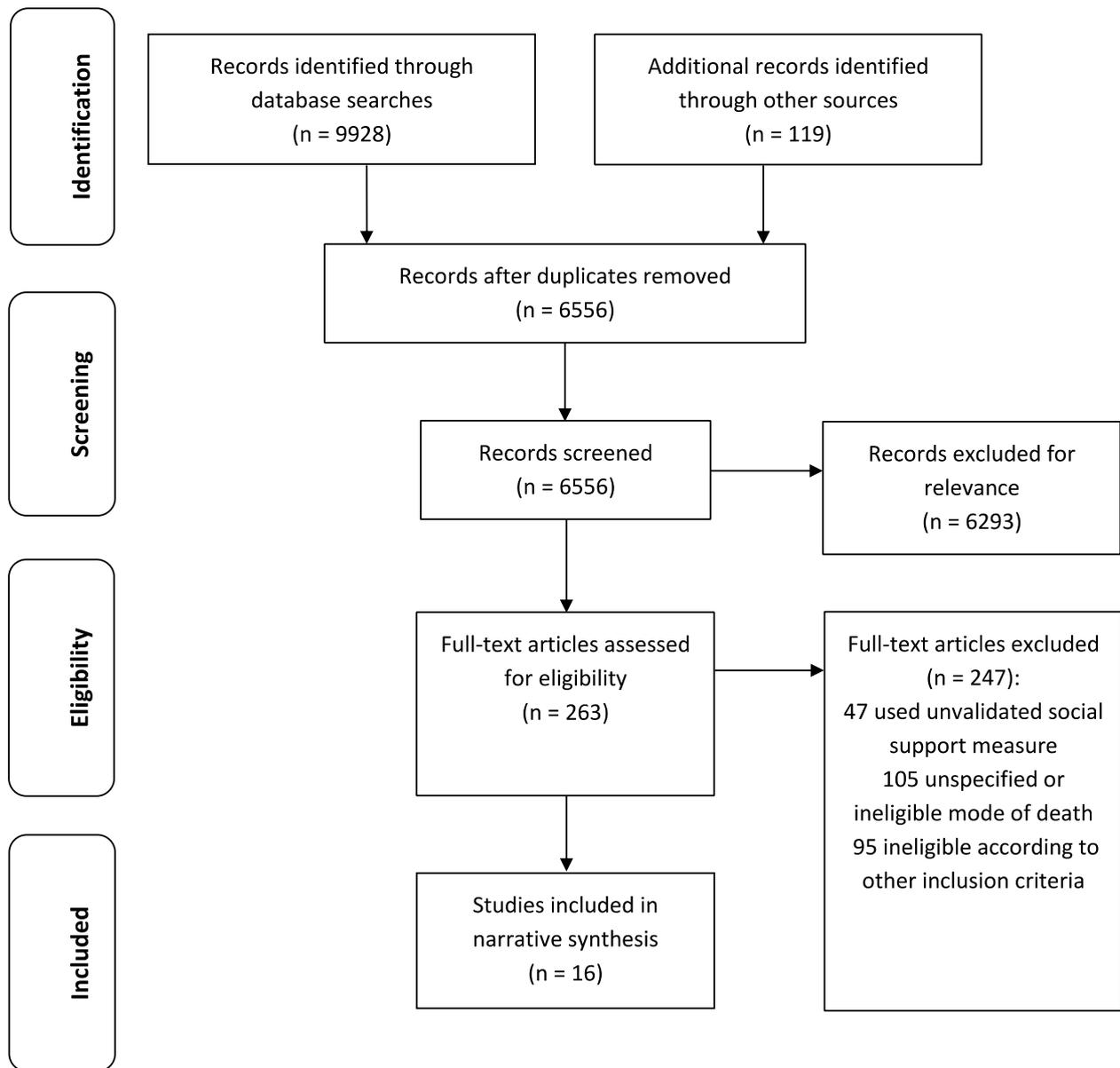
2.4.2 Study characteristics

The 16 included papers reported results from 15 different studies, with one study reported in two included papers (Cowan & Murphy, 1985; Murphy, 1988) at different follow-up time points.

Of the 15 samples included (Table 1), nine sampled populations in North America (USA and Canada) (Bottomley et al., 2017; Cowan & Murphy, 1985; Murphy, 1988; Oexle & Sheehan, 2019; Rheingold & Williams, 2015; Spino et al., 2016; Sprang & McNeil, 1998), two in China (Li, Chow, Shi, & Chan, 2015; Xu et al., 2017) two in Israel (Levi-Belz, 2015; Levi-Belz & Lev-Ari, 2019), one in Colombia (Heeke et al., 2017) and one in Norway (Kristensen et al., 2010). The earliest study was

published in 1985 and the most recent in 2019. The sample size of included studies ranged between 44 and 803 participants. Mean age of samples ranged between 33 and 79 and, except for one study, the majority of participants in each sample were female. Participant groups were defined as those bereaved by natural disasters (Cowan & Murphy, 1985; Kristensen et al., 2010; Li et al., 2015; Murphy, 1988; Xu et al., 2017), homicide (Bailey, Sharma, & Jubin, 2013; Bottomley et al., 2017; Burke et al., 2010; Rheingold & Williams, 2015), suicide (Levi-Belz, 2015; Levi-Belz & Lev-Ari, 2019; Oexle & Sheehan, 2019; Spino et al., 2016), accidental death (Fullerton, Ursano, Kao, & Bharitya, 1999; Sprang & McNeil, 1998) or armed conflict (Heeke et al., 2017). One study was longitudinal in design (Bottomley et al., 2017), and measured outcomes six months after baseline measurement (at a mean of 1.66 years post-loss). Another study (Murphy, 1988) followed-up a sample described in an included cross-sectional analysis (Cowan & Murphy, 1985) but reported different measures, so was essentially a separate cross-sectional analysis and not comparable. All other studies were cross-sectional in design.

Table 1: Study characteristics

Author, year, country	Study design Sample source	Sample demographics	Mode of bereavement Time since bereavement	Social support measures	Measured outcomes
Bailey 2013 Canada	Cross-sectional Community organisation	*n*=48 mean age=51.5 100% female	Child lost to gun violence 0.5-12 years	Multidimensional Scale of Perceived Social Support (MSPSS)	Resilience
Bottomley 2017 U.S.A.	Longitudinal (6 month follow-up) Support organisation	*n*=47 mean age=49.7 89.4% female	Family member lost to homicide Mean length= 1.66 years at T1, 2.16 at T2	Arizona Social Support Interview Schedule (ASSIS)	PTSD, complicated grief, depression, anxiety
Burke 2010 U.S.A.	Cross-sectional Support organisation	*n*=54 mean age=48.6 88.9% female	Family member lost to homicide Mean length= 1.75 years	ASSIS, Inventory of Social Support (ISS)(Hogan & Schmidt, 2002) & MSPSS	PTSD, complicated grief, depression
Cowan 1985 U.S.A.*	Cross-sectional Death certificates/ court records	*n*=119 (50 control) mean age=unclear 70% female	Friends and family lost in natural disaster Mean length= .92 years	Coppel Index of Social Support (CISS)(Coppel, 1980)	Depression
Murphy 1988 U.S.A.*	Cross-sectional Death certificates/ court records Official population records	*n*= 49 (bereaved) /36 (control) mean age= 30/37 74%/65% female	Friends and family lost in natural disaster Mean length= 3 years (estimate)	CISS	Mental distress, recovery

Fullerton 1999 U.S.A.	Cross-sectional Air force squadron	*n*=71 mean age=33 4.0% female	Squadron members of personnel lost in plane crash Mean length= 0.17 years	Perceived Social Support Scales (Family and Friends)(Procidano & Heller, 1983)	Depression, initial impact of event
Heeke 2017 Colombia	Cross-sectional Humanitarian organisation	*n*=308 mean age=48.5 61.7% female	Significant other lost in armed conflict Mean length= 12.4 years	DUKE-UNC Functional Social Support Questionnaire	PTSD, Prolonged grief, emotional distress
Kristensen 2010 Norway	Cross-sectional Official population records (police deceased list and population register)	*n*=130 mean age=45.7 51.5% female	Family member lost in natural disaster Mean length= 2.2 years	Crisis Support Scale (CSS)	Complicated grief
Levi-Belz 2015 Israel	Cross-sectional Support organisation/online support forum	*n*=135 mean age=40.3 77.0% female	Family member lost to suicide Mean length = 3.5 years	MSPSS	Stress-related growth
Levi-Belz 2019 Israel	Cross-sectional Support organisation/online support forum/online advertising	*n*=156 mean age=40.7 81.4% female	Family member or friend lost to suicide Mean length = 10 years	MSPSS	Complicated grief

Li 2015 China	Cross-sectional Official population records	n=803 mean age=46.7 63% female	Family lost to natural disaster Mean length = 1.0 years	MSPSS	Complicated grief
Oexle 2019 U.S.A	Cross-sectional Support organisation/online advertising	n=195 mean age=50 92% female	Immediate family lost to suicide Mean length = 8.9 years	Perceived Social Support Questionnaire (PSSQ)	Depression, personal growth, grief difficulties, suicidal ideation
Rheingold 2015 U.S.A.	Cross-sectional Official population records	n=47 mean age=78.7 78.7% female	Immediate family lost to homicide Mean length = 2.1 years	ISS	PTSD, complicated grief, depression
Spino 2016 U.S.A.	Cross-sectional Social support group/online advertising	n=44 mean age=44 75% female	Adults bereaved by suicide Length of loss unclear	Norbeck Social Support Questionnaire (NSSQ)	Depression, loneliness
Sprang 1998 U.S.A.	Cross-sectional Support organisation	n=171 mean age=34 54.4% female	Immediate family killed by drunk driver Mean length = 2.3 years	Provisions of Social Relations Scale (PSRS)	PTSD, grief, mourning
Xu 2017 China	Cross-sectional Official population records	n=176 mean age=54.7 52.3% female	Child lost to natural disaster 6.0-6.3 years	Social Support Rating Scale (SSRS)	PTSD

*Murphy 1988 is a follow-up of Cowan 1985, but measured different outcomes so is not comparable

Across the 15 different studies, 11 different validated measures of social support were used (table 2). The Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988) was the most frequently included measure, employed in five studies (A. Bailey et al., 2013; Burke et al., 2010; Levi-Belz, 2015; Levi-Belz & Lev-Ari, 2019; Li et al., 2015).

Measures were based on different theoretical approaches to social support, with some distinguishing between perceived and received social support (measuring one or both), and some distinguishing between structural support (integration with social network) and functional support (specific functions provided by others) and measuring one or both (Lakey & Cohen, 2000), and some developed and validated for specific populations.

Table 2: Social support measures used in studies included in this review

Measure	Type of social support assessed by measure	Type of measurement tool	Use of measure in included study	
Arizona Social Support Interview Schedule (ASSIS) (Barrera et al., 1981)	Size and availability of and satisfaction with support network.	Structured interview.	Bottomley 2017	12 variables derived. Perceived need for and satisfaction with each of 6 categories: intimate interaction, material aid, advice and information, positive feedback, physical assistance, social participation
			Burke 2010	5 variables derived: available support network for family and non-family, actual support network, anticipated and actual negative relationships
Coppel Index of Social Support	Structural and functional support	Self-report questionnaire. 15	Cowan 1985	Items across domains summed for total score of perceived social support.

		items on a 5 point Likert scale	Murphy 1988	Items across domains summed for total score of perceived social support.
Crisis Support Scale (CSS)(Elklit, Schmidt Pedersen, & Jind, 2001; Joseph, Williams, & Yule, 1992)*	Received social support	Self-report questionnaire. 7 items on a 7 point Likert scale	Kristensen 2010	Scandinavian version. Factors summed separately to measure positive social support and negative social response.
DUKE-UNC Functional Social Support Questionnaire (Broadhead, Gehlbach, de Gruy, & Kaplan, 1988)	Functional social support	Self-report questionnaire. 11 items on a 5 point Likert scale	Heeke 2017	Translated version. Items summed for total score of perceived social support.
Inventory of Social Support (ISS)(Hogan & Schmidt, 2002)*	Perceived social support for grief	Self-report questionnaire. 5 items on a 5 point Likert scale	Burke 2010	Items summed for total score of available grief support.
			Rheingold 2015	Items summed for total score of perceived social support.
Multidimensional Scale of Perceived Social Support (MSPSS)(Zimet et al., 1988)	Perceived presence and level of support across three domains: family, friends and significant other.	Self-report questionnaire. 12 items on 7 point Likert scale	Bailey 2013	Items across domains summed for total score of perceived social support.
			Burke 2010	Items across domains summed for total score of available general support.
			Levi-Belz 2015	Items across domains summed for total score of

| | | | Levi-Belz 2019 | available perceived support.

Items across domains summed for total score of perceived support. |
			Li 2015	Translated version. Items across domains summed for total score of general social support.
Norbeck Social Support Questionnaire (NSSQ)(Norbeck, Lindsey, & Carrieri, 1981)	Perceived social support: functional support	Self-report questionnaire. Amount of support from supportive network members listed.	Spino 2016	Network score, relationship score and both combined for total score.
Perceived Social Support Scales, friends and family (PSS-Fr, PSS-Fa)(Procidano & Heller, 1983)	Perceived social support from friends and family	Self-report questionnaires. 20 items on a 3 point Likert scale	Fullerton 1999	Items summed for each scale for total score of support from friends and support from family.
Provisions of Social Relations Scale (PSRS)(Vaux et al., 1986)	Perceived social support	Self-report questionnaire. 18 items on a 5 point Likert scale	Sprang 1998	Family support and friend support subscales combined for a total score of cognitive appraisal of support.
Perceived Social Support Questionnaire (PSSQ)(Kliem et al., 2015)	Perceived social support	Self-report questionnaire. 6 items on a 5 point Likert scale	Oexle 2019	Items summed for a total score of perceived support.
Social Support Rating Scale	Subjective support,	Self-report questionnaire	Xu 2017	Three domains of social support combined for a

(SSRS)(Xiao, 1993)	objective support and support availability	developed for Chinese populations. 10 items	total score and categorised into low, medium and high support.

*Assessment tools that have 2 references by their name are those that have been initially described in one study and validated in a separate study. All other assessment tool references include an initial description and validation of the tool in one study.

Across the 15 different studies, 15 different mental health and psychological wellbeing outcomes were measured. The most frequently measured outcomes were post-traumatic stress disorder (Bottomley et al., 2017; Burke et al., 2010; Heeke et al., 2017; Rheingold & Williams, 2015; Sprang & McNeil, 1998; Xu et al., 2017), depression (Bottomley et al., 2017; Cowan & Murphy, 1985; Fullerton et al., 1999; Oexle & Sheehan, 2019; Rheingold & Williams, 2015; Spino et al., 2016) and complicated grief (Bottomley et al., 2017; Burke et al., 2010; Kristensen et al., 2010; Levi-Belz & Lev-Ari, 2019; Rheingold & Williams, 2015). The remaining measures were of other distinct psychiatric and psychological wellbeing outcomes (table 3). No studies measured service use as an indicator of wellbeing. Where studies measured prevalence of an outcome rather than symptom severity, a cut-off score on an assessment tool was used rather than self-report of an existing clinical diagnosis.

Table 3: Findings grouped by outcome

Outcome	Study	Exploratory or specific hypothesis	Analysis method	Covariates included in models	Sample size (n)	Findings
Psychiatric outcomes						
PTSD	Bottomley 2017	Exploratory	Regression model with social support as a predictor.	T1 PTSD (at a mean of 1.66 years since loss)	47	Of 12 social support variables, need for advice, need for physical assistance and satisfaction with physical assistance were included in the model. Satisfaction with physical assistance was the only significant predictor, negatively predicting PTSD severity at T2 (6 month follow-up) (p<.03, b=-.18).
	Burke 2010	Exploratory	Correlations	n/a	54	Of 6 variables measured, percentage of actual negative relationships significantly correlated with PTSD severity (.28, p<.05).
	Heeke 2017	Specific hypothesis	Latent class analysis	Gender, years of education, number of assaultive/accidental traumatic events, relationship to person lost, how loss happened and time since loss.	308	Social support was the only factor associated with PTSD symptoms compared to the resilient class (OR= .95, p=.005).

	Rheingold 2015	Exploratory	Generalised estimating equations	Variables found to significantly differ by diagnostic status: employment status, deceased contributing to household income.	47	Lack of social support was independently associated with increased risk of meeting criteria for PTSD (beta =.19, Wald x2 = 4.64, p<.05).
	Sprang 1998	Exploratory	Regression model with social support as a predictor.	Gender, age, race, subjective health status, income, marital status, past experience with death, time since death and religious beliefs.	171	Greater social support was associated with lower rates of PTSD symptoms (beta=.415, p<.005; 43.2% of variance).
	Xu 2017	Exploratory	Regression model with social support as a predictor.	Ethnicity, residence location, gender, age, monthly income, education level, age of child and gender of child.	176	Low social support was a significant risk factor for meeting criteria for PTSD (OR= .244, beta=-1.41, p=.002, 95% CI).
Depression	Bottomley 2017	Exploratory	Regression model with social support as a predictor.	T1 depression (at a mean of 1.66 years since loss)	47	Of twelve social support variables, need for advice, need for physical assistance and satisfaction with physical assistance were included in the model but none were significant predictors.
	Burke 2010	Exploratory	Correlations	n/a	54	Of six social support measures, two were significantly correlated with depression severity:

					grief support (-.27, p<.05) and percentage of anticipated negative relationships (.28, p<.05).
	Cowan 1985	Exploratory	Regression model with social support as a predictor.	Stress, age, gender, importance of deceased and perceived preventability of death.	69	Perceived social support was associated with greater depression severity (p<.05, b=-.14), accounting for 38% of variance in the model.
	Fullerton 1999	Exploratory	Regression model with social support as a predictor.	Age, marital status, social network index, disaster specific social support, family distress, maximum closeness to deceased crew, transience, hardiness, social desirability and initial impact of event (IES).	71	Support from friends and support from family were entered as separate predictors in each model. In models controlling for total IES and IES intrusion scores, neither perceived social support variable was associated with depression severity. Controlling for IES avoidance (10%), perceived social support from friends was negatively associated with depression severity (5% of variance; beta=-.03, p=.027).
	Oexle 2019	Specific hypothesis	Regression model with social support as a predictor.	Age, gender, pre-loss mental illness, time since loss, relationship to deceased and perceived closeness to deceased.	195	Greater perceived social support was significantly associated with a lower level of depressive symptoms (beta=-.53, p<.001).
	Rheingold 2015	Exploratory	Generalised estimating equations with	Variables found to significantly differ by diagnostic status: age,	47	Lack of social support was independently associated with increased risk of meeting criteria for MDD (beta =.40, Wald x2 = 14.37, p<.005).

			social support as a predictor.	employment status, deceased contributing to household income.		
	Spino 2016	Specific hypothesis	Regression model with social support as a predictor.	Physical health encumbrance.	44	Three social support variables were used as predictors. In a linear regression model, higher network score was associated with a significant decrease depression severity (beta= -0.53, p=.011). In a linear regression model, higher relationship score was associated with a significant decrease depression severity (beta= -0.18, p=.011). In the multiple regression model, higher total support score (beta= -0.02, p=.001) was associated with a significant decrease in depression severity.
Complicate d grief	Bottomley 2017	Exploratory	Regression model with social support as a predictor.	T1 complicated grief (at a mean of 1.66 years since loss)	47	Of twelve social support variables, satisfaction with physical assistance was the only significant predictor out of the three social support variables included in the model, positively predicting complicated grief severity at T2 (6 month follow-up) (beta=.20, p<.05).
	Burke 2010	Exploratory	Correlations	n/a	54	Of six social support measures, two were significantly correlated with complicated grief severity: percentage of actual negative relationships (.28, p<.05) and available support system (-.28, p<.05).

	Kristensen 2010	Exploratory	Regression model with social support as a predictor.	Gender, pre-disaster employment, relationship to deceased, previous experience of loss, time elapsed before death confirmed.	130	Two social support variables were included in analysis: low positive social support (OR=.24, p=.012) and high negative social support (OR=3.81, p=.012) were significantly associated with meeting criteria for complicated grief.
	Levi-Belz 2019	Specific hypothesis	Regression model with social support as a predictor.	Time since loss, attachment style, self-disclosure and interaction between secure attachment, social support and self-disclosure.	156	Greater perceived social support was significantly associated with lower severity of complicated grief (beta=-.30, p<.01).
	Li 2015	Exploratory	Regression model with social support as a predictor.	n/a	803	Social support was not significantly associated with meeting criteria for complicated grief.
	Rheingold 2015	Exploratory	Generalised estimating equations with social support as a predictor.	Variables found to significantly differ by diagnostic status: age, deceased contributing to household income.	47	Lack of social support was not significantly associated with increased risk of meeting criteria for complicated grief.
Anxiety	Bottomley 2017	Exploratory	Regression model with social support as a predictor.	T1 anxiety (at a mean of 1.66 years since loss)	47	Need for advice, need for physical assistance and satisfaction with physical assistance were included in the model. Satisfaction with physical assistance was the only significant predictor,

						negatively predicting anxiety severity at T2 (6 month follow-up) (p<.001, b=-.30).
Prolonged grief	Heeke 2017	Specific hypothesis	Latent class analysis with social support as a predictor.	Gender, years of education, number of assaultive/accidental traumatic events, relationship to person lost, how loss happened and time since loss.	308	The amount of perceived social support did not predict membership of the PGD class.
Suicidal ideation	Oexle 2019	Specific hypothesis	Regression model with social support as a predictor.	Age, gender, pre-loss mental illness, time since loss, relationship to deceased and perceived closeness to deceased.	195	Greater perceived social support was significantly associated with lower severity of suicidal ideation (beta=-2.87, p<.001).
Psychological wellbeing outcomes						
Emotional distress	Heeke 2017	Specific hypothesis	Latent class analysis with social support as a predictor.	Gender, years of education, number of assaultive/accidental traumatic events, relationship to person lost, how loss happened and time since loss.	308	Less social support was a predictor of the emotional distress class (OR= .92, p<.001).

Grief	Sprang 1998	Exploratory	Regression model with social support as a predictor.	Gender, age, race, subjective health status, income, marital status, past experience with death, time since death and religious beliefs.	171	Greater social support predicted lower extent of grief (beta=-.479, p<.005).
Grief difficulties	Oexle 2019	Specific hypothesis	Regression model with social support as a predictor.	Age, gender, pre-loss mental illness, time since loss, relationship to deceased and perceived closeness to deceased.	195	Greater perceived social support was significantly associated with decreased grief difficulties (beta=-.47, p<.001).
Initial impact of event	Fullerton 1999	Exploratory	Regression model with social support as a predictor.	Age, marital status, social network index, disaster specific social support, family distress, maximum closeness to deceased crew, transience, hardiness and social desirability.	71	Neither perceived social support measure (support from friends/ support from family) was a good predictor of total or avoidance IES. Low perceived social support from friends predicted a higher intrusive initial IES score (beta=-.44, p=.044).
Loneliness	Spino 2016		n/a	n/a	n/a	Statistical analyses not reported.

Mental distress	Murphy 1988	Exploratory	Regression model with social support as a predictor.	T1 mental distress, age, sex, education, stress, self-efficacy and social support	49	Social support did not significantly predict severity of mental distress
Mourning	Sprang 1998	Exploratory	Regression model with social support as a predictor.	Gender, age, race, subjective health status, income, marital status, past experience with death, time since death and religious beliefs.	171	Greater social support significantly predicted lower extent of mourning (beta=.350, p<.005).
Personal growth	Oexle 2019		Regression model with social support as a predictor.	Age, gender, pre-loss mental illness, time since loss, relationship to deceased and perceived closeness to deceased.	195	Greater perceived social support was significantly associated with increased personal growth (beta=-44, p<.05).
Recovery	Murphy 1988	Exploratory	n/a	n/a	n/a	Social support was not included in the regression model predicting recovery.
Resilience*	Bailey 2013	Exploratory	Regression model with social support as a predictor.	n/a	48	Unadjusted model where traumatic stress predicted greater levels of resilience was significant (b = -.241, p<.049). The adjusted model with social support as a mediator was also significant (b=.297, p=.032).

| Stress-related growth | Levi-Belz 2015 | Specific hypothesis | Regression model with social support as a predictor. | Time since loss, adaptive coping, maladaptive coping, self-disclosure, interaction between time and interpersonal variables. | 135 | Combined with self-disclosure as a predictive interpersonal variable, social support predicted levels stress-related growth (beta=.11, p=.027). |

* Resilience was defined as stress coping ability

2.4.3 Quality assessments

Table 4 shows the results of the NOS quality assessments for included studies. Most studies were judged as either good quality (Kristensen et al., 2010; Levi-Belz & Lev-Ari, 2019; Oexle & Sheehan, 2019; Rheingold & Williams, 2015; Sprang & McNeil, 1998; Xu et al., 2017) or fair quality (Bottomley et al., 2017; Cowan & Murphy, 1985; Fullerton et al., 1999; Heeke et al., 2017; Murphy, 1988), and five studies were rated as poor quality (A. Bailey et al., 2013; Burke et al., 2010; Levi-Belz, 2015; Li et al., 2015; Spino et al., 2016). The most frequent source of bias was sample size. No studies were deemed to have a justified sample size as none had carried out a power calculation. Low response rate or no response rate, and lack of comparison between respondents and non-respondents were also a common source of bias across studies, where 13 studies did not meet the criteria to score a point in this category.

Table 4: Newcastle-Ottawa Quality Assessment Scale

Adapted for cross-sectional studies								
	Selection				Comparability	Outcome		
Study	Representativeness of sample	Sample size	Non-respondents	Ascertainment of exposure	Confounding factors controlled	Assessment of the outcome	Statistical test	Quality
Bailey 2013	1	0	1	2	0	1	1	Poor
Burke 2010	0	0	0	2	0	1	1	Poor
Cowan 1985*	1	0	0	2	1	1	1	Fair
Murphy 1988	1	0	0	2	1	1	1	Fair
Fullerton 1999	1	0	0	2	1	1	1	Fair
Heeke 2017	0	0	0	2	2	1	1	Fair
Kristensen 2010	1	0	1	2	1	1	1	Good
Levi-Belz 2015	1	0	0	2	0	1	1	Poor
Levi-Belz 2019	1	0	0	2	2	1	1	Good
Li 2015	1	0	0	2	0	1	1	Poor
Oexle 2019	0	0	1	2	2	1	1	Good
Rheingold 2015	1	0	0	2	1	1	1	Good
Spino 2016	0	0	0	2	0	1	1	Poor
Sprang 1998	1	0	0	2	2	1	1	Good
Xu 2017	1	0	0	2	1	1	1	Good
NOS for cohort studies								
	Selection				Comparability	Outcome		

	Representativeness	Selection of non-exposed cohort	Ascertainment of exposure	Outcome of interest not present at start of study	Comparability of cohorts	Assessment of outcome	Follow-up long enough for outcome to occur	Adequacy of follow-up	Quality
Bottomley 2017	0	n/a	1	0	1	1	1	1	Fair

*taking into account only participants who were bereaved, not control participants

In addition to the NOS, I noted that exploratory approaches were common, with multiple statistical models often used in study analyses, reflecting multiple outcomes and exposure variables. There was also a great deal of variation in the degree to which analyses controlled for potential confounding variables, and in the specific variables chosen as potential confounders, resulting in a risk of residual confounding in reported estimates.

2.4.4 Summary of findings

Table 5 summarises the overall findings extracted from included studies for each outcome type.

Table 5: Summary of the number of studies indicating an association between social support and each outcome

		Number of studies indicating an association between social support and outcome			
		Positive association*	Partial positive association†	No association	Negative association
Outcome					
Psychiatric	Depression (N=7)	4 (Cowan, 1985; Oexle, 2019; Rheingold, 2015; Spino, 2016)	2 (Burke, 2010, Fullerton, 1999)	1 (Bottomley, 2017)	-
	PTSD (N=6)	4 (Heeke, 2017; Rheingold, 2015; Sprang, 1998; Xu, 2017)	2 (Bottomley, 2017; Burke, 2010)	-	-
	Complicated grief (N=6)	2 (Kristensen, 2010; Levi-Belz, 2019	1 (Burke, 2010)	2 (Li, 2015; Rheingold, 2015)	1 (Bottomley, 2017)
	Prolonged grief (N=1)	-	-	1 (Heeke, 2017)	-
	Anxiety (N=1)	-	1 (Bottomley, 2017)	-	-
	Suicidal ideation (N=1)	1 (Oexle, 2019)	-	-	-

Psychological	Emotional distress (N=1)	1 (Heeke, 2017)	-	-	-
	Grief (N=1)	1 (Sprang, 1998)	-	-	-
	Grief difficulties (N=1)	1 (Oexle, 2019)	-	-	-
	Initial impact of event (N=1)	-	1 (Fullerton, 1999)	-	-
	Mental distress (N=1)	-	-	1 (Murphy, 1988)	-
	Mourning (N=1)	1 (Sprang, 1998)	-	-	-
	Personal growth (N=1)	1 (Oexle, 2019)	-	-	-
	Resilience (N=1)	1 (Bailey, 2013)	-	-	-
	Stress-related growth (N=1)	1 (Levi-Belz, 2015)	-	-	-

* all measured social support variables had a significant positive association with the reduced severity of, or reduced likelihood for meeting the threshold of diagnosis for a measured outcome.

† some, but not all of the included social support variables had a significant positive association with reduced severity of, or reduced likelihood for meeting the threshold of diagnosis for the measured outcome, with the remaining included variables not significantly associated with the outcome.

2.4.4.1 Psychiatric Outcomes

Depression (seven studies)

There was limited evidence that social support was associated with reduced risk of meeting the threshold for depression diagnosis or reduced depression symptom severity, with seven studies (Bottomley et al., 2017; Burke et al., 2010; Cowan & Murphy, 1985; Fullerton et al., 1999; Oexle & Sheehan, 2019; Rheingold & Williams, 2015; Spino et al., 2016) measuring this outcome. The single longitudinal study (Bottomley et al., 2017) included in this review was of fair quality and was exploratory in nature, but did control for baseline outcome measures. This study found no association between the two variables.

Four studies (Cowan & Murphy, 1985; Oexle & Sheehan, 2019; Rheingold & Williams, 2015; Spino et al., 2016) reported a positive association between measures of social support and depression;

two were good quality (Oexle & Sheehan, 2019; Rheingold & Williams, 2015), one was fair quality (Cowan & Murphy, 1985) and one was poor quality (Spino et al., 2016).

Two more exploratory studies reported a partial positive association between social support and depression. A study judged as fair quality (Fullerton et al., 1999) found that only one (perceived support from friends) of two social support variables in one of three analysis models was cross-sectionally associated with reduced symptom severity, with the other 2 models finding no association. A poor quality study (Burke et al., 2010) found that two (grief support and percentage of anticipated negative relationships) of six social support variables correlated significantly with reduced symptom severity.

PTSD (six studies)

There was limited evidence that social support was associated with a reduced risk of meeting the threshold for PTSD diagnosis or with reduced symptom severity. All six studies (Bottomley et al., 2017; Burke et al., 2010; Heeke et al., 2017; Rheingold & Williams, 2015; Sprang & McNeil, 1998; Xu et al., 2017) that measured PTSD as an outcome found some evidence of an association between increased social support and reduced severity of/likelihood of meeting threshold for PTSD, however studies were of mixed quality.

In the longitudinal study (Bottomley et al., 2017), one (satisfaction with physical assistance) out of twelve measured social support variables predicted lower symptom severity. Another poor quality study (Burke et al., 2010) found a partial positive association, with only one (percentage of actual negative relationships) of out six social support variables correlated with lower symptom severity.

Four other studies (Heeke et al., 2017; Rheingold & Williams, 2015; Sprang & McNeil, 1998; Xu et al., 2017) found a positive association between social support and PTSD. Three of these studies were of good quality (Rheingold & Williams, 2015; Sprang & McNeil, 1998; Xu et al., 2017) and one was of fair quality (Heeke et al., 2017).

Complicated grief [CG] (six studies)

There was mixed evidence regarding whether social support was associated with a reduced risk of meeting the threshold for CG diagnosis or reduced symptom severity, with six studies (Bottomley et al., 2017; Burke et al., 2010; Kristensen et al., 2010; Levi-Belz & Lev-Ari, 2019; Li et al., 2015; Rheingold & Williams, 2015) [31, 32, 34, 37, 40, 42] measuring this outcome. The included longitudinal study (Bottomley et al., 2017) found that only one (satisfaction with physical assistance) of twelve social support variables was associated with CG, predicting increased severity of symptoms.

Two studies reported a positive association: two good quality studies (Kristensen et al., 2012; Levi-Belz & Lev-Ari, 2019) reported a positive association between the social support risk of CG. Another study (Burke et al., 2010) found a partial positive association; this poor quality study

found that two (percentage of actual negative relationships and available support system) of six social support variables was correlated with reduced symptom severity of CG.

Two more studies, one poor quality (Li et al., 2015) and one good quality (Rheingold & Williams, 2015), found no cross-sectional association between social support and CG.

In one fair quality cross-sectional study (Heeke et al., 2017) assessed the outcome of prolonged grief, a concept similar to CG, and found no association with social support.

2.4.4.2 Other psychiatric outcomes (two studies)

The outcome of anxiety was measured in the included longitudinal study (Bottomley et al., 2017), where one of twelve measured social support variables at T1 significantly predicted lower levels of anxiety at T2 and the other variables showing no association. A separate good quality study (Oexle & Sheehan, 2019) found a significant positive association between a global social support measure and lower levels of suicidal ideation.

2.4.4.3 Other psychological wellbeing outcomes (eight studies)

Nine separate psychological wellbeing outcomes were measured, demonstrating limited evidence that social support is associated with improved psychological wellbeing.

There was consistent evidence that social support influences positive wellbeing, with three separate studies (A. Bailey et al., 2013; Levi-Belz, 2015; Levi-Belz & Lev-Ari, 2019) measuring personal growth, stress-related growth and resilience. A good quality study (Oexle & Sheehan, 2019) found that increased personal growth was cross-sectionally associated with increased social support, and a low quality study (Levi-Belz, 2015) found that increased stress-related growth was cross-sectionally associated with increased social support. Social support mediated the association between traumatic stress and resilience in a poor quality study (A. Bailey et al., 2013).

The similar constructs of grief, mourning, and extent of grief difficulties, were each significantly cross-sectionally associated with social support in two separate exploratory studies (Oexle & Sheehan, 2019; Sprang & McNeil, 1998), both high quality.

Two studies measured distress with conflicting findings; one fair quality study (Heeke et al., 2017) found a positive association between social support and emotional distress whereas another fair quality study (Murphy, 1988) found no cross-sectional association between social support and mental distress.

A single fair quality study (Fullerton et al., 1999) assessed the initial impact of event (IES) and found that one (perceived support from friends) of two social support variables in one of three analysis models was cross-sectionally associated with reduced impact, the other two models finding no association.

Two further psychological outcomes, loneliness (Spino et al., 2016) and recovery (Murphy, 1988), were mentioned as having been measured in the methods sections of separate studies but were not included in statistical analysis models reported.

2.4.4.4 Subgroup: people bereaved by suicide (four studies)

Four of the cross-sectional studies reported above (Levi-Belz, 2015; Levi-Belz & Lev-Ari, 2019; Oexle & Sheehan, 2019; Spino et al., 2016) included only participants who had been bereaved by suicide, each controlling for a range of demographic and health-related variables. Study results consistently found that increased social support was associated with higher levels of wellbeing.

One poor quality study (Levi-Belz, 2015) found a partial positive association between social support and stress-related growth, and another good quality study (Levi-Belz & Lev-Ari, 2019) found that social support was cross-sectionally associated with a significantly reduced risk of CG.

Two other exploratory cross-sectional studies; one good quality (Oexle & Sheehan, 2019) and one poor quality (Spino et al., 2016), demonstrated a positive association between social support and depressive symptoms, suicidal ideation and grief difficulties.

2.4.4.5 Other subgroups

No other meaningful patterns of results defined by subgroups became apparent during the process of data synthesis, whether based on type of loss or type of social support measurement. Insufficient information was provided in studies to compare results by relationship type or time since loss and the limited number of longitudinal studies did not allow for consideration of whether studies support or refute the main effects or buffering models of social support.

2.5 Discussion

2.5.1 Summary of main findings

To my knowledge, this is the first systematic review of studies describing the relationship between post-loss social support and psychological wellbeing after sudden and/or violent bereavement. I found only one longitudinal study among a total of 16 identified observational studies. From these studies, I found limited yet consistent evidence that receipt of greater social support is associated with lower severity/risk of PTSD, and that social support is associated with

better psychological wellbeing after bereavement by suicide. There was predominantly consistent evidence that social support is associated with lower severity of depressive symptoms/risk of depression, but a longitudinal study found no association. I found conflicting evidence for an association between social support and CG severity/risk. For the majority of other psychiatric and psychological wellbeing outcomes measured in this body of literature, apart from mental distress, each was associated with social support, but for each this was only assessed in a single study.

On balance, the evidence suggests that better social support after sudden or violent bereavement is associated with better psychological wellbeing, and that this is a consistent finding among those bereaved by suicide. However, there are a number of key limitations of the current body of literature, as highlighted throughout this review, and summarised below. This suggests a need for high quality cohort studies to further test the hypothesis that social support predicts better wellbeing.

2.5.2 Strengths and limitations of included studies

The tendency of included studies to focus on three clinical outcomes of PTSD, depression and CG mirrors that of other reviews measuring these outcomes (Lobb et al., 2010; Pitman et al., 2014; Schnider, Elhai, & Gray, 1997), generally finding these to be more common or severe among people who experience and traumatic losses as compared to other bereavements. There is clearly a need to measure other outcomes post-bereavement, including substance use, suicide attempt, and severe mental illness, as well as non-clinical outcomes such as blame, guilt and emptiness (Shields et al., 2017). However, one explanation for this is that validated measures for psychiatric outcomes are more available than those for non-clinical constructs.

I found similar methodological weaknesses in a number of the included studies; notably the use of small sample sizes and cross-sectional designs. Studies tended to be exploratory in design and many included a range of predictive and outcome variables rather than testing a specific association theoretically informed by a research question. Some studies could also have been more sensitive had they used a more specific measure of social support that broke support down into categories rather than using a single perceived support score.

Additionally, many studies included samples that were predominantly female, over 30 years old and, where reported, of White ethnicity. This limited demographic variability, along with low response rates and convenience sampling through peer support groups, seem to be a feature of bereavement research in general (Linde et al., 2017; Pitman et al., 2014; Sveen & Walby, 2008) and limit the generalisability of results. The variation in the potential confounding variables adjusted for in study models (table 3) indicates inconsistency in what is thought to influence the relationship between social support and wellbeing. Key potentially confounding variables to account for in future analyses would include time since bereavement (Feigelman, Jordan, & Gorman, 2009) as support is likely to vary over time and nature of relationship with the deceased

(Pitman, Osborn, Rantell, & King, 2016; Tidemalm et al., 2011) as this influences the wellbeing impact of bereavement. In this review only a small number of studies controlled for either of these variables, instead typically including demographic variables as covariates. Whilst cohort study designs are practically challenging, pre-bereavement psychological wellbeing would also be valuable to assess (Bolton et al., 2013).

2.5.3 Strengths and weaknesses of the review

The strengths of this review are that it used a systematic approach, including a thorough search of the grey literature. The lack of additional studies found through reference list searching, citation tracking and grey literature searching increases confidence that our search strategy was comprehensive and all relevant studies were retrieved. Although the majority of the title and abstract screening was completed by one author, we use independent rating of a proportion, and agreement between both reviewing authors was high.

Whilst it would be desirable to carry out a meta-analysis to produce a combined estimated effect size from the included studies, this was not appropriate in this review, given the differences in measurements of social support and the range of variables that each study controlled for in their statistical analysis models.

Ten different social support measurement tools were used across the fifteen studies, and these tools were not all based on the same conceptualisation of social support, making comparison difficult and potentially explaining some of the inconsistent findings of the review. The studies that did use the same measure did not always use it in the same way: the two studies that used the ASSIS (Barrera et al., 1981) extracted entirely different sets of variables from the measure. Where certain measurement tools had separate factors, some studies did not analyse these factors and instead just used a combined total score (Cowan & Murphy, 1985; Murphy, 1988; Sprang & McNeil, 1998; Xu et al., 2017) and so lost specificity. The CSS (Joseph, Williams, & Yule, 1992) was designed to measure received rather than perceived support, but as a self-report measure, it will inevitably include an element of perception.

This demonstrates that there is a lack of clarity about how best to define and operationalise social support, which may explain some of the inconsistent results in this review. Using global measures of support rather than measuring specific aspects risks failing to capture the 'active ingredients' of social support that may benefit mental health and psychological wellbeing after bereavement. The variation in the conceptualisations of social support in the studies included in this review, and in the tools used to measure it, reflect the variety observed in social support literature more generally (Wang et al., 2017).

Some potentially relevant studies had to be excluded, as additional information about categorisation of deaths was not provided by authors: inclusion of these studies may have altered our main findings. It was also not possible to ensure completely consistent categorization

for the inclusion criteria used. Deaths through illness were excluded but can be sudden in certain circumstances (e.g. death caused by a heart attack), and some of the samples recruited through support groups may have completed measures of social support with reference to their support group rather than informal support from friends and family.

Overall, generalisability is limited by the homogeneity of age and gender and the under-representation of ethnic minorities in included samples. However, cross-cultural validity is relatively good for research in this area, with the inclusion of non-Western populations that represent different cultural approaches to grief and bereavement (Cacciatore & DeFrain, 2015). The inclusion of samples recruited exclusively through support organisations would limit generalisability in these studies to those who have proactively sought help, and are well enough to be involved with these organisations.

Only four of the studies included non-family members as participants, and so the experiences of friends and colleagues are not represented in this review. It is likely that non-family members have a different social experience of a bereavement, given the difference in this kind of relationship and positioning within a social network, but are not necessarily less impacted (Bartik et al., 2013b). This remains a relatively under-researched area. There was good variation in length of time since loss; however, for studies with samples where participants had been bereaved for different lengths of time, only five controlled for this in their analysis.

The conclusions that can be drawn from this review are limited by the lack of published longitudinal studies to clarify the temporal direction of associations. The cross-sectional studies identified do not establish whether social support improves psychological wellbeing following bereavement, or if poor psychological wellbeing following bereavement reduces actual or perceived social support through its impact on relationships with others (Hannays-King et al., 2015). Establishing the temporal direction of associations is critical in understanding these relationships and using this in the development of interventions based on informal social support. Additionally, cross-sectional studies are unable to provide empirical evidence that supports or refutes either the main effects or the buffering model of social support as measuring the rate at which wellbeing improves according to level of social support received is necessary to distinguish between the two.

2.5.4 Implications for research and practice

The findings of this research suggest that professionals supporting those who have been bereaved through sudden and/or violent causes, and especially those bereaved through suicide, should consider how the quantity and quality of available informal social support could be increased as a potential means to improve outcomes for their service users (Logan et al., 2018).

Priorities for research in this area should be to establish which specific types of informal support are most likely to improve psychological wellbeing, the temporal association between the degree

of informal social support and a broad range of psychological wellbeing outcomes after bereavement, and the extent to which the degree of psychological morbidity influences the amount of social support available. The wider social support literature includes evidence to support a bidirectional relationship between social support and PTSD (Laffaye, Cavella, Drescher, & Rosen, 2008; Ozer, Best, Lipsey, & Weiss, 2003). Whilst general studies of support find that depression erodes social support (Peirce et al., 2000; Stice, Ragan, & Randall, 2004), very few studies have examined whether social support decreases the severity of depression (Wade & Kendler, 2000).

Very little research has explored the relationship between CG and social support, most of which relates to sudden and/or violent losses, and so there is limited evidence of a relationship beyond this review. Cognitive models explaining CG highlight rumination as being a contributor to CG (Eisma et al., 2013). A recent study showed that rumination moderates the relationship between meaning-making and prolonged grief (conceptually similar to complicated grief), where less meaning-making as rumination increased predicted higher levels of prolonged grief (Milman et al., 2019). During the bereavement process, emotional support from others is likely to consist of opportunities to discuss the loss and its consequences, thus encouraging rumination (Rose, Carlson, & Waller, 2007). This finding, along with the results of this review that show mixed evidence for an effect of social support on CG symptoms suggest that this relationship should be explored further with a focus on understanding how emotional support impacts complicated grief.

2.6 Conclusions

This systematic review of studies describing the relationship between post-loss informal social support and psychological wellbeing after sudden and/or violent bereavement suggests that informal social support may be important in improving psychological wellbeing following violent and/or sudden bereavement. However, current evidence is of insufficient quality or quantity to permit robust conclusions. Large, longitudinal studies with demographically varied samples are required to better understand the temporal direction of the relationships between different types of informal social support and psychological wellbeing following sudden bereavement. This information is important to the development and evaluation of programs to enhance the availability or use of specific types of informal social support for people experiencing sudden and/or violent bereavement.

The findings of this systematic review justify the focus of the following chapters in this thesis, suggesting that improving social support after a sudden or violent loss such as suicide could positively impact on wellbeing. This suggests that qualitative research to understand valued informal social support and the challenges to giving and receiving this support within networks may be valuable to the development of future resources or interventions to improve social support within social groups after loss to suicide. However, the majority of included studies were exploratory rather than having a clearly defined hypothesis and were inconsistent in the variables that were controlled for in analysis. This suggests that there is a limited understanding of how the relationship between social support and wellbeing after a loss works. Qualitative research is suited

to investigating the nuances of this relationship and generating more theoretical knowledge about the impact of social support.

2.7 Recent relevant publications

I carried out a non-systematic in search in October 2020 (using the saved searches from the initial search with updated data parameters) to identify papers published since the last systematic search date that fit the inclusion criteria for this review. Two studies met the inclusion criteria, one finding a positive association between social support and wellbeing, one finding no association.

A study of Israeli parents bereaved through combat (Schiff et al., 2020) split their analysis by gender, finding that whilst mothers reported higher levels of social support, it was only for fathers that social support was positively associated with meaningful life success (but not functioning, the other wellbeing variable measured). The authors did suggest that a limitation of their study was that having used the MSPSS, type of support offered wasn't assessed, and that a mismatch between type of support offered and needed could impact negatively on its effectiveness.

Another study examining the effects of sudden death bereavement compared to a control group found that bereaved participants perceived less social support than those who hadn't been bereaved (Hamdan et al, 2020). 90 bereaved participants were recruited through support organisations and matched on demographic characteristics to 90 non-bereaved participants; social support was measured using the MSPSS. However, in a regression model testing the association between bereavement and suicide risk, social support was included as a controlled variable but did not moderate the relationship.

The results of these more recent studies are aligned with those of the studies included in the review, and so do not fundamentally alter the conclusions of the review.

Chapter 3: Methods for qualitative study

3.1 Summary

This study fills the gaps in knowledge that have been highlighted in previous chapters by providing a better understanding of the experience of family and friend groups who have lost somebody to suicide, and the impact of bereavement on relationships and support within the group. Qualitative methodology was chosen with the purpose of enabling a deep understanding of the experiences and perspectives of participants and I approached the study from a critical realist standpoint, focusing on the differences and similarities in how participants interpreted their experience.

Sampling for the study aimed to include a demographically-varied group of participants who had experienced suicide bereavement personally, or who had supported a bereaved friend or family member. The majority of participants had a friend or family member who also participated in the study to allow for comparison of experience within and across social network. Given the sensitivity of the topic, participants were interviewed separately to allow them to speak honestly about their experiences.

During interviews, participants completed an exercise that consisted of drawing two maps representing their close personal network both before the loss and present day. The maps were based on the hierarchical mapping technique [HMT; Antonucci, 1986], and were formed of three concentric circles into which the participant places members of their personal network according to how close they felt to them. This exercise served as an introduction to the semi-structured qualitative interview that followed it, which covered questions about the impact of loss on participants' close relationships and the support given and received within social network. Data was analysed at the individual level, comparing each participant against the other, and at the group level, comparing participants' experiences within their social network, and comparing each network's overall experience. PPI group members provided input at each stage of the project.

3.2 Aims

The project aimed to address the following research questions:

1. What are the experiences of support of a family and friend group who has lost somebody to suicide, both from within the group and from others?
2. How does suicide loss impact on existing relationships between individuals, and on family and friend groups as a whole?

3.3 Epistemological position

I approached this study from a post-positivist perspective, specifically critical realism, taking the view that objective truth about a phenomena does exist, but it can only be observed through the lens of human experienced, and so is mediated by perception and interpretation (Archer, Bhaskar, Collier, Lawson, & Norrie, 2013). By taking this standpoint, I essentially positioned myself in between the two opposing and arguably more reductive standpoints of positivism (research can reveal an observable, objective truth) and interpretivism (there is no single truth, only each individual's own constructed truth) (Lin Chih, 1998).

I also was conscious of my position in relation to existing literature; as the qualitative study was explorative, it was not completed oriented towards a single theoretical approach. In chapter 1 I describe the Dual Process Model (Schut & Stroebe, 1999) as being a key theoretical approach in this thesis. However, prior to starting the qualitative study I did not know if findings would map onto the DPM well, and expected to encounter findings that the model does not explicitly account for. For example, the findings around interpersonal processes in relation to support would possibly align with the DPM, but the original model focuses only on individual coping. It was also important to be conscious of other pre-existing theories and ideas that I had encountered in reviewing the literature presented in chapter 1, and be aware of how they might shape how I approached the data, but not use them to guide the analysis in such a way that it was a purely deductive process.

In this study, I therefore aimed to understand the experiences of friend and family groups after suicide loss, focusing on group members' relationships with each other and the support they offered each other (Ribbens McCarthy, Holland, & Gillies, 2003). Objectively, the members of each group had experienced losing the same person to suicide and therefore the same underlying reality, but each group member had their own perception of what happened and of their social interactions after the loss. I aimed to understand how each participants' own truth of what happened differed from and aligned with others, and to combine perspectives of participants within groups to move towards an informed understanding of that group's experience of suicide bereavement, recognising that no one group member's experience was more valid than another's. This allowed for analysis not only at an individual level, but also at a group level, comparing within and across social networks.

Whilst participants' experiences in some sense existed independently of me, the researcher, the act of studying them added further subjectivity to the data. My approach to designing the study, carrying out interviews and analysis all injected my own perspective into the recorded data. In keeping with common practice in qualitative research, I took measures throughout the research period to document and understand my influence on the study, including acknowledging my own personal and professional positionality in relation to the study and keeping a reflexive diary to understand my actions and decisions during the study. Rather than eliminate bias of my own personal perspective from the study, the aim was to provide context for the research, and present this openly. Additionally, I relied on experienced researchers (my supervisory panel) and those with lived experience (a PPI group) to review these actions and decisions and to challenge any potential biases or assumptions that I made, ensuring that my own voice didn't drown out the voices of the participants. The narrative produced from the research was therefore jointly constructed and the result of combined perspectives on the data.

3.4 Positionality and reflexivity

Researcher positionality is the position a researcher takes in relation to their research task, something that may predispose them to certain beliefs or perspectives (Savin-Baden & Major, 2013) which may influence their approach to research. Here, I position myself in relation to this study and its participants as well as the context of the research, acknowledging both my personal and my epistemological position (Willig, 2013).

I am somebody who has been bereaved by suicide and so I have a personal connection with the study and a specific motivation for taking on the project. I have my own experiences of formal and social support after loss to suicide, and ideas about what has constituted good and bad support for mw, which may impact on how I relate to the participants themselves and the data they provide. Having been a listening volunteer with the Samaritans for 7 years, I am familiar with talking about mental health issues, suicide and bereavement and so see myself as being experienced at managing sensitive and challenging conversations. However, in these conversations I am used to taking on a fairly passive role and allowing the other party to control where the conversation goes. Coming to interviews in this study with the purpose of gaining specific knowledge is something unfamiliar to me and required me to consciously take a different approach to conversation.

At the start of my PhD program, my research experience was primarily in quantitative research and so I tended towards a positivist view of research. This has changed over the course of the project, having gained more experience and training in qualitative research. I am aware that my positionality may also have inevitably changed over time due to immersion in the culture of the university department I study in, as a department typically focused on epidemiology and quantitative psychiatric research. At the same time, interactions with participants and PPI group members are likely to have impacted on my positionality as I engaged with other suicide bereavement experiences that conflicted or aligned with my own, challenging my assumptions

about the topic and causing me to revisit my own interpretation of my experience. I am also aware that having approached the research from the viewpoint of critical realism, I have placed a particular emphasis on comparing individual and collective experience in this study, rather than phenomenology or social construction and so will produce a narrative from the results of the study that would have been different had I approached it from another philosophical perspective.

Having acknowledged my own positionality, it was important to remain conscious of this throughout the research process and include this as part of my reflexive thinking and consideration of how I shaped the study. Throughout, members of the PPI group and supervisory panel were consulted to ensure that my own unconscious bias did not unduly influence the study. Both academics and those with lived experience offered different perspectives on the project which were incorporated into the study to ensure scientific rigour.

My own suicide bereavement arguably positions me as an "insider" researcher (Dwyer & Buckle, 2009). However, the insider/outsider divide is oversimplified: I may still be an "outsider" to participants in other contexts, for example, to somebody who has lost a child to suicide. I have never been a parent and so I have no personal understanding of what it is like to lose a child. Despite this, it may be overall easier for me to connect with participants in interview settings than it would be with somebody who had no experience of suicide bereavement.

At the same time, drawing on personal experiences of the topic during the study have the potential to influence my approach to methodology and analysis, requiring careful reflection how my voice impacts that of my participants. The current literature does not decisively state positioning oneself as an insider or outsider is best, rather, more recent papers suggest it is better to consider the difference between insider and outsider on a continuum rather than a dichotomy (Dwyer & Buckle, 2009; Holmes, 2014). The related issue of self-disclosure will be discussed further in section 3.7.2.

Insight into my own personal beliefs and assumptions was particularly important throughout the data analysis stage. Qualitative data analysis cannot be neutral, in that every researcher interacts with the data with preconceptions about what it will elicit through personal experience and knowledge of prior literature (Mauthner & Doucet, 2003).

In recognition of my positionality and the importance of reflexivity, I kept a research diary throughout the project to enable reflection on the project, to note down at each stage which of my assumptions were challenged, what choices were made and why (Watt, 2007).

3.5 PPI Involvement

Involvement of PPI groups across every stage of a research study is widely believed to improve the quality and usefulness of research by enabling those with lived experience to prioritise research

questions that they believe to be most applicable to them, to ensure that study designs are appropriate for participants and that produced data reflects lived experience and is communicated in a way that is understandable and useful to a non-academic audience (Staniszewska et al., 2011). A systematic review investigating the impact of PPI involvement in health and social care research found that despite some practical challenges in terms of additional time and cost and recruitment of PPI groups, PPI involvement in studies had an overall positive effect on the design, analysis and dissemination of studies (Brett et al., 2014), enhancing validity and reliability.

The PPI group in this study consists primarily of those outside the academic profession who either have lived experience of being bereaved by suicide, or who have experience of working with people who have been bereaved by suicide. The group consisted of 19 members; the majority of these were recruited at the beginning of the project through social media posts and promotion through suicide prevention and bereavement charities. Four members joined partway through the project as individuals who were ineligible for participation in the qualitative study but who wanted to be involved in the project.

The group's involvement was supported by the McPin Foundation, a London-based mental health research charity. As an organisation that focuses on involving people with lived experience, staff (including the research director, who was also a member of this project's supervisory panel) were able to advise on achievable yet effective PPI involvement for the project.

 The PPI group input on the research project at every stage (although not every PPI group member was involved at each stage of consultation), advising on the focus of the systematic review, the design and analysis of the qualitative study, and the content of the public resource. Their input in the qualitative study will be described throughout this chapter.

3.6 Sample

3.6.1 Sampling approach

I followed a purposive sampling approach for this study, in which potential participants were deliberately approached based on their qualities (Etikan, Musa & Alkassim, 2016), in order to mitigate some of the limitations of unrepresentative samples often seen in this field of research. This approach aimed to recruit a demographically diverse group of participants; I viewed ethnicity, gender and age as being important variables in which to have diversity, given the existing literature described in Chapter 1 indicating that these can have a considerable impact on social groups and support. In addition, friends as well as family members were recruited as they can be as affected by a loss as family members (Sklar & Hartley, 1990). I aimed to involve participants from across the rural/urban divide as urban living is thought to negatively influence feelings of social isolation and cohesion (Hall, Havens, & G., 2004; Ziersch, Baum, Darmawan, Kavanagh, & Bentley, 2009), and those bereaved in rural areas report that formal support is difficult to access

(Feigelman et al., 2008). Involving those who had and hadn't sought help for their bereavement was also important so as to include a range of overall support experiences.

As recruitment progressed, I used more selective approaches in order to achieve as diverse a sample as possible, for example by explaining to participants that I was particularly interested in hearing about the experiences of friends to facilitate snowball sampling, and working with charities focused on supporting ethnic minorities to advertise the study through their networks.

The target sample size was set at 20-40 participants to provide sufficient data for analysis at the individual level. This number was arrived upon by taking into account guidance laid out by Morse (2000); considering the broad scope of the study (increasing the saturation point), the nature of the topic (the clarity of the interview topic making it easier to obtain information), the inclusion of shadowed data (in talking about support given and received it was expected that participants would comment on others' experiences) and the expected quality of data (the sensitivity of the topic may have made it more difficult for some participants to express themselves).

For group level analysis, no standard guidance exists for recommended sample sizes, given the scarcity of existing previous work using similar methodology. A target of 10 groups with up to 10 participants in each group was set with the expectation that this would provide a sufficient amount of data for meaningful interpretation, yet allow for in-depth analysis of relationships in each group and across groups to be carried out within the timeframe of the PhD.

3.6.2 Eligibility criteria

Inclusion:

> · Participants aged 18 years or above who self-identified as having been bereaved by suicide or having experience of supporting somebody bereaved by suicide.

> · Participants bereaved between 18 months and 8 years ago.

> · Participants living in England.

Exclusion:

> · Participants who were bereaved when they were under 18 years old.

> · Participants who lacked capacity to give consent.

> · Participants whose English was not sufficient to be able to take part in a qualitative interview.

It is believed that it takes individuals between 18 months and two years to process and adapt to a bereavement (Horowitz et al., 1997). It was expected that participating in research within this

adjustment period would be a significant emotional challenge for participants, so only those who had been bereaved more than 18 months ago were recruited. An 8 year cut-off point was chosen after consultation with the supervisory panel and PPI group, with the expectation that people bereaved for more than 8 years would have trouble accurately remembering events and feelings related to the immediate bereavement period (the first 3 months after the loss).

Those bereaved as a child were excluded as they often have a very different social experience of bereavement compared to adults do. Depending on the age, they may not fully understand what death is and may not be told details about the death or involved in rituals such as wakes and funerals (Saldinger et al., 2004). Adult family members and school staff are more likely to proactively offer support in a care-taking role, and their peers are likely to offer support in a very different way to adults so their social experience of bereavement is different to that of adults (Currier, Holland, & Neimeyer, 2007).

3.7 Ethical considerations

Ethical approval for this study was granted on 17th October 2018, with an extension to the approval granted on 19th October 2019. An amendment to the ethics application was granted on 27th November 2019 for some minor changes to the recruitment process (referenced in section 3.6 below). The ethics application for the study can be found in appendix 6, with the changes made for the amendment to the original application highlighted.

The flow diagram provided to participants is presented below (figure 3) to demonstrate the involvement of participants and the use of data throughout the study.

Figure 3: Flow of participants and data through study

Study flow

Recruitment

Potential participant responds to advertisement or is referred by a friend/family member.

↓

Information sheet sent and screening telephone conversation carried out.

Potential participant eligible and willing to participate.

Potential participant excluded or declines to participate.

Participation

Audio recorded interview and social network mapping.

Analysis

Transcription and de-identification of audio recordings.

Anonymisation of map and demographic data.

Participants who opted in sent transcripts for review.

De-identified data is analysed.

Publication

Results published in academic journal.

Results published as part of PhD thesis.

Results used to create public resource.

Data storage

Contact details stored in data safe haven.

Potential participant eligible and willing to participate.

Potential participant excluded or declines to participate.

Contact details deleted.

Audio recordings stored in the data safe haven.

Paper maps, demographics and consent forms stored in locked cabinet on campus.

De-identified transcripts and anonymised map and demographic data stored in encrypted files on UCL N drive.

Audio recordings deleted and paper maps destroyed at the end of the project.

At project end, personal contact details deleted, de-identified data transferred to UK Data Service for long-term storage.

3.7.1 Confidentiality

During the transcription process, appropriate efforts were made to anonymise the data by removing names of people, places and other identifiers. However, it is possible that a participant, when reading the write-up of this study, would be able to identify themselves and others in their network by recognising certain language or contexts that the researcher is not able to predict as being identifying. The information sheets given to participants make it clear that I could not categorically ensure that the data would be fully unidentifiable. Participants were given the opportunity to check their transcript and request that certain lines were removed or further de-specified before publication so that they could be comfortable with the data that would go into the public domain.

Close friends or colleagues were not recruited for the study, but given my existing involvement with charities and communities of people bereaved by suicide, I did have distant relationships at a personal or professional level with some participants. I took additional care to reassure these participants that interviews were confidential and that I wouldn't refer to anything they'd said in the future.

Additional challenges to maintaining confidentiality existed due to the group element of this project. Given the potential sensitivity of the issues discussed, there is a duty of care not to publish anything that may cause upset to participants. As participants would know the other participants in their group, greater care had to be taken in interviews and in the writing up of results to ensure that participants didn't discover sensitive information about their friends or family. This meant that I had to be cautious during interviews to ensure that I didn't reveal anything about one participant to another, and I had a duty of care not to knowingly publish anything that may cause upset should somebody read it and be able to identify their network.

Field notes from interviews included details of network characteristics that immediately struck me as being potentially sensitive or identifying so that I could ensure that this information wasn't present in publicly available documents. I was advised by my supervisory panel, members of the PPI group and another researcher experienced in dyadic analysis to ensure that a balance was found between writing a results section that was meaningful yet sensitive to the relationships discussed.

The network summaries included in this thesis will be redacted from the version that is stored in the UCL thesis repository and made available online. The case studies used for consultation with PPI group members were abbreviated versions with quotes and specific details removed in case any of the group members knew the participants and could have recognised them based on the descriptions of their network.

3.7.2 Sensitivity, self-disclosure and researcher wellbeing during data collection

Given that it prompts memories of the death and in-depth consideration of the bereavement period, discussion of social support after a loss to suicide is considered a sensitive interview topic (Cowles, 1988). Therefore, measures were taken to ensure that participants felt comfortable participating in this study. Research has shown that if studies are well-planned, those participating in research about potentially distressing topics experience very few negative reactions, but instead appreciate the opportunity to be listened to and for their distressing experience to have some sort of positive outcome (Currie, Roche, Christian, Bakitas, & Meneses, 2016; Jorm, Kelly, & Morgan, 2007; Newman & Kaloupek, 2004). In relation to this study, a systematic review has found that the majority of people bereaved by suicide taking part in postvention studies reported having a positive experience (Andriessen, Krysinska, Draper, Dudley, & Mitchell, 2018).

Sensitive interviewing requires considerable investment from a researcher. Taylor (2002) posits that sensitive interviewing demands sustained engagement to earn trust from participants, and therefore their offering of honest and personal information. Many studies exploring sensitive topics take time to build rapport with participants before the interview and continue to engage with them afterwards so that they feel valued (Campbell, Adams, Wasco, Ahrens, & Sefl, 2009; Dickson-Swift, James, Kippen, & Liamputtong, 2007; Elmir, Schmied, Jackson, & Wilkes, 2011). Considering this, my initial contact with participants allowed time for rapport building and allow participants the opportunity to talk about their bereavement, as previous research has indicated that this can be an important factor in people's decisions to take part in research of this nature (Andriessen, Krysinska, et al., 2018).

For the researcher themselves, there is debate in the literature about whether or not self-disclosure is appropriate. Some believe that the researcher's self should be entirely removed from the interview to avoid influencing what a participant feels able to talk about, whilst others argue strategic self-disclosure encourages rapport-building and reduces a potential power imbalance that may come about due to unequal amounts of personal (and therefore vulnerable) information being disclosed by one party (Abell, Locke, Condor, Gibson, & Stevenson, 2006). It also allows a researcher to be open about their interest in the research area, which can promote reflection on the researcher's influence on the interviews. Previous research suggests that people who have been bereaved by suicide feel more comfortable discussing their bereavement with somebody who has had the same experience (Chapple & Ziebland, 2011), so for this study, disclosure about my experience of suicide bereavement may be particularly helpful.

Too much self-disclosure, however, may leave participants feeling emotionally burdened by the researcher's beliefs or experiences, or may discourage the participant from speaking openly for fear of causing upset (Sieber & Stanley, 1988). Participants in sensitive research suggest that the researcher should avoid preconceptions, be prepared for strong emotional reactions to questions and guard from becoming too emotional themselves (Campbell et al., 2009).

In summary, the literature broadly points to the necessity for the researcher to take on a dual identity: to have some level of emotional investment in their relationship with their participants,

but at the same time maintain a sense of control and professionalism. To achieve this balance, I presented myself as an insider to participants and disclosed to them that I had been bereaved by suicide, but deflected questions about my own experiences or beliefs during the interviews so as not to actively shape with my own perceptions. I decided that I would respond to personal questions about my experience in contact with participants outside of interviews, but would never reveal personal opinions about potentially controversial issues, such as self-determination, so that the participants feel able to express whatever opinion they want without judgement. I took cues from the language used by the participant to describe the death and other related terms, but ensure that I never used stigmatising language, such as negative terms for mental health issues or "commit suicide", even if the participant did. This was a decision in line with my positionality, where I chose to be open with participants about my motivation for carrying out the research and my own experience of suicide bereavement and therefore honest with myself about the perspective that I brought to interviews. The conversations that took place before and after interviews also supported my reflexive thinking and the feeling of joint ownership of the research. Questions participants asked about my experience and opinions often prompted me to actively reflect on my perspective and consider alternative approaches to thinking that were valuable when it came to working on data analysis.

In order to maintain good emotional health throughout the interview period, I limited interviews to one per day. Standard remote working practice was followed when interviews took place outside of UCL, where I checked in and out with a nominated colleague for each interview. As part of my field notes, I recorded any strong emotions or reactions I had to interviews as a way of processing the emotional impact that they may have had on me and understanding why I might have had these feelings. My primary supervisor was also available to debrief after particularly challenging contacts and in addition a clinical psychologist was available through the McPin Foundation for clinical supervision sessions.

3.8 Recruitment

3.8.1 Approach to recruitment

In 2019, there were 5,691 deaths by suicide in England and Wales (Office for National Statistics, 2020); this yearly figure has held relatively steady for the past 7 years (Office for National Statistics, 2014, 2015, 2016, 2017a, 2018, 2019), With a conservative estimate of bereavement of between 6 and 10 people who are significantly impacted by each loss (Andriessen & Krysinska, 2012), over 200,000 people in England and Wales were bereaved by suicide between 18 months and 8 years prior to this study's recruitment period.

Snowball recruitment, where existing participants were asked to nominate others who might be interested in participation, was chosen for this study. This technique has been found to be particularly effective when recruiting from populations that are typically hard to access (Robins Sadler, Lee, Lim, & Fullerton, 2010), and also complies with GDPR regulations.

The recruitment strategy for this study aimed to recruit participants who are not typically involved in bereavement research, and data protection laws prohibit any form of "cold contact" that may allow a researcher to proactively contact a participant's friends and family directly. The advantage of this technique is that many participants were approached about participation by a friend or family member who knew them well, and who had some insight into whether they would want to participate. The methodological limitations of this sampling method are acknowledged; recruitment may have been biased towards individuals with strong and supportive networks where network members felt comfortable asking each other about participation.

3.8.2 Method

The recruitment period took place between February 2019 and February 2020, with a 12 week interruption between May and August during which I undertook an internship. Interviews took place between 1st May 2019 and 6th March 2020 (with the exception of the pilot participants included in the final sample, who were interviewed December 2018) and interview period ended prematurely due to the COVID-19 pandemic.

Participants were recruited from across England to ensure that there was a geographical variance in participant groups, ideally involving participants from a mixture of urban and rural areas. Participants living in other countries in the British Isles were excluded as travel to participants for interviews needed to be feasible.

Participants were self-selecting, in that it was each individual's decision to identify as somebody who met the inclusion criteria and to respond to adverts for the study. In order to recruit family and friend networks, participants were asked to nominate friends or family members who might be interested in participation. Once a participant had been identified through primary recruitment methods, they were asked to make contact with friends and family members who they thought would be willing to participate, and either pass on the researcher's contact details or obtain permission for them to be contacted directly.

After an initial expression of interest, potential participants were provided with an information sheet. All participants then had an in-person or phone screening conversation with the researcher to ensure that they met the eligibility criteria and were willing and able to talk about their experiences in-depth. This conversation also served to establish rapport with each participant so that they felt more comfortable at the interview stage. Potential participants who hadn't responded to contact within seven days were prompted twice, then had their contact details removed from all records.

Once participants had been screened, I scheduled an interview with them. During the initial period of recruitment, interviews were only scheduled once at least one other member of the same social network had also agreed to participate in order to ensure that all participants were part of a group.

Recruitment was carried out through social media and relevant bereavement and mental health charities. Deliberate efforts were made to involve ethic minority participants, making contact with charities who work to support ethnic minorities with mental health issues (e.g. Black Thrive) to request dissemination of information about the project although only one responded and advertised the study.

Social media was chosen first and foremost as it has the potential to reach a large number of people with a range of backgrounds and experiences and has previously been shown to be an effective recruitment tool in bereavement research (Johnson, Dias, Clarkson, & Schreier, 2019). Facebook and Twitter were used as these two platforms are most popular with adults. I regularly Tweeted about my study, these Tweets were retweeted by other researchers in relevant fields. I also posted on mental health/bereavement-related Facebook groups.

Charities were chosen as people would be likely to respond to a request for involvement from a trusted source. They would also be able to reach people who were already engaged with research and improving support for others. Charities employed a range of methods to promote the study, including emailing out to mailing lists, posting on their own social media pages and using word of mouth between staff and service users and circulating posters and fliers in centres. Whilst this method would primarily have identified participants who were help-seeking, the nomination of family and friends accessed people who hadn't necessarily sought support.

3.8.3 Challenges of recruitment

The initial recruitment period, between February-November 2019, was challenging and recruitment methods produced limited results. Whilst potential participants were regularly making contact to express their interest in the study, the majority dropped off after the initial contact stage. Where it was possible to ascertain why participation could not go ahead (as opposed to an individual not responding to further contact after an initial expression of interest), there were two frequent reasons for exclusion. Firstly, participants were often bereaved too recently or too long ago to meet the inclusion criteria (despite this criterion being stipulated in recruitment material). Some of these individuals became PPI group members instead of participating in the study itself. Secondly, potential participants often expressed that they did not have a friend or family member who they felt comfortable asking to participate.

In order to collect enough data to produce meaningful results from the study, the recruitment strategy was revisited and altered to make it easier to engage participants. An ethics amendment was applied for and granted in November 2019 to enable individuals to participate without another friend or family member. It was thought that they could provide important information about social support within groups even without another group member's account to compare against.

This change in recruitment strategy was successful, with people more willing to commit to an interview for themselves and over half of the sample was recruited after this change. Several participants who agreed to participate on their own subsequently invited a friend or family member to be involved in the study after their interview. Whilst it was never stated explicitly, participants seemed to feel more comfortable with their friends and family being involved once they had met the researcher and had first-hand experience of what an interview was like and concerns about distress or discomfort were alleviated.

Another recruitment strategy that proved effective was to build personal connections with charities so that they were invested in the project and willing to share details of it with their supporters. This was a lengthy process which mostly came to fruition towards the end of the recruitment process. I used my personal connections or those of my supervisory panel/PPI group to access the gatekeepers of some charities; using these contacts made building a relationship with a charity significantly easier than if I had started by making a cold contact.

3.9 Interview tools

3.9.1 Hierarchical mapping

Hierarchical maps were used as a way of visually representing each participants' social network to serve as a basis for the qualitative interviews. This exercise is an adapted version of the process used by Antonucci (1986). As this mapping technique has not been used extensively in psychological research, I piloted the network maps with my PPI group as part of the design phase of this project to ensure that it was useful for interviews and achievable for participants to complete (Appendix 7). The full rationale for choosing the HMT over other mapping methods is described in Appendix 7; in brief, it allows for a visual representation of social network that is comparable and allows for participants to create their maps without having to use relationship levels (e.g. father, colleague) that can be associated with a perceived level of intimacy that may not match the participants' own feelings.

Participants were provided with two identical blank maps (Figure 4) comprising three concentric circles; one map to represent their social network immediately before the loss, and one to represent their social network on the day of the interview to allow for comparison over time. The whole map represented their personal network of friends and family members, with each circle representing a different level of emotional closeness. The inner circle represented "those in your life you are closest to", often only including a few people. The middle circle represented "people to whom you may not feel quite that close but who are still important to you" and the outer circle represented "people who you haven't already mentioned but who are close enough and important enough in your life that they should be placed in your personal network".

Figure 4: Image used by participants in the hierarchical mapping exercise

Personal network map
Please place up to 10 people in the circles.

Inner circle: those in your life who you are closest to.

Middle circle: those who are not as close but are still important to you.

Outer circle: those not already placed but who are close enough that they should be included in your personal network.
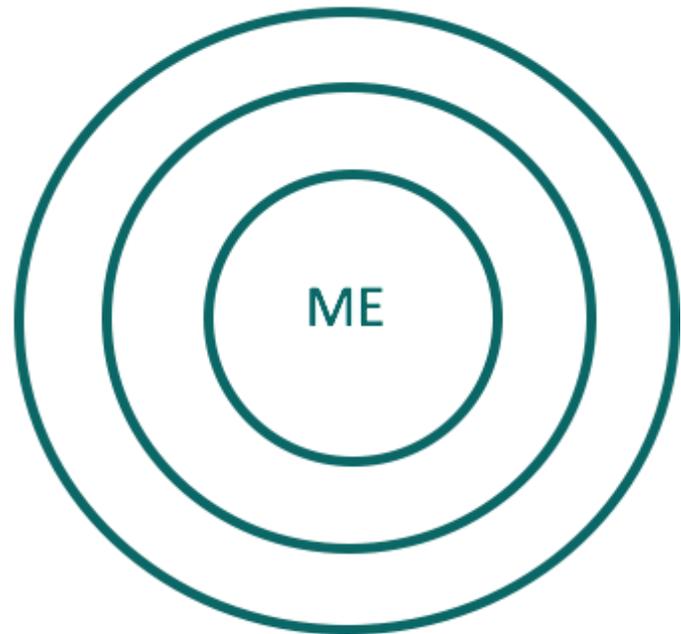
Participants were asked to write down up to ten names within the circles of the map according to where they would place their friends and family. A cap of ten people was imposed to ensure that the process wasn't excessively lengthy, however participants were able to add to their maps during the interview if they wished, or place groups of people on their map, such as "church friends" or "work colleagues". Participants created the "present" map first, as this was an easier exercise, and then created their "past" map subsequently.

Participants were asked to create the maps without thinking too much, working instinctively as opposed to extensive examination of their relationships and getting caught up on making the maps perfect.

3.9.2 Semi-structured interviews

I developed the interview schedule by using existing literature to identify topics that would be important to discuss with participants. Based on conclusions drawn in chapter 1, I believed that exploring relationship changes, barriers to support, and understanding the relationship between formal and informal support were particularly relevant. Guided by the dual process model of bereavement, I made sure that I explored both loss-oriented and restoration-oriented stressors with participants, and how support related to their ability to cope with these stressors.

The review suggests that social support is important for bereavement outcomes. However, social support is a multi-faceted construct and the different measures used in included studies assessed a range of types of support. It is not clear from current evidence which type or types of support are more related to health and wellbeing outcomes. Therefore, I ensured that the interview schedule focused on different types of support to ensure that no potentially important experiences would be missed, as well as the different supportive roles that friends and family might have to play depending on their relationship to the participant. As a small number of studies in the review explored outcomes related to grief and mourning, I also ensured that interviews facilitated exploration of how social support related to these constructs as well as more typical psychiatric outcomes. The longitudinal study included in the review prompted me to consider how the relationship between support and wellbeing may change over the course of the bereavement period, and as a result, question 4 in the interview schedule asks about change in support over time.

The guide went through several iterations as drafts were progressively refined through discussion with the supervisory and the PPI group. In particular, PPI group members commented on the language used and the phrasing of questions to ensure that they were sensitive and comprehensible.

Semi-structured interviews were used to enable participants to talk in-depth about their social network after their loss. I asked questions and gave prompts listed in the interview schedule (Appendix 8); questions covered the supportive relationships between the participants and each of their close personal network, differences in support from different groups (such as people who did and didn't know the person who died), whether professional support was sought and how it may have differed from informal social support, and perspectives on what kinds of support are the most helpful. The interview schedule was piloted with two participants before recruitment started and was found to be an effective framework for the interview. As the interview schedule did not need to be changed, these pilot participants became Group 1.

During interviews I adapted the structure and order of questions as necessary to ensure topics were explored in ways that best suited each participant and that conversation flowed naturally. I realised after initial interviews that the interview schedule didn't include a specific reference to workplaces, but that this was something that was important to participants. I then started to ensure that I followed up on workplaces or colleagues if they were mentioned in passing, or brought it into the conversation if it wasn't mentioned by a participant.

Reflections on the interview structure

I found that the initial interview question about changes in closeness referencing the social network maps could at times take up to half of the interview time; initially I would be concerned about whether there would be enough time to complete the interview, but in actual fact, these long discussions about networks provided crucial context for the interview and were often something I referred back to when asking questions later in the interview. Interviews with people who were primarily in a supportive role for their network were much shorter than other interviews with those who had known the person who died well. These participants did not have a

story to tell about the loss in the same way as somebody who was directly bereaved, and details about their close personal network were not very relevant.

I found that sometimes participants didn't have the language to explain what support meant to them, and these interviews were more challenging as they required a lot more input and prompting. People tended to be very upfront about descriptions of the death in a way that might not be appropriate for typical conversations, as they could be difficult to hear.

Interviews with somebody who had experienced another significant loss as well as the primary suicide loss could be quite different from interviews where the participant had no other impactful bereavement. For these participants the two traumas often merged together as one and it was difficult to separate out feelings and experiences around them.

3.10 Procedure

Two PPI group members reviewed the proposed procedural plan before it was sent for approval by the ethics committee, commenting on the measures put in place to support participants and ensure their comfort.

3.10.1 Rapport building

I invited each participant to choose where they wanted their interview to take place; most participants chose to be interviewed in their home, but some living in or close to London chose to be interviewed in a meeting room on the UCL campus.

Before the formal recorded interview started, I facilitated some relaxed conversation with the participant in order to build rapport and create a comfortable atmosphere for the interview. I also asked about the participant's bereavement in general to give them a chance to talk about the person they lost and their wider experience of bereavement and express what was important to them even if this wasn't related to support. As this conversation sometimes provided important context for the interview, I asked for permission to refer back to it during the interview to avoid repetition.

After this rapport-building conversation, participants read and signed the consent form and I reminded them of the purpose of the study, the protocols around confidentiality and of the possibility to pause or stop interviews at any time. I also recorded basic demographic information; date of birth, gender, ethnicity and time since loss.

Participants were made aware that interviews were kept confidential from friends and family members. However, it was also made clear to participants prior to the interview that if they disclosed that they or somebody else was at risk of serious harm, the researcher may pass this information on to ensure safety. A risk protocol (Appendix 9) that was approved by the ethics committee was in place for these situations.

3.10.2 Social network mapping

After switching the audio recorder on, I explained the hierarchical mapping exercise to participants and gave them as much time as needed to complete the two maps. I asked participants to label each point on their maps with a name or initials so that we could refer to the people or groups of people they had included during the interview. Maps were referred to throughout the interview, and I often used them as a way to re-focus interviews that were going off-topic by asking about people on maps that hadn't been yet been mentioned by the participant. Some participants added to their maps during the interview as they remembered additional network members they thought were important.

3.10.3 Interview

The semi-structured interview took place immediately after the mapping exercise and referenced the drawn maps. Interviews were only ever face-to-face to allow for use of the hierarchical network maps and to allow me to watch for any non-verbal cues that may indicate discomfort.

Participants were able to take breaks at any point during their interview, or stop it at any time. I would also pause interviews if I noticed the participant becoming distressed to give them time to collect their thoughts and to decide if they wished to continue the interview. I was also prepared to pause interviews if there was a need to enact safeguarding protocol, although this was never necessary. If I noticed that participants were finding a certain topic particularly emotional or uncomfortable to talk about, I would limit the questions I asked about this topic.

Interviews (not including the mapping exercise) lasted between 30 and 120 minutes. Interviews were ended at the 120 minute mark even if they were not complete to prevent over-burdening myself and the participant.

3.10.4 Interview Ending

At the end of the interview, I spent time debriefing with each participant so that they weren't immediately left on their own having re-lived their difficult experiences. I made sure that participants could feedback about their experience of participation and ask questions about the study if they wished as well as chatting about lighter conversation topics before leaving.

I offered all participants a physical copy of the "Help is at Hand" booklet (Public Health England, 2015), a resource developed by Public Health England and the National Suicide Prevention Alliance which offers information about bereavement by suicide. I also gave them an information sheet listing charities and services that offer support to people who have been bereaved by suicide and that offer general mental health support. Additionally, I reassured participants that follow-up contacts were available should they experience any distress or wish to debrief further in the days following participation.

After each interview, I recorded reflexive notes about observations I had made about the interview.

3.10.5 Post-interview

Data was stored according to the EU General Data Protection Regulation (GDPR: Information Commisioner's Office, 2018) and guidance from the UCL data protection team; physical paper data was stored in secure UCL storage facilities and digital data was sorted in UCL's Data Safe Haven.

Due to data protection requirements and the emotional impact of working with interviews about sensitive topics (Etherington, 2007), transcription was not outsourced. Instead, I transcribed all audio recordings and during this process, identifying details such as names and places were removed or de-specified.

During the consent process I gave participants the option to review and keep copies of their transcripts. This was primarily to confirm that they were comfortable with the things they had said being used in write-ups of the study, but also as a way to reflect on their own thoughts and feelings. The return of transcripts also gave participants ownership of their interview narratives and allowed them to check that they had represented themselves in a way that they were satisfied with (in line with the critical realist standpoint that data is socially constructed), giving them ownership over their data as they were able to request the removal of any data they didn't feel comfortable having in the public domain. Some researchers also suggest that this practice improves the rigour of a study (Tong, Sainsbury, & Craig, 2007).

Once transcription had been completed, I contacted participants to make sure that they still wanted a copy of their transcript and to make them aware that they would be receiving it. Participants were posted a copy of the transcript and had 2 weeks to contact me and request the removal of any parts of their interview. Participants who chose not to receive a copy of their transcript understood that their data would be used as recorded.

3.11 Analysis

3.11.1 Hierarchical map data analysis

Previous research has used the HMT to quantitatively assess social networks by measuring characteristics like connectivity, relative network size and strength of relationship (Carrasco, Hogan, Wellman, & Miller, 2008; Hurtado-de-Mendoza et al., 2016; Julal, Carnelley, & Rowe, 2017). One study combined the method alongside semi-structured interviews, with the qualitative and quantitative data complementing each other. In that research, HMT was used to examine the types of relationship that existed in the most supportive networks and the relationship between placement of network members on maps and extent of support offered (Reza, 2017).

Here, maps were primarily used as stimuli for the semi-structured interview, to prompt participants to start thinking about which people in their life they felt close to and why. It was believed that using a structured exercise and allowing participants to generate their thoughts in their own time was a more manageable way to get a sense of their social network than verbal questions. It also put participants in the right frame of mind to start an interview that examined their relationships in-depth.

The maps were not intended to be a complete representation of an individual's social network as there was a limit on the number of people each participant was asked to include; rather it prompted participants to think about the relative closeness of key friends and family members.

As pilot work (Appendix 7) showed that participants tended to use and interpret maps differently, they were not used for any quantitative analysis. Instead, they served to enrich interpretation of the qualitative data by providing context for the final case studies, as trends in maps were expected to mirror themes found in the qualitative data. For example, if the loss was related to a lot of tension in relationships for one participant, this was expected to reflect in group members moving outwards on their map.

3.11.2 Interview analysis

3.11.2.1 Theoretical approach to analysis

In order to effectively answer the research questions presented at the start of this chapter, I analysed collected data at two conceptual levels:

Individual level: at this level each participant was treated as an individual, regardless of which network they belonged to, and their individual experiences of bereavement were compared to those of other participants in the sample.

Group level: at this level, analysis focused on the similarities and differences in bereavement experiences between members of a single social network and between whole social networks.

Two different methods of qualitative analysis were required to explore the data; thematic analysis was used to explore data at the individual level and a novel analysis method based on dyadic analysis was used to explore data at the group levels.

Thematic analysis (individual level)

Taking into account the numerous potential approaches to qualitative data analysis, I identified thematic analysis as the most appropriate approach for the data collected in this study.

Thematic analysis was particularly suited given that the interviews generated a relatively large and complex dataset collected from a heterogeneous sample that needed to be analysed at multiple theoretical levels. This style of analysis allowed me to produce a manageable and organised

framework for the data and develop a rich interpretation that focused on comparison of accounts and identification of themes and patterns across the dataset (Braun, Clarke, & Terry, 2014; Starks & Trinidad, 2007; Thorne, 2000). In comparison to narrative or phenomenological approaches, I was able to focus on comparing data across participants in line with my critical realist standpoint and with the aims of the study, rather than be limited by a focus on the uniqueness of individual experience for a phenomena understood to impact individuals and social networks very differently.

The analysis was carried out according to the commonly used phased framework: familiarisation with data, generation of codes, searching for themes, reviewing themes and defining themes (Braun et al., 2014), which will be described in the following sections.

Group-level analysis

As highlighted in Chapter 1, previous research in the area of suicide bereavement has focused on individuals and how they have coped with this loss without considering the context of their social environment. Exploration has often been framed in terms of an individual's need for support and their perception of the support they received, rather than taking into account each social network member's provision and receipt of support.

Despite the fact that suicide is a specific type of death, the circumstances leading up to a death and the community in which it occurs can differ extensively, leading to friend and family groups having different bereavement experiences. Within groups, individuals have had different relationships with the person who died and different relationships with each other, influencing how they interact with and support each other after the death. Commonly used qualitative analysis methods such as thematic analysis or IPA are not suited to drawing out the complexities of these relationships as they do not allow for the grouping of participants. Instead, methods like dyadic analysis (Eisikovits & Koren, 2010) which allow for a focus on comparing participants' perceptions of the same event are more suited to the rich interpersonal data acquired in this study.

The process of dyadic analysis is the analysis of interviews carried out with a pair of participants (either separately or alone) with a connection to each other, and can be used to create a deeper understanding of a phenomenon by using each participant's narrative to inform the other and ultimately create a single collective narrative (Eisikovits & Koren, 2010). This technique has not commonly been used in qualitative research, in fact Eiskovits and Koren (2010) note in their published paper that they seemed to be the first to document a study that used dyadic analysis on individual interviews. This paper also provides one of the clearest descriptions of the methodology of dyadic analysis.

Researchers who have used this method tend to adapt the methodology to suit their specific research question. For example, Ummel and Achille (2015) describe creating timelines of stories from each of their participants and using these representations to visually compare data from each participant, a method suited to examining accounts of a shared event, but not to abstract and relationship-focused concepts. Paradiso de Sayu & Chanmugam (2016) focused on language in their dyadic analysis of empowerment in research partnerships, and used participants' question responses to categorise levels of agreement within dyads. More commonly, studies including dyads and larger family groups describe coding each individual's interview using standard thematic analysis or IPA approaches, then considering the resulting themes and codes together for each network group (Alexander et al., 2012; Dancyger, Smith, Jacobs, Wallace, & Michie, 2010; Morgan, Ataie, Carder, & Hoffman, 2013; Van Parys, Provoost, De Sutter, Pennings, & Buysse, 2017).

Given that interviews in this study sought to explore individual perspectives and experiences, there was sometimes limited data from participants' interviews that directly related to another participant. Additionally, the relationships between included participants differed across groups, and so carrying out a direct dyadic-type analysis would have limited comparability across groups and would only represent a small proportion of the wider social group.

Multiadic analysis (Manning, 2013) was developed from dyadic analysis as a tool to effectively explore family communication through examining multiple sets of relationships within a family group and how these relationships impacted on each other. This method of analysis has been used in several studies, but framed through the examination of the discourse taking place between participants in joint interviews as well as topics from individual interviews (Manning & Kunkel, 2014, 2015). Joint interviews were not appropriate for this study given the sensitivity of the topic, so facilitating conversation between participants and analysing their communication with each other was not possible.

In this study, direct comparisons between individual participants in a network were used as examples of congruence or contrast in experience within a group of participants, and a broader comparative approach was taken to analyse participants' social networks and communities as a whole. Here, when a participant mentioned any member of their social network, this was treated as data to be coded and analysed in order to build up an overall picture of the support and dynamics within the group, and differences and similarities in each member's bereavement experience. Using the methodology of Eiskovitz and Koren (2010), data was examined at different levels. At one level, "open reality" was considered, comparing and contrasting what participants

said in their interviews, and their descriptions of events; at another level, "hidden reality" was considered, comparing and contrasting my interpretation of participants' beliefs, gaps in knowledge and the subtext of what they said. This approach was ultimately similar to thematic analysis, just applied to data from groups rather than individuals.

Following the practice of collaborative coding, often used to enhance validity in qualitative research, (Cornish, Gillespie, & Zittoun, 2013), two members of the supervisory panel coded one transcript each independently at the beginning of the analysis process in order to explore how their interpretations of the data compared to mine. Three-way discussions based on this process enhanced my conceptual thinking around the data and guided analysis as it progressed from being mostly descriptive in the early stages to more interpretive in the latter stages. I analysed all of the data, and in all stages of analysis, I initially coded data and generated themes, and made decisions about the structure and content of the coding framework. It was particularly useful to collaborate with relative "outsiders" to the experience of suicide bereavement to support my critical engagement with the data and prevent my own experience from dominating my interpretation. As a novel method of analysis, discussing techniques with supervisors was also valuable in supporting the validity of the group-level analysis process ultimately used.

3.11.2.2 Process of analysis

Whilst papers describing qualitative analysis suggest that it has distinct stages to it, the process followed in this project was more fluid. Stages of analysis were often being carried out in parallel, and as this was a novel process, sometimes techniques were tried, tested and abandoned or adjusted in search for a rigorous and systematic method of analysis. The general temporal stages of analysis are described below. Approaching data from a critical realist perspective, I understood participants' accounts to be broadly reflective of an objective truth that was mediated by their beliefs and formative experiences.

Stage 1: individual level analysis

The first stage of the analysis focused solely on the individual level, with an inductive approach taken to coding. Although a coding framework was used during analysis, this was never closed and so alterations to this framework were made through the analysis process as new codes and themes came to light. At first a thematic analysis was carried out for four individuals from four different networks to create an initial coding framework that captured the diversity of experience of each network. These individuals were chosen to represent networks with a range of different bereavement experiences so that the initial coding framework reflected this diversity of experience. The coding framework that I created was reviewed with my primary and secondary supervisor; I refined this framework after discussion between the three parties and an initial set of themes was generated. This process was repeated again after two new transcripts had been coded, with supervisors reading one of the new transcripts each and comparing it to the revised framework. After a second discussion, only minor changes to the coding framework were needed, and so it was established that the framework was adequate in its current structure and was unlikely to need major changes going forward. Throughout the rest of the analysis, minor adjustments to nodes and structure were made as necessary as themes continued to be reviewed

and refined. Appendix 10 presents a transcript excerpt with examples of codes used and a description of how each developed over the course of the analysis process.

I carried out coding at the individual level one network at a time to facilitate the second stage of analysis. A write-up of this analysis is presented in chapter 4.

Stage 2: group level analysis and case study development

 Once the initial coding framework was relatively finalised in its use at the individual level, I examined all of the data again and identified new nodes that specifically related to interpersonal processes (e.g. "group harmony"). These were then added to the coding framework and new themes were generated that were relevant at the group level. Once the coding framework was established at both the individual and the group level and had been discussed in depth with my supervisory panel, coding of the remaining data was completed with both the individual and group level coding being carried out in parallel.

Case studies were developed as a way to make data analysis at the group manageable. These were overviews of each social network, summarising participants' perspectives of the impact of the loss on the network, and of support offered and received. Where networks were represented by one participant, their case study was based on data from a single participant's interview. Case studies of networks with multiple participants were based on multiple data sources, and so required some analytic work in order to be to summarise and integrate the experience of each participant.

 At the beginning of the analysis process I created a set of network summaries which noted key characteristics of each participant group (e.g. relationship to the person who died/other participants) and relationships, beliefs or events that seemed to be particularly impactful (e.g. significant fall-outs between group members) using notes from my reflexive diary. As these notes progressed, I started to record the same type of data for each group, (such as which group member seemed to be the focus of support), allowing for comparison across groups.

Developing these into full case studies became an iterative process alongside coding and an important part of the group-level analysis, where themes that emerged through coding prompted me to add information to case studies, and patterns that I noticed in writing case studies prompted me to refute or verify potential patterns in the data through examination of my coding. Two of these case studies and their accompanying transcripts were reviewed by my primary supervisor, and my second supervised reviewed another two separately.

By the end of the analysis process, I had developed a full case study for each participant group that reflected the theme structure of the group level coding. These case studies provided accessible summaries of the data collected, illustrating key themes at both the individual and group level. Selected case studies are presented at the beginning of chapters 4 and 5 (with the rest of the case studies presented in appendices 11 and 12) to provide context for the results that follow them,

and serving as illustrations of how themes are expressed within a social network, and how they relate to each other. They were also effective tools for PPI consultation, enabling PPI group members to engage with and critique findings without needing to spend a long time working through the coding frameworks. I added each participants' hierarchical map to their respective case study to provide additional context.

Where participants had participated alone, they were still treated as a "group" at the group level of analysis. It was accepted that they would produce less detailed network summaries of groups of participants, and they lacked the context of clarifying or conflicting statements from other members of the group, but their interviews still contained valuable insights into the group processes and social contexts related to suicide loss that were of interest in this level of analysis.

I created a separate secondary coding framework to code for instances where participants directly referred to each other or both referred to another network member to support direct comparisons of their accounts. This supported the part of the analysis that was most similar to the dyadic analysis referenced above and allowed the development of a deeper understanding of each group, highlighting demonstrable similarities and differences in experience across participants within each group, as well as generating examples of interactions. Hierarchical network maps were anonymised and digitised at this stage and included in network summaries to provide additional context for the relationships between network members.

Stage 3: generation of themes and validity checking

Once coding had been completed and the coding framework was finalised, I focused on generating higher and lower order themes. This process was relatively straightforward for the individual level, but was more complex at the group level.

To ensure that analysis at this stage was rigorous, I produced summaries of each node that related to interpersonal processes in NVivo, producing a list of all the quotes in that dataset that were coded under that node. Using these summaries and the secondary coding framework, quotes from each group were examined in turn to compare and contrast what participants had said about their experiences and each other. Once I had identified the interpersonal processes that occurred within each group, I compared these experiences across groups, using the grouped node summaries and the reflexive diary in which during data collection I had noted overall impressions of each group. Themes were then generated at the group level.

PPI groups were involved at this stage of analysis in order to comment on the validity of the analysis. In order to use the time that I had with my PPI group effectively, I chose not to present them with the data files and coding frameworks as group members were not familiar with qualitative research methods. PPI group members were instead presented with several of the case studies and asked to comment on whether or not they felt they were representative of their experiences of suicide bereavement. Their comments were used to confirm that interpretations and representations of social network were fair and reflective of their experience of suicide

bereavement. Input on analysis from multiple researchers was particularly important at the group level, as in analysis with groups of participants there is a possibility of a researcher connecting more with one participant than another (Ummel & Achille, 2015), and therefore being more likely to accept and promote their perceptions and interpretations than the other's. Involving my supervisors in independent coding and PPI group members in checking case studies and themes ensured that my own lived experience did not overly influence interpretation of the data.

3.12 Resource development methods

The following section describes the decision-making behind the proposed public resource. The planned content of the resource, based on the results of the qualitative study, and example content are presented in chapter 6.

In order to identify the key findings from this study that would be most applicable for an informative resource, I first used the completed individual and group level coding frameworks to identify which codes were commonly referenced across the entire sample (as opposed to just a few participant groups). Having identified these, I examined the data attached to these codes to establish which of the codes related to common experiences and consistently held beliefs (e.g. what are the qualities of a good supporter). I then summarised each of these into one or two sentences and noted what the relevant advice would be (e.g. "People valued it when supporters were consistent. Supporters should keep offering support across the bereavement period and even if it is not always accepted.") in preparation for the write up of some example content for the proposed resource. I present these identified codes in the final sections of chapters 4 and 5, focusing on advice and information for the close personal network and wider social network as the intended readership for the resource. Where participants described negative feelings or challenging situations, I also noted when they mentioned a method of coping with this (e.g. being careful what they discussed with their family in relation to the loss).

Decisions about the format and content of the resource were supported by the project's PPI group. Seven group members were consulted about the resource, two individually and five as part of a group discussion. These group discussions took place during the same sessions held to review the themes and case studies from the qualitative study, so that the resource could be discussed in the context of the data from which it came. Group members were able to comment on the ideas for the content and format that I presented; key decisions about content and format that arose as a result of PPI group discussion are presented in chapter 6.

Once initial ideas had been developed, they were discussed with the wider supervisory panel, and the example content presented at the end of this chapter was reviewed by members of the PPI group who had not taken part in the consultation groups mentioned above. I also researched guidance produced by the NHS for the development of their patient health information materials. I found several guidance documents (Bodley, 2015; Department of Health, 2003; Shetland, 2007; Welsh Assembly Government, 2005) and took applicable advice into account, including guidance on formatting and conveying complex information.

Chapter 4: Individual level results

4.1 Sample characteristics

The sample consisted of 26 participants in total. The sample included 8 separate networks of between two and four participants; a total of 21 participants. An additional 5 participants were individuals with no other friend or family member involved in the study.

Participants were aged between 23 and 77 years old (mean age: 51). Eighteen participants were female, seven male and one gender-fluid. Time since death ranged between 1.5-8 years, (mean length of loss: 4.5 years). All participants identified as being of White British ethnicity. A full break-down of participants' relationship to their network member who died is presented in table 6; with the majority of participants being blood relatives.

To help protect the anonymity of participants, specific locations of participants are not documented in this thesis, but a map (figure 5) presents approximate locations of participants across England in a mixture of urban and rural areas, the majority of participants being in South East England.

Figure 5: Participant home locations

Table 6: Participant's relationship to friend/family member who died by suicide

Relationship type	Number of participants
Mother	3
Father	4
Brother	1
Sister	6
Child	2
Uncle	1
Cousin	2
Partner/Spouse	3
Friend	1
No relationship: friend of bereaved	3

Table 7: Number of participants in each participant group

Number of participants in group	Group number
1	5, 8, 9, 11, 12
2	1, 4, 7, 10
3	3, 6, 13
4	2

As outlined in the recruitment section, participants were recruited through charities, social media and word of mouth. There was therefore a mix of help-seeking and non help-seeking participants. Table 8 shows the channels of recruitment used and resulting contacts from each channel.

Table 8: Channels used for recruitment and resulting contacts

Platform	Method of recruitment	Number of initial contacts	Number of participant groups included
Twitter	Tweets from personal account and from researchers and relevant organisations	76	3
Facebook	Posts in UK wellbeing/mental health groups	13	0
MHRUK	Website post/talk at Scholar's Day	3	1
Samaritans	Post on volunteer's online forum	2	0
Black Thrive	Social media posts and newsletter	0	0
McPin Foundation	Social media posts	3	1
The Listening Place	Fliers in volunteer workspaces	4	1
SOBS	Website post/talk at AGM	20	4
Suicide Bereaved Network	Social media posts, email out to network and video at AGM	8	1
If U Care Share	Social media posts	6	1
MQ	Online recruitment platform	1	0
Community centres/libraries (East London)	Fliers posted on noticeboards	0	0
Word of mouth	Personal contacts	12	1

4.2 Case studies

Two of the case studies used as part of the analysis process are presented here to illustrate participants' experiences and some of the themes relating to supportive acts and personal change captured at the individual level of analysis. The case studies represent two quite different bereavement experiences; one of a young adult who lost their partner, whose social ties are focused on friendships; and an adult who lost her brother and whose close social ties are focused primarily on family. These individuals participated without another member of their social network and so their accounts are the sole perspectives gained from their groups. Diagrams representing participants' completed hierarchical maps are presented with case studies to illustrate the changes in closeness of friends and family over the course of the bereavement period. The other case studies for participants involved as sole representatives of their group are presented in appendix 11.

[redacted]

In this chapter I will present the results of the thematic analysis at the individual level, considering the experience of each individual participant regardless of the context of their social network, which will be covered in the following chapter and will expand on some of the ideas presented here. The impact of suicide loss on an individual's life provides important context for support needs they have and for their capacity to support others and so relate to the barriers and facilitators of informal social support. Two key overarching areas emerged at this level of analysis which will be discussed in this chapter: the individual impact of suicide loss and the supportive acts that were related to the loss. The thematic structure of the chapter is presented in figure 6.

Figure 6: Thematic structure of individual level results
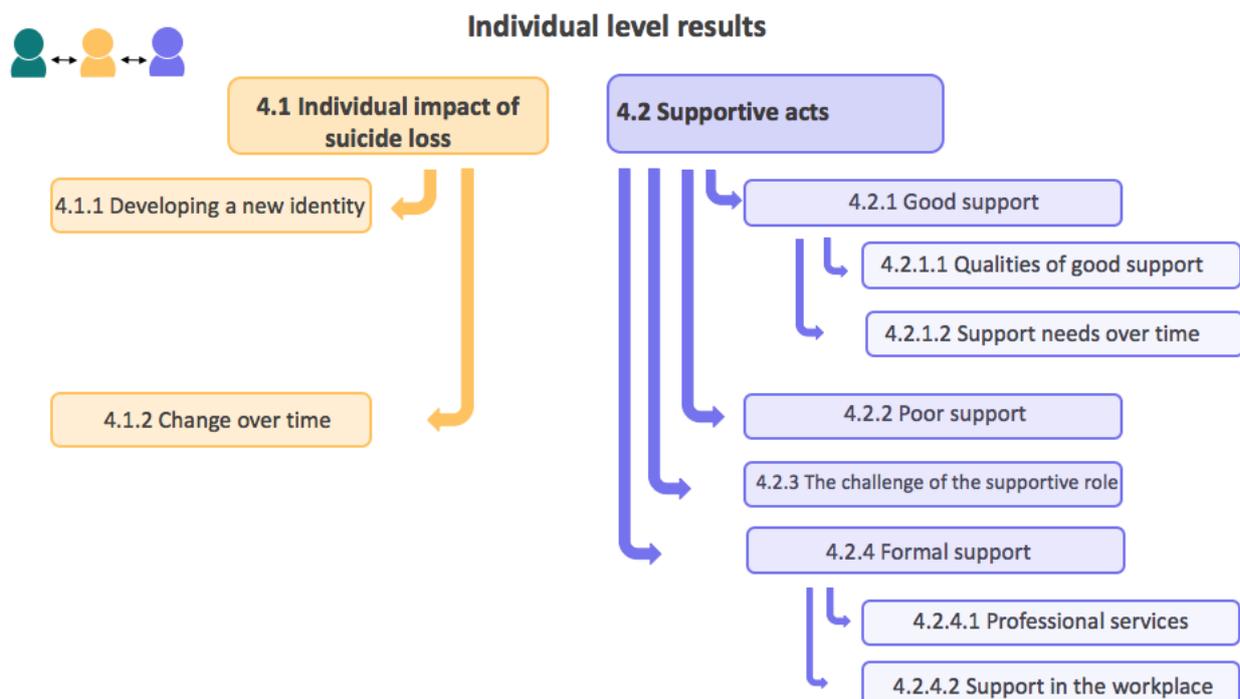
To aid analysis, there were distinctions made between different subsets of a participant's social network:

Close personal network – participants' closest friends and family, typically interlinked with the close personal networks of other participants from the same social group and more often family than friends.

Social network (or group) - other less close family and friends who were involved in participant's lives.

Community - other people in participant's lives, such as neighbours, colleagues or members of voluntary or recreational groups that participants were involved in. These were people who participants often encountered in their daily life but with whom they did not have a close

relationship.

4.3 The individual impact of suicide loss

It was clear that the interpersonal elements of bereavement impacted individuals in specific ways. During analysis it became clear that for participants, their bereavement was a significant life transition with a far-reaching impact on who they perceived themselves to be, and how others perceived them. Of interest for this project was how the bereavement impacted the way in which participants related with their social world.

4.3.1 Developing a new identity: "You're just part of this new club. That you don't want to be a member of." [P201; male, 50-60]

Most participants indicated that they felt like they were a different person, at least to some extent, as a result of their loss and this impacted on how they related to their social world. Whether they were comfortable with this or not, for many participants, their loss shifted them into a new phase of their life and "being bereaved" became a part of their identity in their eyes and the eyes of others. Participants often re-evaluated their priorities and their relationships, finding that they couldn't interact with the world in the way they did before the loss.

> "*The world feels different now, it's evolved into looking like a different place.*" [P701; female, 30-40]

Participants frequently expressed heightened concern for others in their social network after their loss. In particular, participants were often fearful that there may be another suicide within their social network and many were conscious of the statistics that show that those bereaved by suicide are at heightened risk themselves of dying by suicide, although only a few explicitly stated that they had felt suicidal since the loss. Here, P601 talks about his concern for another family member and suggests that his assumption has come from how their perception of the acceptability of suicide has changed:

> "*[family member], I think he's a potential risk because I think, I think the whole thing around mental health and- because I think he sees suicide now as an option. And I think if you lose somebody to suicide that's close to you, it becomes a more realistic option [...] It is a very strange thing when it becomes acceptable in your own head. And that's a risk.*" [P601; male, 50-60]

Some participants had not known that the deceased was struggling with their mental health before the loss and so the loss was very sudden to them. This added to the sense of insecurity about the wellbeing of those within their social network, as it was then a plausible reality that someone else in their social network could die by suicide without them being aware that that person was struggling. This insecurity was not limited only to those who were close to the person who died, with several participants mentioning that this heightened concern extended through the community to people who didn't directly know the person who died.

> *"Some of my friends were like, it really spooked them because it had suddenly become so close to them and they suddenly start to look at their own children, looking for signs."* [P401; male, 60-70]

Linked to this was a common change in behaviour where participants were more proactive about checking the wellbeing of their friends and family. This "checking in" seemed to be partly to ensure that they were supporting others through the challenging bereavement period, but also an attempt to check if friends and family were showing signs of suicidal feelings and so to prevent another death. One participant talked about how her friend who had lost a family member had become very conscious of checking in with other friends after her loss.

> *"She's very good at making sure now that she checks- that everyone else if they're going through a tough time, you know her immediate concern is 'are they safe?' 'will they do anything, what can I do to help?' um and that must be quite draining, you know, because it's almost like she's hyper-vigilant, understandably, as probably everyone associated with [person who died] looks for signs of things."* [P203; female, 40-50]

Whilst this participant's experience of hyper-vigilance was a stronger reaction to her loss than many other participants, most participants described an enhanced sense of responsibility towards the wellbeing of their group. This was even the case for participants who had not been personally impacted by the loss, who felt that it was their role to support their bereaved friend, as described by P203:

> *"You're going to have some awkward conversations and hear stuff that perhaps you don't want to hear. But actually if that's helping the person you care about deal with it, then you've got to do it."* [P203; female, 40-50]

The death also prompted a number of participants to research the science and statistics around suicide. Some would find themselves more drawn to suicide-related topics in the media and would share these with others in their social group to promote education. While most participants who did this didn't talk explicitly about why, one participant explained that it was one of the tools they used to help process and understand the loss, and one of the supporters explained that she thought it would help her support her friend in the best way possible.

More broadly, participants often focused more on prosocial acts after their loss, with their experience resulting in a sense of responsibility to contribute to suicide prevention or supporting others who had experienced loss to suicide. During interview sessions, a number of participants expressed that they were motivated to participate in this research study by the idea that they could help others in the same situation. Most participants chose to support mental health-related charities through fundraising, awareness-raising or direct volunteering after their loss and this helping of others could provide a sense of catharsis.

> *"The biggest therapy for me, and I can only talk about what helps me, is helping other people. It's absolutely massive."* [P602; female, 50-60]

Some participants underwent major shifts in their priorities and life goals. A few participant groups had set up or helped to run mental health charities in memory of their loved one. One participant talked about finding it challenging to move forward after their family member's death until they

left their job in the private sector and took on a role at a local primary school. They told me about they discussed during the interview for the role:

> "*I said 'and I've come to realise that's not what life's about. I'll only take out the pot what I need to sustain myself because I'm not a materialistic person. It's about what I put back into the pot, I don't want to go into corporate, I want to be for a purpose.' I said 'If I don't work here I'll work at a charity, I'll do something other than, you know the normal.' And that's what swung it. It's great, you know, every job I do, I do it for the school. If I put a shelf up or if I put a desk in it's for the benefit of that child [...] I'm a much happier person and I deal with [person who died] so much better now that I'm out of that work.*" [P401; male, 60-70]

Participants were conscious of how they were viewed by their wider community after their loss, and the impact that their loss had on their wider network, although explicit stigma at this level was not a prominent theme in interviews, despite stigma often being a prominent issue in studies of suicide bereavement (Pitman et al., 2014). A small number of participants expressed instances of overt stigma, where people responded negatively to the death. It was more common for participants to perceive that people in their community may avoid speaking to them entirely or avoid the topic of the bereavement because it felt "taboo". P301's thoughts demonstrate how participants could have heightened awareness of potential stigma:

> "*I can't say people have ever said to me 'oh yeah your partner died, suicide' but it makes me wonder whether they do treat me differently because of what's happened*" [P301; female, 50-60]

Preventative action was taken by a few participants to avoid expected stigma from their community, either by withdrawing slightly and avoiding interaction themselves or by withholding information:

> "*My sisters didn't tell my mother he [ended his life] and I thought 'Why not?' Because she lives in a small town in Scotland, there's a lot of shame associated with that.*" [P1101; male, 60-70]

It seemed like there could therefore be negative responses from the community, but also withdrawal and avoidance by bereaved participants, compounding the discomfort felt by both groups and likely further hindering supportive efforts.

The new social identity of participants in relation to their social network will be discussed further in the next chapter.

4.3.2 Change over time

Participants, particularly those who had been bereaved for several years, experienced a change in how their loss impacted them over time.

As described in Chapter 1, meaning-making is a key part of the bereavement process, in which individuals seek to cognitively understand a loss that has disrupted their understanding of the

world by searching for meaning in the death (Stroebe & Schut, 2004). In the case of suicide, this process is particularly challenging as the death is self-inflicted, unlike any other types of death with a clear external cause. In the period immediately after the loss, participants went through this process and so talking about the loss could lead to emotionally charged conversations in which strong emotions and views were expressed. Over time, as individuals developed their understanding of what happened and learned to cope with related emotions, it often became easier to think and talk about, although the interpersonal context of meaning-making, described further in section 5.2.2.1, added a layer of complexity to this.

> *"As time goes on it's not that, it's not that time heals the pain because it doesn't but you learn how to manage those emotions and those situations and I suppose your story. So I suppose with [sister], if we need to talk about it, we would. But we don't generally need to."* [P702; female, 30-40]

Whilst the loss typically got easier to talk about over time with close friends and family, as participants went on to meet with less close social network members and make new acquaintances after the death they were faced with deciding whether to tell them about their bereavement, and if so, how much information to give them.

> *"The hardest is when you're talking to people who didn't know him and don't know what happened. So you're left in a quandary there, sometimes there's no choice- people start asking about children and you have to tell them the truth."* [P102; male, 60-70]

Even for participants who found value in talking about their loss with others, there could be a reluctance to tell people they met about the loss. Encounters with others where they had to decide this seemed to be uncomfortable social situations requiring careful navigation, where participants had to consider people's potential reactions to the information, and how it might influence a relationship going forward.

Another thing that was inevitable over the passing of time was the return to triggering places or activities, where certain things or actions were reminders of the person who died and brought painful memories to the forefront. In particular, participants noted places that had an emotional connection to the person who died (such as a theatre they used to visit together or the place where they died) as being difficult to return to, and photographs of the person who died could be difficult to look at.

Markers of the passage of time in itself could be a trigger, with participants finding particular dates such as birthdays, death dates, Christmases and family weddings more difficult than other days. These dates remained markedly more difficult than other days for most participants as years went by, with some noting that the week or month around a particular date could be challenging, not just the day itself, as just the anticipation of the anniversary could increase rumination.

> *"It's a bit of a weird time. Yeah you just find yourself thinking about all of it again, thinking about how it happened, where you were when you got the phone call. Exactly what you did after that happened. It just all plays out again and you find yourself feeling all the things you felt at the time"* [P1201; female, 30-40]

Social events marking these dates tended to be important to participants, and a number talked about organising family gatherings or larger events as an opportunity to reminisce together about the person who died.

> *We always tend to do something, it's just another way of remembering him really so he doesn't- not get forgotten about but do you know what I mean, like reminding yourself of it and it's nice everyone coming together for it"* [P402; female, 18-30]

These personal changes in relation to identity could relate to individuals' support needs, which will be discussed in the next section.

4.4 Supportive Acts

The idea of support meant different things to different participants. As set out in chapter 1, in research social support is commonly categorised into four types of support: emotional, tangible, informational and companionship (Wills, 1991), and exemplified in this study using participants' experiences:

Emotional: being engaged in conversation about feelings, having company while crying

Tangible: being provided with cooked meals, having the dogs walked.

Informational: being provided with a list of charities that offer bereavement support, being prepared for the experience of counselling.

Companionship: being taken out for a meal, being accompanied to a football match.

Emotional support can be broadly defined as expressions of empathy and caring (Wills, 1991); in the instance of informal social support it could be argued that tangible, informational and companionship support are all expressions of caring from family and friends and so come under the umbrella of emotional support. For the purposes of this chapter, "emotional support" refers to conversations between participants where feelings and emotions relating to the loss were shared, or where it was related to processing and better understanding the loss.

4.4.1 Good support

4.4.1.1 Qualities of good support

Participants differed in their perception of what "good support" meant to them. Considering the categories of support, emotional support was most commonly mentioned as being received and offered within social networks, with practical support also common. Instances of companionship were described by participants slightly less often, and instances of informational support were described by only a minority of participants, suggesting that this type of support was used rarely within social networks. The temporal element of these types of support will be considered in the next section. Here, the qualities that good supporters had and the elements of their supportive

acts that were meaningful will be set out. Four key qualities of support which were valued were proactivity, consistency, acceptance of change and facilitation of communication.

Participants frequently commented on the value of supporters being proactive, regardless of what type of support they were offering. Being offered support without needing to ask for it took the burden of help-seeking off participants and demonstrated empathy on the part of the supporter. P801 described the evening he came home from his partner's funeral:

> "*I remember quite clearly the moment they heard the front door, [neighbours] rang and said 'What are you doing tonight?' and I said 'I don't know' and they said 'Well you're coming here.'*" [P801; male, 70-80]

In terms of receipt of support, participants sometimes stated that they found asking for help difficult as it could feel awkward. Whilst they often felt that it was important for supporters to ask how best they could help, some participants acknowledged that they were not always sure what they needed.

Additionally, participants appreciated supporters who were reliable and persistent in their supportive efforts. Knowing that they had supporters who could be called on for support whenever it was needed provided an important sense of security to participants.

> "*She's not someone that's going to be always in your face and always talking to you but the moment you're like 'I'm struggling', she'll stay up and talk to you and be like 'tomorrow we'll meet up and do this', if it was an emergency she's always the first person to turn up regardless of where in the UK she is.*" [P302; female, 18-30]

Whilst single gestures of support were remembered and valued, participants appreciated supporters in their close personal network offering support consistently during the immediate bereavement period, by continuing to check in with participants and offer opportunities to talk or help in practical ways. To participants, this demonstrated that they hadn't been forgotten about and weren't alone in their grief

> "*[friend] was just incredible, she phoned me every single day, just to make sure that- because she knew about my mental health, just to make sure that I'd got out.*" [P1001; female, 40-50]

A few participants also mentioned the value of supporters who hadn't been dissuaded when they had declined their offer of support because they hadn't needed it at that particular time, and had continued to offer it in case it was needed at a different time.

Linked to this was the concept of acceptance; others understanding that participants had gone through a significant life event and would not necessarily be the same person that they were before.

"Just after the loss what I wanted was for people to put up with me being different and to treat me as though I was not being different. Like as someone who was very sad all the time obviously, and I just didn't want people to react as though they were surprised that I was sad, I just wanted them to take it in their stride and just deal with it." [P501: female, 18-30]

Support was particularly effective if supporters were able to take into account the personality of the participant and consider support needs from their perspective, and if they were able to consider specific situational factors in order to understand needs. An example of this that several participants mentioned is that they were not always in the right headspace to have emotive conversations about the loss and so supporters needed to be able to identify the right moments in which to offer emotional support. Support was therefore effective if it was sensitive to needs in the moment.

For supporters providing emotional support, it was important that they facilitated communication and helped participants to express themselves and process their emotions. 'Good' supporters would create an outlet for emotions and encourage deep conversation. This participant talks about supporting her friend who had lost a sibling:

> "*I wanted her to be able to have the space to say whatever she needs to say and… and I'd just be there and I knew I couldn't really do anything or say anything that was going to change this horrible thing but that was what I thought my role was, just to be a kind of sounding board in a way.*" [P204; female, 40-50]

Crucially, good emotional supporters were able to absorb these emotions and respond appropriately, without making participants feel like they had made them uncomfortable or upset. For P1302, these were "*people who can cope with the enormity of grief*". It was important to participants that their supporters listened and tried to empathise with their feelings, rather than attempting to provide solutions. Some participants also mentioned the need to talk through the same events and feelings multiple times, and so their supporters needed to be patient with this.

Participants often talked about the comfort derived from others who had experienced their own suicide bereavement in the past (e.g. friends who had lost a family member) who could help to normalise the experience and empathise with feelings. A number also valued being emotionally supported by others in their social network who were grieving the loss of the same person, although typically only described this kind of support occurring within the immediate bereavement period. There was a sense that it could be easier to talk about their feelings with others who would have a level of understanding of what they had gone through and the pain that was felt. In the case of friends and family who also knew the person who died, individuals appreciated being able to share memories of the person with each other. P901 had very few people in her social network who knew her deceased partner well, and talked about the reciprocal support between her and a close friend:

> "*We were able to share important information with each other, like her telling me [person who died] ended his own life and then eventually I was able to tell her like, after the inquest about what actually happened, how he died and stuff. Yeah and because we were both very close to him, so being able to talk about the impact of losing him.*" [P901; gender-fluid, 18-30]

This kind of reciprocity seemed to be easier where there was an implicit understanding of the specific circumstances of that loss between two people who knew the person who died and the opportunity to come to an understanding of the loss together.

4.4.1.2 Support needs over time

The type of support that participants identified as being beneficial tended to change over the course of the bereavement period. As discussed in section 4.3.2, the impact of a loss changes over time, so it follows that people's needs change in accordance to this. Across all participants, a broad temporal pattern of the usefulness of types of support could be identified: practical support first, then informational support, then emotional support, and finally companionship.

Immediately following the death, practical support was typically most important. The weeks after the death could be a busy time for the close friends and family of the person who died, as they dealt with the practicalities associated with the end of life (such as closing bank accounts and cancelling appointments), breaking the news of the death to others and planning the funeral. These tasks demanded both time and emotional energy, and competed with the energy required to cognitively process the death. Participants' capacity for completing and even remembering routine tasks was reduced as a result, so having assistance with these was valuable.

> *"It was just small acts of kindness which weren't necessarily sacrificing everything but it was helping with the little things that you forget to do when you're grieving because you do forget to eat, you do forget to do some cleaning things and in my family everyone was doing that so it was left on me so having someone come in and help with that, it was a lot less pressure."* [P302; female, 18-30]

Although only a small number of participants talked about informational support at all, it seemed as though this was of benefit to participants after the initial shock of the death had passed. Family members faced things like registering the death and the inquest which they often did not have previous experience of and so information related to these processes was valued. This early period was also the point at which support groups could be particularly effective in terms of preparing people for what bereavement would be like.

Whilst participants often mentioned that there was a tendency of close friends and family to gather and spend more time together immediately after the loss, they generally didn't indicate that this time spent together involved supportive conversations. It was possible that participants drew comfort from just being around others who were grieving the same loss at this time.

> *"My aunt and uncle, they immediately afterwards became much closer than they were but then over time they, not drifted, we still see each other but probably not just as much as we did before, but in the immediate aftermath everyone was very close and we did a lot of things together but we tend not to do stuff as a family together now"* [P603; female, 30-40]

At the same time, participants wanted those from outside their close family and friend group to acknowledge the loss during their first contact with them after it had happened, which would open an opportunity for them to speak about it if they wanted to.

"You don't want to go in to it every time you see people but I think the acknowledgement is really important, just to say 'I'm so sorry.'" [P1201; female, 30-40]

A number of participants felt that they were not ready for emotional support immediately after their loss, and only wanted these kinds of conversations once the immediate bereavement period was over and they had had a chance to process what had happened.

> *"Around the time that it happened I didn't have much to say, and I didn't really want to talk about it. And then as we got further and further from it, I wanted to talk about it more. Because I had sufficient distance to try and understand my own experiences."* [P501; female, 18-30]

Across the sample, it was consistently felt that emotional support naturally faded over time; for some this felt appropriate, but for others this fading did not match with support needs; this will be discussed in section 4.2.2.

> *"When we do meet now, we do sometimes meet up and it doesn't come up. Which is- that never happened sort of even a year ago, that wouldn't have happened, it would always come up at some point."* [P204; female, 40-50]

In the long term (beyond the acute 18 month bereavement period), companionship became more important than emotional and practical support to participants as the practical and emotional demands on them eased. Participants wanted to continue to be a valued part of their social circle despite the trauma and change in social identity that they had experienced.

> *"I think probably I've realised more through [friend] than myself just how important it is that people don't let go of you."* [P401; male, 60-70]

Part of friends and family accepting participants' new social identity was the continued remembrance of both the life and death of the person who died and recognising that they continued to play an important part in their life. Conversations or gestures could show that supporters hadn't forgotten about the person who died, as in this instance, where the supporter places the focus of the memory on their personality and what they contributed in their life, rather than how they died:

> *"[person who died] made these earrings and [friend] had bought them for me for my birthday and for a long time when I went round I thought 'I must put these earrings on' and like I just wanted to show her that I hadn't forgotten her either, and I think things like that are kind of- little things, or saying 'I saw this thing and thought of her.'"* [P203; female, 40-50]

These events could invoke positive shared memories and implicitly give group members permission to talk about their loved one. A few participants also commented on the nuance of supporters using language that didn't place the person who died and their death in the past, as though it was something that they had moved on from.

> *"It's really helpful if they can say 'How are you feeling about [person who died]'s coming birthday?' As opposed to sort of referring to it all in the past. Because it's eight years or nearly eight years since [person who died] died. He's not in the past to us. He's totally with us."* [P1302; female, 60-70]

Commemorative acts were meaningful to participants in the long-term as a way to remember their loved one's life and give them a sense of connection with them. It was therefore appreciated when supporters took part in these commemorative acts, or initiated them, again, to demonstrate

that they hadn't forgotten the importance of the person who died. P101 had been bereaved for over 7 years and consequently experienced limited support from family and friends in relation to the bereavement. She talked about how touching it was when the friends of her deceased family member showed that they were still thinking about them:

> *"They don't offer support consistently but every so often somebody will come up with something- like [person who died's friend] is a musician and so she's released this [album] just recently and what we didn't know was-*
>
> *Interviewer: Ahhh dedicated to [person who died]. That's lovely.*
>
> *P101: And the song 'things end too soon'"* [P101; female, 60-70]

4.4.2 Poor support: "they'll support me but they won't talk about it" [P1001; female, 40-50]

Interview question prompts included asking participants about instances of support that were most and least helpful. Negative instances of support seemed to be more salient than positive ones for participants, as they were often more able to describe unhelpful or hurtful instances of support than they were able to describe what good support was to them. Two types of negative experience that were raised consistently were that of people avoiding talking about the loss, and people responding inappropriately in conversation about that loss.

It was common for participants to find that others either avoided talking about the loss with them after it happened, or avoided contact entirely, and would perceive this as a lack of care. In some cases, participants felt that this was as a result of stigma and being uncomfortable with the way in which their loved one died, but in other cases they thought it might be that people may want to address it but didn't know what best to say, or were worried about upsetting them further. In reference to conversations about his partner who died several years ago, P801 said:

> *"There's a tendency sometimes for people not to mention the war now* [...] *and they don't talk about [partner] because they think somehow it'll bring it all up."* [P801; male, 70-80]

He found that people were less likely to ask about how he was doing with the loss years after it had happened, expecting that this would cause painful memories and emotions to resurface.

The inappropriate responses participants talked about could generally be categorised into three different types of response and demonstrated misguided helping (Fales et al., 2014), where responses were intended to be helpful but weren't interpreted as such. Firstly, questions about the loss that were born out of curiosity and possibly a natural attempt to show interest in the conversation, but felt inappropriate to participants, such as:

> *"I went to see my accountant to give him my end of year books, I said 'oh things have been really rough because my sister had died' and the first thing he said was 'oh how did she do it?' and um that felt really wrong to me to actually have to tell him."* [P201: male, 50-60]

People responding with cliché phrases also felt inappropriate to participants, as they felt untrue:

> *"People will talk about 'Oh time heals' along with 'what doesn't kill you, makes you stronger.' In the really painful raw bits, saying 'time heals' is again one of those things that can make you really, really angry because it suggests that in time it won't matter and this will matter until the day I die."* [P1302; female, 60-70]

Finally, responses where others tried to empathise through sharing similar experiences or feelings that weren't around their own personal experience of suicide loss were also interpreted negatively. Participants saw it as trying to diminish their loss by comparing it to what they believed to be a lesser trauma, or trying to take the focus away from their difficulties.

> *"I was saying I was feeling a bit upset and [sister] said 'oh I know how you feel, I was the same when dad went.' He was my dad too and it's nothing. My dad was 84, he had had a long life, he was extremely poorly [...] so she's coming at the death of my son from her grief at losing our father."* [P101; female, 60-70]

With both of these issues, lack of response and inappropriate response, initial reactions were particularly important. Participants found it upsetting when others didn't acknowledge their loss in their first encounter with them after the death had occurred. Similarly, inappropriate responses from friends or family in initial conversations about the loss had a lasting impact on the way participants perceived them, and could cause them to pull away.

Another thing participants found difficult was when people from their community withdrew support before they felt ready to be able to cope without the enhanced levels of support they received in the immediate bereavement period. The phrase "*move on*" was used by a number of participants in the context of what they felt others' expectations were for them. On the part of supporters, it did not seem to be an active decision to withdraw support, rather something that occurred naturally as they adjusted to the loss quicker than those who were closer to the person who died.

> *"Oh goodness, that slight feeling of abandonment. It was ok, people have to go back to- there was that sense though, you did feel like you were enveloped in this supportiveness which was quite comforting and then there's going back to normality."* [P1101; male, 60-70]

It was felt that the withdrawal of support could be quite sudden and unexpected, even if participants accepted that this was a natural occurrence and that supporters had the right to withdraw high levels of support. For a few participants, this did retrospectively sour their perception of the help they had from family and friends; P302 talks about how she felt used by her friend group who she felt supported her only while the loss was novel.

> *"The fact that they disappeared right after and stopped really caring or making an effort as if the grief goes as soon as the funeral goes which we know is not the case. It felt like they were more like trying to be the... person who is in the inner circles of that so they could be like 'oh I'm part of this and it's very sad' and it just felt like that with the way they were acting but at the time I was just grateful for any and all attention that I got because it was difficult."* [P302; female, 18-30]

4.4.3 The challenge of the supportive role: "Am I doing the right thing?" [P203; female, 40-50]

Participants did acknowledge that there were barriers to others being able to offer support to them, and that helping somebody bereaved by suicide was not easy. A few suggested that they themselves would struggle to help somebody in the same situation as they were in, even having gone through their own loss and knowing what did and didn't help them, due to the difficulty of it. Those in a primarily supportive role referred to the challenges they faced, and those receiving support talked about their perceptions of what may be difficult for supporters.

The unfamiliarity that most people had with suicide and suicide bereavement prior to the death could make it challenging for people to know how to act and react and how to best help the bereaved person. To be able to effectively provide emotional support, there had to be a willingness and capacity to overcome this discomfort which required a level of confidence both in the relationship and the supporter's capabilities. P1201 highlights just how difficult starting a conversation about a loss can be; having felt hurt herself by friends who didn't acknowledge her family member's death, she was aware that she had done the same thing to somebody else in her social circle.

> "*Ironically, there's someone I know who I had a brief relationship with a few years ago, he lost his brother to suicide [...] And I still to this day have not acknowledged it, and that sits really heavily with me, knowing how I feel about it now and having been through that experience.*" [P1201; female, 30-40]

Without having a framework for how best to help, people could feel insecure about what best to do for their friend or family member, sometimes being concerned about their potential to make things worse. For example, P204 describes the process of feeling conflicted about whether the help she was offering to her friend was ultimately beneficial, judging it to be unhelpful, and trying to sensitively reduce this support.

> "*I'd feel like we'd get into the same rut of discussion. I just thought that's just what needs to happen and sometimes I thought 'I'm not sure this is helpful anymore' and I think we had so many of those conversations I think there was a little bit of backing off very gradually over time. Just to sort of try and stop that, it just seemed a bit destructive sometimes, or just not helpful.*" [P204; female, 40-50]

This participant's experience contradicted most participants' preferences for consistent and continuous support. As somebody not personally impacted by a loss, she may have had a more objective perspective about what did and didn't help, but this issue wasn't touched on in interviews with other supporters, so can't be confirmed or refuted. Where participants talked about supporters who had overcome this difficulty, they tended to have been reflective about their strengths in terms of what kinds of support they could offer, and willing to respond to changing needs.

> "*Sometimes people really don't want to see you or don't find you helpful but if you could just indicate that you're around and if they don't want to talk then offer some practical help.*" [P1301; female, 60-70]

There was also a balance that had to be struck between being overbearing with the amount and frequency of support offered, and not backing off so much so as to give the impression of not caring. There were no clear opinions as to what was the correct balance, but participants tended to err on the side of being persistent and patient with support attempts.

Participants commented on the lack of understanding about how to act more frequently than they cited instances of people acting negatively about the suicide itself. The stigma that they felt was attributed to people not understanding how best to help, rather than not wanting to, or being judgmental about the cause of death.

There were practical issues that could make offering support challenging. Those in supportive roles for friends or family had to dedicate their resources, especially time, which competed with their own usual responsibilities such as work or caring for children. Geography was also a commonly mentioned difficulty, with supporters who were further away unable to be physically present at short notice. This was more important in the case of offering practical or companionship support but also inevitably made communication more difficult when relying on technology for communication.

> "*I was more on the periphery than other friends who offered more support, for instance with going to sort [person who died]'s flat out and going to the inquest. And those sort of things are really important to have someone with you but I didn't go because I was working.*" [P1301; female, 60-70]

Those in the receipt of support could also create barriers. Participants spoke about feeling comfortable receiving emotional support from select group members rather than anyone in their social circle, tying in to the widely used categorisation of functional support, where specific people held specific supportive roles for each participant (Cohen et al., 1985); this will be explored in the context of social networks in the next chapter. Whilst participants didn't directly talk about the number of people who they talked to about their feelings about their loss, there was a general sense that they tended not to want or need a large collection of people who consistently provided them with emotional support even though they had more potential supporters available.

> "*I've got a few friends that would listen and I'd have coffees with them but not, not people that I feel I would go to if I was having a hard time.*" [P201; male, 50-60]

This was possibly due to the bond that they had with current supporters, and to protect themselves from having to have too many emotionally challenging conversations. Some participants also suggested that they couldn't trust people around them to react in a way that helped if they did talk about their loss and a few would actively discourage conversation in that area.

> "*I don't need to ban people or not talk to them or whatever, but there will be lots of people that I keep very much at a distance and for whom I would give out a vibe that I do not want to talk about [person who died]. Which probably reinforces their attitude to how you cope with somebody's grief, which isn't helpful but, you know, it's just like I can't, I can't teach them enough about how I need them to be.*" [P1302; female, 60-70]

Whilst these judgements were logical and may well have been fair, they were assumptive on the part of participants, and by restricting conversations to their small group of existing supporters, they potentially lost out on building new connections and accessing more good quality support.

Considering these challenges, it was frequently acknowledged that being a supporter could be emotionally demanding, particularly if they were offering emotional support.

> "*you just want to be able to do something and there's nothing you can do so that's very difficult. So I just felt like I needed to let her-... It was weird, it was upsetting.*" [P204; female, 40-50]

However, expressions of resentment in relation to a supportive role were rare; rather participants often felt that it was their responsibility to help even if they weren't fully sure how best to do so. This responsibility and the taking on of a supportive role will be explored further in subsequent chapters.

4.5.1 Formal Support

Whilst interviews were focused on informal social support, formal support was an additional interview topic that provided context to the needs of informal social support. Participants described their experiences of contact with support organisations and whether these organisations were able to effectively meet their needs, as well as their experiences of support at the workplace.

4.5.1.1 Professional services

In response to questions about formal support access, participants reflected on their interactions with the professionals and support agencies that they came into contact with after their loss. Immediate family members came into contact with a member of the NHS or police force immediately after the loss, whereas friends and extended family tended not to. In the following weeks and months, almost all participants had at least one contact with a wider range of third sector and primary care agencies; table 8 below lists the agencies that the participants in this study had contact with. Motivation to seek formal support did not seem to be connected to participants' satisfaction with the informal social support that they had received, nor did it seem to be greater in those who expressed the greatest levels of distress.

Table 9: List of professionals that engaged with participants to provide support

Peer support groups	Other third sector organisations	Primary care agencies

Survivors of Bereavement by Suicide: peer support and support phone line	Local church: spiritual bereavement teaching	Police
Facing the Future	If U Care Share: one-to-one support and advice	Inquest services
The Compassionate Friends	Salvation Army: provision of food	GP
The Anthony Seddon Fund		Privately sourced therapy
		NHS funded therapy
		Funeral homes

Some participants had accessed talking therapy, either privately (often through workplace/university programs), or through the NHS. Most of the participants who accessed talking therapy found it to be helpful, although a few felt that they did not connect with their therapist. The most common issue was access to therapy, particularly access to specialist therapy services for suicide bereavement, with participants believing that as suicide bereavement is unique, it requires a unique approach to support. All of the participants who had therapy had actively sought it out as opposed to having it offered to them. There was generally a long wait for therapy provided through the NHS; for some, therapy became available after the point that it would have been most helpful. P302 was bereaved in her late teens and was not able to gain access to adult or child therapeutic services until several years after her loss:

> "I fought for support for a very long time, they wouldn't give it to me and then I got offered it a couple of weeks ago. I'm like 'but they're just going to want to talk about it all over again, I've done so much of that, I don't need it now because I've done it myself.'" [P302; female, 18-30]

This issue of access was prevalent more generally, with a number of participants stating that they hadn't known where to go to find the support available in the UK for people who have been bereaved by suicide. They felt particularly let down when there had been no proactive offer of support or signposting from primary care agencies; participants seemed to have an expectation that this should happen, given that deaths would be recorded and that one family member would always have to have contact with the police or healthcare worker after the death.

"There's no service that I know of, certainly where we were, in [south east England]. We weren't contacted at all. I remember going to the GP with my mum, she went on to antidepressants after it happened, I think she's still on them. And just the GP being so shit, just like rubbish, I remember he asked her how he did it and I was incensed. I was like 'how dare you?' I mean, I know from a

rational side it's just his own ignorance and lack of training that would make him say that but the insensitivity of that, yeah the GP didn't know what to do, no mental health professional contacted us." [P1201; female, 30-40]

P1201 highlights an issue in the referral process, in that participants sometimes only knew to contact their GP for support, yet GP's generally do not have expertise in supporting those bereaved by suicide. When asked in interviews what were the kinds of support that would have helped them cope with their loss, participants consistently referred to access to formal support, saying that somebody who could help them access services or even just signpost to appropriate resources would have been valuable. This was particularly the case in the early weeks of bereavement, where participants gave examples of things like practical explanations of what would happen in the first weeks and help with navigating unfamiliar processes such as the inquest.

> *"In those first days you're just so lost, you're lost, first months I'd say you're lost and I wouldn't have even known what an inquest was before [person who died] died."* [P1001; female, 40-50]

A few participants did have more positive experiences of their GP. Similarly, several participants had contact with the police and professionals during the inquest process and again had mixed experiences. These seemed to be influenced more by the sensitivity of the individuals they had contact with rather than procedures that were followed. Participants' opinions were also influenced by whether they felt that a particular organisation was to blame for the loss, with participants who felt that an organisation contributed to the death of their loved one tending to feel disenfranchised and less positive towards that same organisation if involved in their post-loss care.

> *"We had to go through an inquest and we got no support from the GP or the mental health services and it looked pretty clear to me at the inquest, the place was full of people that we'd never seen from the mental health service who were more worried about being sued than anything else."* [P102; male, 60-70]

Awareness of peer support services amongst participants was high, and these were the formal support services that participants spoke about most often. Of the participants who were personally bereaved, ten had participated in at least one peer support group session and six others were aware of peer support groups but did not feel as though they needed or wanted to join a group. As referenced in section 1.2.6, peer support groups have qualities of both formal support services, in that they are pre-planned and structured activity and of informal support, in that the providers of support are untrained and relying on their own lived experiences and support preferences to help others.

Section 4.4.1.1 set out the personal qualities of supporters that participants valued: in particular, it was those with their own experience of suicide (either the same loss or another loss) and those who were slightly removed from the close personal network. Members of peer support groups fall into both of these categories and so had the potential to be highly effective supporters, and particularly important if individuals don't have anyone within their social group with previous experience of suicide bereavement.

There were diverging opinions about peer support groups amongst participants. The group element of peer support was mentioned frequently, where it seemed to be down to individual preferences and personalities as to whether individuals felt that it was right for them. For some, the opportunity to share experiences and feelings and get advice and insight from others was the primary appeal of joining a support group. Participants spoke about being able to share their feelings with group members in a way that they couldn't with friends and family for fear of judgement, misunderstanding or placing too much emotional burden on them (this phenomenon is described in more detail in section 5.2.2.3). Whilst P102 never felt the need to seek out a support group himself, he recognised the value in them for his daughter who had lost her brother and found it difficult to talk about the loss with her parents:

> *"I'm so glad [daughter] found [suicide bereavement group] as opposed to being jealous that she couldn't share her feelings with us. I think it's good to have that external access to that external, maybe dispassionate and yet not altogether dispassionate- because the same thing has happened to them but it's a different experience. But there's that commonality about it and so I'm glad she found that."* [P102; male, 60-70]

For others, the idea of group participation was not appealing. Some felt that groups didn't suit their personality; the idea of speaking in groups or sharing intimate details with others was daunting, and some felt that group sizes felt too large for all members to have the chance to express their feelings in a helpful way.

> *"When you've got such a huge group it's, A: it's quite daunting speaking in front of lots of people and B: you know there's just less air time, you don't want to- yeah I suppose you have to have a level of confidence to speak out."* [P1201; female, 30-40]

A few participants also raised the issue of having to absorb others' grief; they didn't feel capable of hearing other people's stories of loss as it felt too great to cope with their grief on top of their own:

> *"I've realised I need to look after myself, so I found it difficult with newly bereaved people, I couldn't deal with it, their loss."* [P1001; female, 40-50]

A number of participants also spoke about the structure and support processes around peer support groups and expressed concern about the safety of them. Given the purpose of the groups, challenging topics of discussion were expected, but the way in which they were discussed and the behaviour of other group members (in terms of their communication style and reactions to others) could be unsettling. It was felt that peer facilitators were not always equipped to manage these and could feel uncomfortable in the space as a result. This participant describes their experience of their only visit to a peer support group in which they suggest that the facilitator wasn't equipped to manage the session well, but also that group members were not always there for the right reasons:

> *"I went to [peer support charity] and I think it's a really badly run organisation, I think it's a lot of enthusiastic amateurs who probably- they are enthusiastic amateurs, caring, sincere people who have not got the skills. I was in a group one night, there must have been 20 people in a group. Just blabbing on. It wasn't held, too big. At one point the moderator said*

'what about you?' 'Oh I'm fine, I just like to be surrounded by suicide.' That poor woman. And there was the anger in the room. The anger at police, and I felt that they were really unhelpful." [P1101; male, 60-70]

This feeling of anger at services within the group was something several participants picked up on. One participant who worked in mental healthcare felt that she would have accessed her local peer support group but for her job: she did not want to listen to others blame the healthcare service for which she worked for their loss or risk meeting the families of past clients.

A smaller number of participants had experienced a peer support group led by trained facilitators as opposed to other peers, and all viewed it positively, mentioning the small sizes of the groups and the structured way that it was run. P1101 spoke about his experience with this group in comparison to the first peer support group that he attended:

"It was self-regulating though because I'm very capable of just going 'bleh. Do you know how horrible this story is and this could be a film and it would be terrible and I don't know how I've survived all this' and my responsibility to the other participants, there was something about the way that the moderator, that the holding was done, it was all modelled on sensitivity to others." [P1101; male, 60-70]

4.5.1.2 Support in the workplace

Whilst workplaces and places of study are not specific support services, they are required to accommodate the needs of students and employees who have been bereaved by suicide, and will often have protocols in place for how they offer support, with line managers and colleagues providing support at least in part because they are required to but are typically untrained to do so.

The amount of time participants had off after the loss before returning to work varied considerably, from a few days to several months. This related to personal coping methods, with some participants wanting to return to work for a sense of normalcy, but a few participants mentioned that they couldn't afford the time off work, either because they were self-employed or because they weren't offered paid leave.

There was a sense that the return to work could be a hurdle as participants returned to somewhat "normal" activity, having experienced a significant change in their identity. Participants spoke about navigating the social aspect of the workplace and having to set boundaries about what they felt comfortable talking about and how much emotion they wanted to display in a professional setting. Colleagues typically knew about the loss upon the return to work, although it wasn't always clear about whether participants had control over how or when that information got out. This meant that they had to face the typical reactions to suicide bereavement in a very immediate and restricted setting. P402 captured this difficulty in her workplace where her colleagues all knew about the loss:

"You got people who didn't really mention it and you were thinking 'oh come and see if I'm alright' but then if they did come, you didn't feel like you wanted to talk about it either so it felt like you were a bit stuck really at work." [P402; female, 18-30]

Inevitably, line managers were particularly important to the experience of returning to work, their personal ability to manage and interact with their employee seeming to be more important to participants than the organisational guidelines around accommodations; multiple participants mentioned that their managers had overridden guidelines in order to give them extra time off to adjust. Whilst some individuals had positive experiences, others had line managers who were clearly not experienced in supporting people who had been bereaved by suicide, as P603's particularly challenging experience demonstrates:

> *"The lady I worked for wasn't very nice, was outwardly nice but she was a great believer in sort of law of attraction and feng shui and various things and she told me that she didn't want me in the office because I was affecting the energy within the office and the fact that I was bereaved was adding negative energy to the office."* [P603; female, 30-40]

In contrast, the participants who consistently reported positive supportive experiences from colleagues were those that worked in health-related jobs where their colleagues had exposure to mental illness and suicide through work. Colleagues were therefore comfortable having conversations about the loss with the participant and being supportive if necessary. However, there was also a downside to this type of setting, as this workplace exposure to suicide and suicide bereavement couldn't always be avoided by newly-bereaved participants. In this case the participant's workplace did adapt to their new needs:

> *"We do as a public health team, we lead on the suicide prevention strategy but they know that I can't work on that. And I've not even really looked at it because I can't cope with it."* [P1201; female, 30-40]

One participant spoke about having to cope with a less obvious trigger, which suggests that there could be a range of challenges for those bereaved by suicide when returning to the workplace regardless of their role that could be difficult to anticipate.

> *"I've ended up with a phobia of phones because there were so many people phoning up after [person who died] died. And I couldn't, I just couldn't face the phone so when I went to work part of your job is answering the phone: this was not good."* [P101: female, 60-70]

4.6 Chapter summary

This chapter explored the similarities and differences in bereavement experience and support needs across all participants individually.

Individuals felt that their social world changed after their loss. They frequently expressed an increased desire to help their community through volunteering or fundraising for mental health-related charities. With their social network, there was heightened awareness of the potential of a suicide, and individuals often started to check in with others more proactively. The loss often got easier to cope over time, but anniversaries remained difficult to cope with in the long-term.

Individual preferences for support varied considerably, but a common features of good support was that it was proactive and persistent, although one-off acts of support were also valued. Effective support suited the individual's coping style and their specific situation (e.g. those planning the funeral often appreciated help with this). For those providing emotional support, it was important they created opportunities for open and honest communication and were accepting of feelings. Those within the close personal network could connect through shared loss, whilst those in the wider social network often had more emotional capacity for support.

Support needs also varied over time. It was clear that in the short-term, individuals valued practical support the most, and in the long-term they valued companionship; for themselves as well as continued remembrance and acknowledgement for the person who died. Individuals tended to be ready for informational support after the immediate bereavement period, although this was not commonly offered by supporters. They generally valued emotional support during the first years of bereavement to help them cope with their emotions, but only once they had had time to process what happened. As described in section 1.1.2, the Dual Process Model (Schut & Stroebe, 1999) emphasises the importance of different types of coping after a loss, which is reflected in the different types of support valued by participants in this study.

Poor support was often identified as others responding inappropriately to the loss; typically by making insensitive comments. It was also hurtful when others did not acknowledge their loss, or ignored the topic when it was brought up in conversation. Participants also often felt that their social group withdrew support before they were ready to cope without it, and that this could happen quite abruptly. Both those primarily in receipt of support and those primarily offering it acknowledged that there were challenges of providing good support. Supporters faced practical challenges to being able to offer support, and individuals could pre-emptively withdraw from social contact, expecting negative responses, but also barring others from the opportunity of supporting them. Formal support was often perceived as difficult to access and participants had mixed experiences of interactions with support organisations.

Having described impact and support at the individual level, I will present the findings of the group level analysis in the following chapter, and explore the similarities and differences both within social network and across social network.

To facilitate the development of initial content for the public resource (chapter 7), in table 9 I present the most consistent findings from this chapter and how these findings translate into advice that may be helpful to members of friend and family groups bereaved by suicide.

Table 10: Key and consistent findings from chapter 4 and corresponding advice

Finding	Advice
Different people value different kinds of support.	Be aware of the different kinds of support you could offer. Think about which ones you feel able to offer, and which ones would help that

	specific person in their specific situation. Be aware of what kind of support you prefer.
People valued support that was consistent, persistent and did not have to be requested.	Friends/family should proactively offer support across the acute bereavement period, and continue to offer it even if it is not always accepted.
Support needs change over time.	Focus on practical support initially, particularly for those that shared a household with the person who died. In the long-term, show that you continue to remember the person who died.
People are hurt by others avoiding them or avoiding the topic of the loss.	Acknowledge the loss the first time you see friends and family and engage with the topic if brought up in conversation.
Some people (particularly those in the wider social group) move on before others are ready.	Be prepared for people to go back to usual activities/stop bringing up the death in conversation at different times.
Social support tends to diminish over time	Continue offering support over a prolonged period of time.
Emotional support from people outside the close personal network can be helpful.	Offer emotional support even if not a close friend or family member.
People can pre-emptively withdraw from support.	Know who you feel comfortable talking to/asking for help. Try to create an open atmosphere within a social network where people feel comfortable expressing needs.
Shared experience and support from others who have experienced a loss to suicide can be helpful.	If you have lived experience of suicide bereavement, you may be able to help normalise the experience for others.
Comparing the suicide loss to another type of traumatic event could feel like it was minimising or misunderstanding the experience.	Avoid comparing the suicide loss to another type of loss or difficult event, as those bereaved by suicide can often feel as though this experience is unique.
Questions from others about the death can feel intrusive or insensitive.	Avoid asking about details of the death or events that happened around it.

Chapter 5: Group level results

5.1 Case studies

The case studies presented below were developed as analytic tools in order to aid the analysis of a relatively large and complex dataset and were compared against other groups' case studies during the analysis process. These three case studies are presented in order to exemplify some of the themes presented in this chapter, and were chosen as they represent a range of group experiences and demonstrate how varied the impact of a suicide bereavement can be. Group 4 exemplifies a relatively harmonious group in which support experiences and group interactions were almost entirely positive. Group 7, centred on a group of siblings bereaved of a sister, illustrates a group where familial support and narratives of the loss were fractured and group members primarily turned to others for support. Group 10 also had challenging familial relationships after the loss, and demonstrates the perspective of a friend bereaved by suicide, as well as family members. The other case studies for groups involving multiple participants are presented in appendix 12.

[redacted]

Having set out the impact of loss on individuals and the factors that influence the effective provision and receipt of support, I will now describe the themes that emerged from the group level analysis. In the same way that the personal impact of loss influenced an individual's provision and receipt of support, the impact of a loss on a social network of friends and family members provides context for how that group was able to adapt, cope with the loss and support its members. Two key areas became apparent during analysis: the interpersonal impact of loss and the roles that group members took on during the bereavement period. Figure 7 illustrates the thematic structure of this chapter.

Figure 7: Thematic structure of group level results
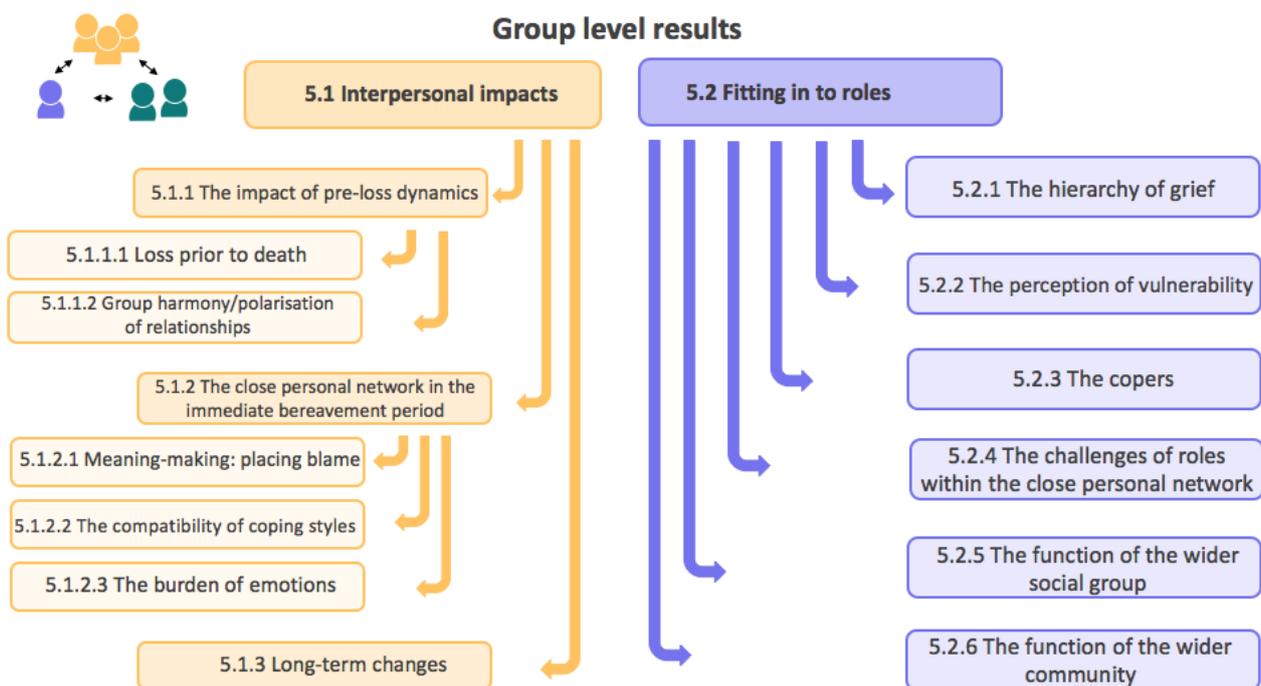
5.2 Interpersonal impacts of suicide bereavement

Chapter 4 alluded to the importance of the interpersonal context of support after suicide loss. Here, I present findings of the interpersonal impact of loss within participant groups in relation to how they impacted on the provision and receipt of support within them. Findings are presented in temporal order, beginning with group dynamics prior to the loss, then relatively immediate post-loss changes and the longer-term impact.

5.2.1 The impact of pre-loss dynamics

5.2.1.1 Loss prior to death

Across groups, individuals had different experiences of loss to other group members depending on how much contact they had had with the person who died prior to their death. In a number of social network, certain members had been distanced from the person who died for some time before their death due to mental health difficulties that they faced. Relationships had typically been negatively impacted due to tensions relating to the mental illness and to a certain extent, these participants had already grieved the loss of their relationship and contact with the person who died. For example, after the loss of her family member with whom she hadn't spoken for several years, P1001 struggled with unanswered questions around the death. P1002 had been a close friend of the person who died up to her death and expressed little conflict and unresolved questions during her interview, but expressed more grief.

> "*I hadn't seen her for two years. She sent back everything I'd bought her, I'd bought her lots of, like, jewellery and posters, all that kind of thing and she just shut me out. Looking back on it now, whether she'd done that- I don't know, I don't know why she did it and I can't- that's one horrible thing isn't it, you have so many questions and you never find the answer [...] because she shut me out of her life I'd kind of grieved that loss in the first year so I don't miss her but I just feel so sad about it*" [P1001; female, 40-50]

> "*[P1001] was estranged from [person who died] the last couple of years of her life for various reasons and I think probably [P1001] has other feelings that I don't have around that. Because she wasn't present in, they weren't like a constant presence whereas as [person who died] was always, we never fell out, there was never any cross words [...] It's devastating and she'll be infinitely missed because, because she was such a big part of my family [...] [P1001] talks a lot about [person who died]'s memory and I just, I just wasn't ready to go there.*" [P1002; female, 30-40]

As exemplified in this group, this difference could make talking about a loss, and supporting each other within the close personal network challenging, as members had different memories and different kinds of emotions to process.

5.2.1.2 Group harmony and polarisation of relationships: "people come closer but others, you can just be done with them" [P402; female, 18-30]

Social harmony is a concept that has been used for research primarily in the context of collectivist cultures and is defined as "the balance achieved in relationships" and is seen as being important to life satisfaction and the functioning of a social network (Lun & Bond, 2006; Tafarodi & Smith, 2001). Here, I operationalise this concept in terms of the (in)congruence in groups of individual's coping styles, interpretations of the loss and ability to effectively support each other. Participants in more harmonious groups had more stable or improved relationships with people in their wider network, as well as others in their close personal network. Participants in less harmonious groups tended to have more relationships that were negatively impacted and experienced more 'fall-outs' (discussed in the next section) within the close personal network.

These relationship changes between individuals within social networks were often symptomatic of group level changes. In groups it seemed to be the case that either those in the close personal network turned to each other for support, or none of them did and found their support elsewhere, typically from friends. It was uncommon to have a single supportive dyad within the immediate personal network if others were not close as well, suggesting that pre-loss group dynamics of using each other for support or turning to others as well as pre-existing tensions impacted the overall coping of the group.

Participants across all groups often experienced a mixture of strengthening and diminishing relationships with others in their social network after the loss; it appeared to be that the trauma of the loss amplified pre-existing qualities in relationships. Relationships that had challenges prior to the loss became more fractured after it had occurred, and relationships that were predominantly positive prior to the loss grew stronger.

> "They've either really come out to be worse, a much worse friend than I thought they were or they've become a more reliable and caring friend." [P302; female, 18-30]

Relationships that improved typically strengthened through the support that was offered between the two group members. As described in the previous chapter, there were personal qualities and specific acts that made for good support.

> "I was always very close to my sisters and brother and I think it's kind of brought us closer in that we've had to deal with a lot of, you know, talking about what's happening." [P201; male, 50-60]

It was generally positive emotional and practical support experiences that strengthened relationships. In terms of emotional support, members often had a foundation of a supportive relationship to build on, whereas it didn't seem to matter whether or not practical support had been part of the relationship previously.

Relationships also typically weakened for reasons relating to support between group members. For example, P501 had previously had a friendship from which they drew limited support, and was willing to look past it until their bereavement increased their need for support.

> "I always assumed that [friend] was a bit shit but he would come through when it mattered, and then finally it mattered and he just did not come through and I was like 'well, huh, that kind of puts a sour taste on all the other stuff' because the whole time we'd been friends I'd always go to him to complain about my problems, but I'd only ever gone to him to complain about trivial problems so therefore when he dismissed them, I was like 'yeah that's fair, this is not a real problem, I've just, like, made it up because I don't want to think about my exams or something.' But then I had a real problem and he was just like, totally useless." [P501; female, 18-30]

A small number of participants experienced an increase in relationship tension that seemed to be triggered by the stress of the loss rather than supportive acts.

> "*I wasn't dealing with it so [eldest son] took on this very controlling persona and at that stage I said 'I can't cope with this, you've got to go, you've got to go. I'll give you time to sort things out but you've got to go, I can't have you in the house'.*" [P301; female, 50-60]

The experience of losing a loved one frequently caused participants to re-examine their existing relationships, as well as re-evaluating priorities more generally, as discussed in the previous chapter. This re-evaluation was mostly referenced by participants who had lost an immediate family member, and seemed to occur in the immediate bereavement period. For some participants, it simply prompted a reflection on the transient nature of relationships, particularly friendships. A few mentioned that after the loss they were more accepting of losing contact with people:

> "*You have to think that you're on this journey, you're on this train and there are going to be people that you can pick up on this train as you go through and they'll come on and they'll help you and then there will be people that you can kick off the train, like my mum, or that decide to get off the train for whatever, wherever they're going*" [P1001; female, 40-50]

For others, there was a more active focus on nurturing relationships in the close personal network that were particularly valued after the loss. There was a sense that participants took these relationships for granted prior to the loss.

> "*I think you realise how important your family is after something like that. I think it brings everyone closer when something- I mean it's sad that that's what it actually takes to bring everyone closer but I think that's just how it goes.*" [P402; female, 18-30]

Similarly, the loss could be a catalyst for identifying relationships that didn't bring any benefit. This was often prompted by support received immediately after the loss, or inappropriate responses to the loss, with participants feeling that the event almost served as a test for relationships in terms of which group members responded in a way that demonstrated caring. Here, a participant talks about her view of her friendship group's response to a parent dying:

> "*it's made people show how much they value me, and a lot of people I don't think did value me enough in a sense that they didn't want to be there when it- they got bored and so I wasn't wanting to have that in my life.*" [P302; female, 18-30]

The funeral and other memorialising activities could be a harmonising experience for the group. Members tended to have strong feelings about what the funeral should be like and it could be a unifying experience for group members if they felt it was a fitting event.

> "*[sister] said "we should carry her coffin, that's what she would have done for us" and [person who died] was physically strong and she, we're all a bit boyish in some ways and so I knew it was true [...] four of us carried it and it was a really lovely way of saying goodbye*" [P701; female, 30-40]

5.2.2 The close personal network in the immediate bereavement period

Given the heightened need for support in the immediate bereavement period, much of a group's time at this point was taken up with processing what had happened and finding ways to cope with their grief. In the initial months after the loss participants tended to gravitate towards others in their close personal network who were grieving in the same way, and who had similar support needs.

> "*My brother doesn't do crying. He'd be like 'oh for Christ's sake,' you know what I mean? He understands and he understands where it comes from but he can't be dealing with it. But we've known that, you know, he's never been any different really. But he can't be coping with it and he gets a bit like 'right I'll come back when you've finished' type of thing whereas my sister's worse than me. So we've got closer even though we never really had much in common.*" [P602; female, 50-60]

This coming together was not always an easy process, and close personal networks did not always function well when trying to support each other in the immediate bereavement period. Issues around meaning-making, personal preferences for support and the desire to protect other group members could impact on supportive relationships; these three factors are discussed in the following three sections of this chapter.

5.2.2.1 Meaning making: placing blame

In this study, participants constructed their own narrative around the death of their loved one, seeking clarity around the events that led up to their death as well as how and why it happened as part of their meaning-making process; often this was done through discussion with other group members affected by the loss. It was likely that this social meaning-making process was associated with the importance of the close personal network coming together in the immediate aftermath of the death, as described in section 4.4.1.2, as groups tried to come to an understand of what had happened.

A key issue within meaning-making was blame; to an understanding of who or what held responsibility for the end of their life. Whilst it may have been the case that other elements of meaning-making were important to group dynamics, responsibility and blame were most salient and were discussed by participants in most groups.

Due to the nature of the death, there were often questions relating to motivation that had no definitive answers. This lack of clarity meant that narratives could vary within groups, as each group member had a different relationship with the person who died, and a different perception of their life. Group members with different narratives found it difficult to process the loss together and support each other emotionally.

> "*We worked really hard, I suppose, to make sure that the differences we had and the different perspectives and the different knowledge we had didn't get in the way of our relationship [...] open conversations couldn't happen with regard to their knowledge of how suicidal [person who died] actually was and that conversation- maybe that conversation*

could happen now but actually there's no point in having that conversation now." [P702; female, 30-40]

Some group members also mentioned hiding their understanding of the loss from other group members, not wanting to distance themselves from others on the basis of different beliefs.

"When people, people go, 'well, why did he do it?' and I just- and I get it. It was like, he never surprised- I don't really talk about it to my family because I don't- because I don't know how they would react. But for me personally, I get why he did it. But I wouldn't tell anybody else that, I wouldn't tell the family that" [P601; male, 50-60]

Conversely, groups who didn't have strong feelings of blame, regardless of any discordant meaning-making within the group, seemed to cope better overall with the loss.

Social networks where participants felt as though someone or something contributed to the death of their loved one also tended to be the groups in which individuals were more emotionally impacted by the death in the long-term, even if group members' narratives matched, and in which there were more challenges to remaining relationships within the close personal network. No clear causal effect can be derived from this data, but the two factors appeared to be connected; the most emotive moments during participant interviews were almost always when a participant talked about a clear target for blame or responsibility.

"I did have a lot of anger about [person who died]'s husband and the things that he did and the way that he treated us in that first year." [P1001; female, 40-50]

Very few participants blamed the person who died for ending their own life, but it was common for them to identify an external person, group of people, or organisation that they felt had contributed to the death. A small number of participants felt that this was an action or neglect that made the person who died's life worse. P202 felt that their family member had died at least partly due to challenges in her marriage caused by her husband and his lack of support while she was struggling with her mental health.

"I felt [decedent's husband] was really instrumental in [person who died]'s death, I mean that is how I feel [...] this cutting off of that side of the family is our only sane way forward because we can't be connected with someone that we do feel has caused her death." [P202; female, 50-60]

Other participants alluded to more passive responsibility; they perceived a lack of intervention on the part of individuals or organisations and therefore missed opportunities to prevent the loss. Several participants spoke about a conversation they or another group member had had with the person who died which, in hindsight, seemed like a forewarning that they were going to end their life that should have been acted on. Where participants felt that another group member was actively responsible for the death, and blamed them for it, there could be strong emotions around the loss and negative interpersonal impact continuing beyond the immediate bereavement period.

"There's just things that came out after it happened that I felt angry at her about. Rightly or not, there's something that he said to her which I've just found very difficult so that definitely creates some distance." [P1201; female, 30-40]

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Participants in social group 4 did not have strong feelings of blame, and did not mention this in relation to other group members. This group was mostly harmonious and group members seemed to have coped well with the loss and accepted what had happened, with P401 attributing his acceptance of his son's death at least partly to being able to being able to read a suicide note from his son.

> "I have absolutely no doubt with the way he wrote it [suicide note], that was a guy who, he knew what he was doing and he was happy to do what he did. And I've got no problems with that." [P401; male, 60-70]

Of the 13 groups included, four experienced significant family fall-outs after the loss where there were significant tensions due to differences of opinion; these were the only groups where the person who died had a partner who had not been interviewed. All of the fall-outs were related to the partner and were mostly centered around the person who died's birth family blaming the partner for their death. There were also significant tensions caused by the aftermath of the death, specifically decisions about the inheritance of the person who died's financial assets and about how to memorialise the person who died.

> "He [person who died's partner] was organising to take the body back to [home city] and that's where we thought it had gone and it hadn't gone and my mum was wrangling in the background and working, doing who knows what and then the morning of the funeral, one of my sisters called. It might have been [sister 1], and said 'have you heard something about [person who died] being buried today?' and I'm like 'No, I thought her body was in [home city]!' and she's like 'No!'" [P701; female, 30-40]

The two other partners that were interviewed as single group representatives did not report a fall-out with family, but a definite lack of connection with them. Whilst one of these participants did not have a relationship with their partner's family prior to the loss, they did reference blame for the loss placed on them by their close friendship group.

> "So like the [friendship group], some of them have said that it's my fault... So obviously that's unhelpful. I think that that did make it harder, it's like the worst thing you could say." [P901; gender-fluid, 18-30]

This participant expressed the hurt caused by having a set of individuals blame her for the death of her partner, and noted that there was a secondary impact of losing a friendship group who had previously been a source of positive social interaction. This is unsurprising, but not something captured well in this study, as the voices of partners bereaved by suicide is not particularly well-represented in this dataset.

5.2.2.2 The compatibility of coping styles

As described in the previous chapter, individual participants had their own personal methods of coping with loss which were typical of how they dealt with any stressful life event. They also followed the commonly used categorisations for coping methods in bereavement research; problem-focused coping, emotional-avoidant and emotional-active coping (Drapeau et al., 2016).

Similarities and differences in coping between members of close personal networks had an impact on how well they were able to support each other and could contribute to polarisation in one-to-one relationships.

> *"I think that it's probably brought us closer in a way, or we're more able to say stuff to each other; we still had that before but it's probably gone up a level as well."* [P203; female, 40-50]

> *"There was just something about us as a family coming together to begin with, seeing a lot of each other, being near each other"* [P1201; female, 30-40]

The way that people coped influenced the type of support that they preferred from others, and the type of support that they tended to offer others. If support styles and coping styles matched, this made for effective support between two individuals and could strengthen their relationship. A mismatch in coping and support could lead to disharmony and negatively impacted relationships.

> *"I don't want to be with anyone else sometimes, I want to be with her because [husband] didn't really know my sister that well, so there's history that I want to talk about and mum just can't go there. And that was the support I needed- I was struggling to know who else to talk to about that, and sometimes I just wanted to be back to a child again and I just wanted her to hug me and say 'it's going to be ok. It's really shit but it's going to be ok'. But she couldn't. And you know if I cry now, if I get low, I don't tell her because you know her attitude is 'come on, you've got a nice husband, a nice house, pull your socks up, learn to appreciate what you've got' but if only it was that easy."* [P1001; female, 40-50]

A minority of participants were accepting of the different coping styles within their close personal network, and remained harmonious through their tolerance of others' preferences.

> *"I need people, I talk. I think [husband] would find it difficult to put 10 people on the chart. He deals with things internally, he deals with things quietly [...] I know that there's all sorts of things that he's got in his shed or on his computer or in his office that he'll suddenly come across that will make him sad about it, it's just what we remember. What triggers a memory, what triggers the sadness is different. And we don't need to be competitive about any of it."* [P1302; female, 60-70]

For some of these participants, this was a conscious process in which they actively sought to recognise and fulfil others' different needs. This husband and wife also demonstrate the gender difference that was sometimes found within groups, where men tended to be less expressive about their grief than women, and were more likely to process it internally without external emotional support. Broader gender patterns in support indicated in previous literature, such as men having less available support (Walen & Lachman, 2000),(Andrews et al., 2003) were not seen in this dataset.

5.2.2.3 The burden of emotions "we both end up trying to protect each other" [P1303; male, 70-80]

In the initial bereavement period, participants valued support from others within their close personal network as there was a shared grief between them (section 4.3.2), and shared knowledge

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was important for meaning-making (section 5.2.2.1). However, a barrier to support within the close personal network seemed to evolve fairly quickly, where there was a reluctance to express feelings about the loss openly with others.

A common change within close personal networks was a reluctance to express feelings about the loss openly with others. Some of these processes seemed to be related to a hierarchy of grief in which groups judged which members were more or less impacted by the loss than others (described further in section 5.3.1), and participants not wanting to place additional burden on others in their social network who they perceived to be more impacted by the loss. It was likely this was a decision resulting from the heightened concern for others described in the previous chapter.

> *"With my aunt and uncle [bereaved parents], I spent a lot of time around them just being like "don't cry, try to help them, don't- it's not about me, they've been through something much worse."* [P501; female, 18-30]

In the previous chapter, supporters in the wider social network expressed uncertainty about how and when to start potentially emotive conversations about the loss. Those within the close personal network also felt challenged by this when interacting with each other and did not feel that it was always appropriate to talk about the death and express their emotions to others for fear of making others feel worse.

> *"It's nice when you can organically talk about [person who died] and it's authentic and you can see that it's not causing a stab in the gut for someone else, it's just that you're laughing about a memory or something, that's nice, that's the best. And actually it's ok when you both have a little bit of emotion and you both feel a bit- it's when one person, you can see that one person doesn't want, doesn't feel like being triggered that day, that's the dynamic.*" [P701; female, 30-40]

Participants who were seen by others as most impacted (at the top of the hierarchy of grief) also talked about their instinct to hide their emotions from others. This sense of responsibility to protect could therefore override the group's hierarchy and perceptions of vulnerability. In this instance (social group 6), a parent who lost their child who did not believe herself to have coped particularly well talks about a conversation with another one of her children which was a pivotal moment in the way she interacted with her family in terms of her grief, changing her belief about what was appropriate to share with them:

> *"I can remember saying once that it was the worst thing that's ever happened to us, you know losing [person who died]. I can remember saying 'it's absolutely devastated us, I can't imagine anything worse' and then [son] said to me... 'It's not' he said 'the worst thing that's ever happened is watching you go through it.' And I felt so bloody guilty and I still do [...] you can see the pain in your loved one's faces, they're going through that pain as well so how can they possibly have time to listen to you going on about yours?"* [P602; female, 50-60]

In contrast, another one of her children who did not live with her and had a slightly less immediate relationship with her drew a sense of comfort from perceiving her mother to have coped well. This was a relatively infrequent instance within a group of a group member not agreeing with others over who was most vulnerable.

"She's a very very strong person and that's helped us all really because had it been that my mum was locked away in her room and constantly crying and we couldn't talk to her, it would have been totally different but it wasn't like that and I think we were all old enough that if that's what she wanted to do she would have done it, not put a brave face on for the kids sort of thing, I mean I don't know, I suppose as a mum you're always a mum and your kids are always your kids no matter how old they are but um no I think because she coped with it so well and that. It was definitely a help for us, definitely." [P603; female, 30-40]

Whilst in this group there was a demonstration of an explicit recognition of the burden of emotion, in most instances participants seemed to be assuming a negative impact of sharing feelings, rather than basing their actions on a specific experience.

This challenge within the close personal network seems likely to be associated with participants' desire for support from people without a connection to the person who died described in the previous chapter. This set of supporters would be external to the grief hierarchy and would be able to provide emotional support without there being this concern that they would have to deal with additional grief on top of their own. In social group 13, P1302 lost her son to suicide and participated in the study along with her friend (P1301) who was not personally affected by the loss. P1302 felt the need not to burden her daughter, who was also impacted by the loss, with her emotions and instead turned to her friend who hadn't known her son well. P1301 spoke in her interview about her awareness of needing to be a supporter:

"She [P1302] is close with her daughter but it's probably more difficult to unload that kind of thing with your daughter because she was going through a very difficult time as well." [P1301; female, 60-70]

P1302 shared this feeling:

"Mainly my friends had to deal with the worst bits of my grief so that she [daughter] didn't- and I was certain that I didn't want her to feel in any way-." [P1302; female, 60-70]

5.2.3 Long-term group changes: "It's a dilemma that can't be resolved." [P202; female, 50-60]

It was common across groups for there to be considerable permanent changes in the structure of the wider social network after the loss, on top of the polarisation to existing relationships.

Several participants lost existing relationships as the person who died had been their link to a particular person or set of people. It was common for partners to lose touch with the blood relatives of the person who died, even if there were no clear tensions between the two parties. There seemed to be a perception held by some participants that losing a partner was easier than losing a family member, as they were able to "move on", find a new partner and therefore "replace" that lost relationship in a way that a sibling or parent relationship couldn't be replaced. Here, the friend of somebody who died talks about their husband:

"He's got a new partner which is great and I'm really happy for him because the boys have got a female presence and he's getting on with his life. And there's an element of almost 'well done, pleased for you. I'm glad you found somebody but I will never find the sort of, that inner circle friend again, I can't recreate that.'" [P1002; female, 30-40]

This fundamental change in which another person was viewed was reflected across other kinds of relationships. Of the three bereaved partners interviewed for the study, all experienced a loss of individual friendships or friendship groups they had been connected to through their partner.

"I didn't see them nearly as much because they- he's retired now, they live down in the country, lovely house- a barn down in [South West England] and we used to go down there and stay and the dynamic is different. I have been down to stay and it's different because I'm in the bedroom that we always had when there were four of us. You know, they would have a dinner party and invite another couple and it worked. It doesn't work as a spare. It doesn't work the same, so it's kind of withered." [P801; male, 70-80]

A few other participants across groups expressed a discomfort with friendships where the connection with each other had been the person who died so the relationship had been centred on them and served as a reminder of their death. There was therefore a sense that any contact with each other would result in conversation about the person who died, something that they did not necessarily want:

"My friend was [person who died] and I knew [P1001] through [person who died]. But what I'm mindful of in that relationship though is that I don't want it to be about [person who died] and every time we get together it's all about [person who died]. Because it's just- sometimes you don't want to discuss it all, do you, it's just constantly going over the same stuff." [P1002; female, 30-40]

Over time, these relationships tended to fade as group members lost touch with each other.

Where the family fall-outs described above occurred, they tended to be long-lasting and had not been resolved even for participants who had been bereaved several years ago. This was the case for all of the social networks that had had a significant fall-out, where after several years, pre-loss relationships had not been repaired.

"It's a dilemma that can't be resolved. The fact that [niece] absolutely hates us, [person who died's] gorgeous daughter absolutely hates me." [P202; female, 50-60]

As these fall-outs were typically linked to blaming partners for the loss, it seemed as though this narrative of the death that formed as part of the meaning-making process remained fixed years after the loss and did not seem to be challenged within the group.

5.3 Fitting in to roles

Across groups, there were specific roles held by individuals. Two types of roles were clearly identifiable in each participant group, with one or more individuals fitting in to each; the role of

the coper and the role of vulnerability (described in sections 5.3.2 and 5.3.3). These roles related to the hierarchy of grief, in which there was a perception of who was more or less impacted by the suicide. There were also patterns across groups as to the function of wider networks and communities in the bereavement process, discussed in sections 5.3.5 and 5.3.6.

5.3.1 The hierarchy of grief

A hierarchical structure of grief within a social network is not something widely covered in academic literature, but seems to be anecdotally popular within communities of people who have been bereaved, including members of the PPI group who were consulted on the data analysis for this study. Whilst disenfranchised grief (Doka, 1999) (where an individual is unable to express their grief due to social constraints) is a more common concept, the results of this study fit with Robson & Walter's (2013) hierarchical structure of grief, where extent of bereavement is ranked within social networks and grief is expressed according to this ranking.

It was common for participants in this study to feel that, within their social network, not everyone was emotionally impacted by the death in the same way, and some group members grieved more or less than others. This created an implicit hierarchy within groups, where participants were almost unanimous in their judgements of where other group members fit into this hierarchy. The structure of hierarchies was consistent across groups, where a group member's place in the hierarchy was generally assigned by familial relationship to the person who died as a proxy for closeness, and therefore level of grief. Mothers were believed to be most impacted, followed by fathers. Children (regardless of age) were next most impacted, followed by siblings. Other family members and friends were deemed to be less impacted than these immediate family members, but it was not possible to categorise further using this data.

> *"Obviously my grief as [decedent's] friend was nothing compared to [person who died's sister]"* [P203; female, 40-50]

> *"Obviously it was difficult for [wife] because she's the mother."* [P401; male, 60-70]

Further hierarchical judgements about extended family members and friends were made by participants; for example, the only cousin interviewed (P501: quoted below) placed herself lower in the hierarchy than the parents and sister of the person who died. In group 10 (case study presented at the start of this chapter), group members placed a friend of the person who died higher in the hierarchy than that person's sister, as they had had a closer relationship in the years leading to her loss. However, there was not enough data on these other relationship types across groups to identify any consistent hierarchical placements.

Only two partners were interviewed; neither seemed to be near the top of the grief hierarchy within their group. This was reflected in other groups where the person who died had a partner when they died; participants rarely acknowledged their loss, instead focusing on other family members. This seemed to be related to the blame often placed on them and their perceived ability to replace that relationship, both discussed above.

This hierarchy was frequently implied in interviews and in interviews where it was explicitly mentioned, participants recognised and expected its existence, feeling that it was appropriate and should be respected.

> "*I remember getting really annoyed with my therapist because he kept saying 'there's no such thing as a hierarchy of grief' because I think I'd said something diminishing my own sadness or something and he was like 'there's no hierarchy of grief' and then I googled it and I was like 'I absolutely believe that there is. There clearly is.' If I was to go to my cousin who lost her sister and go 'I'm really sad about [person who died]' and asked her to cheer me up, that would be absolutely monstrous.*" [P501; female, 18-30]

It seemed to be important within social networks that people acted according to this hierarchy and recognised other who may be more impacted than them. Where group members acted in a way that didn't fit with their hierarchy and placed their needs above another group member who was deemed to be more impacted, this was seen as inappropriate behaviour. For example within group 4 a bereaved father viewed his sister-in-law as being lower down in the hierarchy of grief, and felt that she wrongly put her feelings about the loss before his:

> "*Whenever we were together her grief was always greater than mine. You know, when I'm saying my story, her story was greater and in the end we were in a pub one day talking about something and I just had a right rant at her to the point where she stormed out the pub crying [...] She wanted to be centre of it, not [person who died] or me or [P402] or [partner]. It was only talking about 'me', about 'me'.*" [P401; male, 60-70]

Group members adjusted their supportive behaviour according to the hierarchy of grief, prioritising support for those who were deemed to be most impacted. For example, in group 4, a bereaved sibling felt a responsibility to support her parents:

> "*I'd say my mum and dad, I'd say around the time I was probably more there for them, they were there for me obviously, but I felt like they needed more support at that time so I'd say I was more there for them.*" [P402; female, 18-30]

Their father, P401, recognised this supportive effort from his daughter; it was common for participants to recognise and appreciate supportive efforts from those in their close personal network:

> "*She's just amazing, she's never stopped running around after me, after [ex-wife]*" [P401; male, 60-70]

A few participants noted that this prioritisation of support could sometimes be at a detriment to other members who were struggling to cope:

> "*I didn't appreciate how lonely she [person who died's sister] felt because people were asking about us and she was there saying 'what about me, [person who died's sister]' you know.*" [P101; female, 60-70]

Whilst overall, group members were in agreement about their group's hierarchy, there were a few discrepancies in beliefy about who was most impacted by the loss. These were related to relationship structures that were not typical for a family, where certain group members assumed closeness based on relation, but this closeness did not necessarily exist. In social group 13, P1302 had no contact with her son in the years leading up to his death, so therefore didn't experience an

immediate loss. Contrary to the majority of participants, she did not believe that parental bereavement was worse than other relationships and felt that the loss impacted her daughter more than her, actively correcting those in her network who made the assumption that she was most impacted:

> "People would say to me, oh, 'losing a child, whatever age they are, is the worst thing possible.' And I'd say 'No, it isn't, actually.' This is worse in some ways for [daughter], because you expect to have your siblings forever, you expect your siblings to be the one that helped you cope with things. Also, because of all the other experiences that happened and I think it's worse for people who, if they're at a vulnerable age, still, not necessarily when they're totally adult, but younger people, I think it's worse if you lose a parent then to lose a child." [P1302; female, 60-70]

However, her partner (P1303) followed the more typical hierarchy seen in family groups, and was more focused on the impact on his wife than on his daughter:

> "I mean my daughter who was however old at the time, when I was saying about "mum is so-", well this was a couple of years probably that she was still down and all that, and my daughter had to starkly remind me that she was in mourning too because they were brother and sister and I'd almost forgotten about that because I was concentrating so much on trying to keep [P1302] going" [P1303; male, 70-80]

5.3.2 The perception of vulnerability

Participants frequently referenced other group members who they perceived as being more likely to have their wellbeing negatively impacted by the loss, and similarly to the hierarchy of grief, this was not always an explicit identification. Within groups, participants were generally consistent about which members were designated as vulnerable to a considerable negative impact on their mental health, or to attempting suicide themselves. This perception of vulnerability overlapped with the hierarchy of grief, where those at the top of the hierarchy were generally deemed to be most vulnerable. However, there were additional determinants of perceived vulnerability, such as exposure to previous recent traumatic events (such as another bereavement), pre-existing mental health issues or how well somebody was seen to be coping in the immediate bereavement period. In group 2, one bereaved sibling [P202] was perceived to be more vulnerable to the loss than her other siblings as she had long-standing mental health issues, something she herself recognised:

> "I think the boys were probably really worried about me, about my mental health and how I would cope without [person who died]." [P202; female, 50-60]

> "She had an attempt when she was in her early 20s, she's bipolar and whereas [person who died] isn't and that's why it's so ridiculous- that when my brother rang me up I thought he meant [P202]." [P201; male, 50-60]

> "[P202]'s mental health, that was a big concern for all of us and it was kind of like 'right we've just got to keep an eye on her and support her through it.'" [P203; female, 40-50]

Parents of young children were aware of the intergenerational impact of the loss and perceived them to be vulnerable to the impact of the death, even if they were too young to have a personal relationship with the person who died. They were seen to be particularly vulnerable to the indirect

consequences of the loss, such as seeing their parents grieving, and learning about suicide at a young age. These parents were conscious that their children grew up without a family member or family friend who should have been present in their lives and felt it was important to share stories and memories with them.

> "*You do want them to remember him really because he was their uncle and the only uncle that they've got. They've got two aunties on [partner]'s side but he was the only uncle so it would have been nice to share memories with them, but unfortunately, it's a bit sad but just the way it is.*" [P401; male, 60-70]

Some of these parents also described the challenges of talking with their young children about the death, both in terms of how much information to give them and how to talk about it sensitively. In one group (social group 7), one set of children in the extended family were not given much information about the loss, causing them considerable distress when they did hear the truth about the loss from other children in the family.

In addition to the focused support for those at the top of the grief hierarchy, those identified as being vulnerable tended to talk about experiences of receiving support more than they talked about providing it, suggesting that overall, they were in receipt of support from their group more often than they offered it. Where members who were seen as vulnerable and members who were at the top of the grief hierarchy were not the same, the group adjusted their supportive behaviour so that all could be supported effectively.

> "*I might not see my sisters, even though I don't live that far away I might not see them for six months at a time, But it didn't matter, when [person who died] died, then everything changed. And it was about protecting [mother of deceased]. It was all about supporting her.*" [P601; male, 50-60]

5.3.3 The "copers"

In the same way that group members identified those who were vulnerable, there were particular members of the close personal network who, at least outwardly, processed the loss more easily than others, and expressed less grief. These "copers" existed in almost every participant group and were more often male than female. They seemed to be in this role during the immediate bereavement period rather than permanently and primarily offered practical support to the rest of the group. There was no similar role for emotional support, in which one group member was a consistent provider of emotional support to lots of other group members, possibly because effective emotional support required a higher level of intimacy. As with other roles, this "coper" role often came naturally:

> "*I was focused on everyone else, I sacrificed a lot. Um I gave up college and all sorts of things and that put my life on hold and I don't think I minded because I'm so much like my dad that it's second nature to me to have that empathy and look after them, other people first me later situation.*" [P302; female, 18-30]

These "copers" often preferred to process the loss themselves rather than accessing emotional support, which seemed to be how they typically dealt with stressful events. After the death of his

step-son, P1303 described how he coped with the loss by occupying his mind and focusing on looking after his wife:

"*It was mainly internal and mainly- and learning different programs on the computer, I taught myself at that time desktop publishing and various music composing things, I buried myself in learning things but being there for [wife], always, so I think I was the backstop all the time [...] I'm probably more of a do-er, I do worry but that's always internalised, I very rarely pass worries on.*" [P1303; male, 70-80]

In light of this, regardless of where they were in the hierarchy, copers primarily offered support to other group members and weren't perceived by others to need support. This support was mainly practical, in keeping with the tendency of members to offer each other the type of support they themselves prefer. However, they also seemed to play an indirect role in how groups emotionally coped with the loss, with other group members often reassured that there was a group member that didn't seem to be outwardly struggling with the loss.

Participants in this coping role often suggested that their focus on others was part of their own method of coping as it distracted them from their own grief and made them feel like they were able to do something positive for people they cared about. Whilst no participant explicitly stated this, it seemed as though they were most comfortable offering practical support as opposed to emotional support (in line with their preference not to receive emotional support themselves) and their friends and family tended to feel that this role played to their strengths as a group member. Within social group 6, P602 was perceived by other participants to be somebody who coped well with the loss of her family member, and herself felt a need to focus on supporting her mother after the loss:

"*Interviewer: How was that for you, to be dealing with your own grief and loss and also trying to support her through it?*

602: I understood it. Um I think it helped me to be honest because I kind of didn't have to acknowledge what was going on for me *crying* so it was a distraction, I don't know if distraction is the right word.

Interviewer: Someone else to focus on.

602: But I needed to look after her if you see what I mean." [P602; female, 50-60]

This coping role seemed to be something that group members tended to naturally take on based on how they typically coped with challenging situations and supported others and so it was beneficial to both themselves and the rest of the group. However, in some instances the copers felt that this was a role that they had to fill, but would not have opted for if they had a choice. This will be discussed further in the next section.

It was not clear from the data at what exact point the coping role ceased to be necessary within a group, although it seemed to be a gradual reduction in responsibility in line with the observed decreased need for practical support over time. Whilst other group members supported copers with practical arrangements such as the funeral and memorials, these were not clear roles, rather instances of practical help.

5.3.4 The challenges of roles within the close personal network

Whilst roles within the close personal network typically came about naturally, and aided the overall coping of the group, there were challenges associated with being placed in certain roles.

As described in section 5.2.2.1 above, partners were often assigned some blame for the death by other social network members; essentially the role of a scapegoat. Although only one interviewed participant was a partner who experienced this blame (P901), they expressed that this was emotionally demanding both in terms of losing social contacts and the negative lights they were portrayed in. Another challenging role was that of the close friends who had not been personally impacted by the loss; although only three of these supporters in two different social networks were interviewed, each one seemed to have voluntarily placed themselves in the role of "emotional supporter" but recognised that they felt ill-equipped for this role.

As groups typically worked to provide support to those at the top of the hierarchy, there were certain responsibilities that only these participants could take on. Across all groups, those who were most closely related to the person who died were the ones who organised the funeral. Their homes were also often where people gathered (most commonly parents, where parents in the group were still alive and living independently) in the days following the loss. Close relatives were generally the people who broke the news of the death to others in the immediate aftermath of the loss; these were inevitably emotionally demanding conversations.

> *"The worst thing ever was finding my son. The second worst thing ever was telling my daughter over Skype, that her brother had gone. That's seared in my memory as well. She was in Mexico."* [P101; female, 60-70]

There was a general acceptance of roles, and assignment of these roles based on pre-existing vulnerabilities and personalities, however some group members did not feel comfortable in the role that they were placed. Overall, roles suited the way that people coped individually but there were instances where they felt incongruent with personal needs. A mother [P301] and daughter [P302] in one group each expressed their discomfort with the roles that they felt the other had put them in; these news roles of "coper" and "most in need of support" significantly changed what had previously been more of a typical mother-daughter relationship.

> *"For the relationship with [P302] she literally twisted- the roles twisted and I didn't become the mother I became the child and she became the mother although she was, I think she was around 18 [...] she changed the role, she became the parent and I wasn't."* [P301; female, 50-60]

> *"I supported everyone else. [Brother] disconnected and that may just be his grief but also with autism you can understand a bit differently and feel things and he doesn't experience death in the same way I would. So I was looking after those two and mum, and her grief was very much about herself and it's fine, it's her grief and I accepted that but then it carried on and I think it meant that I wasn't really allowed to grieve [...] me and mum would sit in the living room with the funeral director and he would ask questions and mum*

would sit there and just panic and look at me and so I made almost all the decisions I think." [P302; female, 18-30]

Whilst caring for others could be used as a tool for avoiding loss-oriented stressors, it was also frequently acknowledged that the caring role was a burden and meant that those filling this role were not able to grieve in the same way as others did.

> "*[brother] in particular dealt with a lot of the phone calls, dealing with work and schools and support the husband, he really took on- because he's like the sage, he's the calmest, kindest person and he would go 'oh I can do that, oh well I'll do that' and so he was the person that was most leant on particularly, particularly by [person who died]'s husband and he then felt very much that he had put his own grief on hold in order to support the family*" [P202; female, 50-60]

These roles within the close personal network, whilst in some instances challenging, were generally beneficial to the group's ability to cope with their loss. As with the findings described in section 4.4.1.1 in which individuals tended to identify specific friends or family members who were good at offering a certain type of support, these group roles tie in with the concept of functional support, where different members perform different functions for their group. At the level of the wider network and the community, no clearly defined roles existed, and so supportive relationships at this level will be explored within the context of structural and functional support in the following two sections.

5.3.5 The function of the wider social network "I've definitely got friends that are there for different reasons" [P1001; female, 40-50]

Beyond the specific roles filled by members of the close personal network, there were variations in the functional (specific supportive acts by specific people) and structural support (the number and diversity of supporters) capacities (Cohen et al., 1985) of a participant's wider social network and community.

The way groups as a whole coped with the loss seemed to be influenced by the functional support structure within that group. Beyond the close personal network, participants were often able to identify the capabilities of certain friends and family members in being able to fulfil certain support needs. The majority of participants seemed to be implicitly aware of which group members could and couldn't support them in the way that they needed, communicating this through their network maps and conversations around feelings of closeness. Some participants were, however, explicitly aware of who could meet their needs and were able to talk about this.

> "*My aunt kind of clammed up a bit and didn't really want to talk about it, but she threw herself into this fundraising thing [...] and my uncle was the opposite, he wanted to just talk about it. So I did talk to my uncle a lot actually.*" [P501; female, 18-30]

Across groups, those that coped better with their loss were groups where members were able to make correct judgements about who could meet their needs, and where a group collectively covered all of the necessary kinds of support, with different members playing different functionally supportive roles.

"You need that sometimes, you need that person that's going to be the practical person that will be the person that's making everyone a brew when initially you're just kind of shell-shocked, will be the person that is arranging for, well we all spent so much time at the hospital, who's going to look after your dog, who's going to do that, and [step-father]'s that person that does that so I think he kind of completes the network of support I suppose." [P603; female, 30-40]

Participants seemed to be generally accepting of wider social network member's individual capacities in terms of support, as opposed to the challenges faced when group members in the close personal network had differing narratives, coping styles and support needs. There seemed to be less conflict about receiving support from those outside the personal network than those within it, whose needs and emotions related to the loss had to be considered (described in section 5.2.2.3).

Beyond harmony, a participants group's functional support capacity seemed to be influenced by life stage. Some participants were at the stage of life where they had a partner and dependent children; these participants often talked about turning to this family unit rather than other bereaved family members for support. Dependent children were often positive distractors; they required care and to some extent normal life had to continue in order to look after them. Partners were generally key supporters, as they already had a supportive relationship with the bereaved, but they were likely to have had less of a close relationship with the person who died so were less emotionally impacted. P701 describes actively relying on her husband as a source of support rather than other family members after the loss of her sibling, as she felt that trying to use them for support might negatively impact on her relationships with them:

"We could talk together about that stuff and I suppose that's why everything else could stay, stay more or less where it needed to be, it stopped those relationships being fractured as they could be. So yeah I suppose my husband was the person that I could go to and chat and obviously he was emotionally involved as well, and is still, but we could kind of break things up and do what we needed to do whereas sometimes there's no point going there with family members because actually it's always going to be a place full of emotion, it's always going to be difficult, it's always going to be challenging." [P701; female, 30-40]

A few participants were young adults (under 26) when they were bereaved; generally the important and supportive members of their close personal network were friends rather than the family members that older participants tended towards. They were more likely to be living separately from any family members and therefore spending more time with friends than family.

"Interviewer: What about the support you got from other people in your close network, family and other friends?

901: Um, so [friend 1] and [friend 2] helped, and [friend 3], they are like family, they're those sort of friends." [P901; gender-fluid, 18-30]

Considering the practical demands of being a supporter mentioned in section 4.4.3, it seemed that these younger adults were less likely to have their own family units to support and were more

likely to be studying rather than working, and so had fewer practical barriers to being an effective supporter.

Older adults (over 65) tended to have less available potential support with smaller and denser close personal network (and therefore a limited structural support capacity), drawing on their children and close friends, but typically seeming to have fewer close friends than other participants.

5.3.6 The function of the community

At the community level, the similarities and differences between participants in experiences of support have been described in section 4.4.1.1. Most groups commented on the attendance of the wider community at the funeral or memorial events as something that was particularly valued and appreciated. Beyond this, there was limited data available to examine any patterns across groups in depth.

The majority of groups were positive about support from their communities and there were trends within each group as to whether participants viewed their community support positively or negatively; not unexpected as participants often lived near each other and some overlap in their community. Groups that coped well together didn't seem to expect or need much support from their wider community, having had their needs filled by closer friends or family, but still valued it when it was offered.

> "*The suicide rate in [local area] is one of the highest in the country. It's on the increase, the self-harm rates are just going through the roof. So I've never felt so supported in my life, but not by people who I knew before, necessarily, but by people who've got something in common so that peer support.*" [P602; female, 50-60]

There was some consistency in dissatisfaction with community support, in which a small number of groups had several members who felt that their wider community did not engage with them or show support after their loss. These groups were generally those that struggled to support and related to each other after their loss, so it is possible that they were looking to meet needs that would typically be met by somebody within their social group, although this was not stated explicitly by any participant.

> "*There were people that knew him for a very long time who were there straight up in the initial missing period and the funeral and I feel like they disappeared afterwards.*" [P302; female, 18-30]

> "*I remember sitting with [daughter] in her room and saying 'have you heard from dad's friends then?' He was really- we both knew that they were his really close friends, he worked with them, they were interlinked, they were really close. But we haven't heard from any of them.*" [P301; female, 50-60]

Whilst groups were from a mixture of rural and urban areas, there was no clear trend between embeddedness in community (as is typically seen in more rural communities) and satisfaction with support.

5.4 Chapter summary

It was common for suicide loss to alter how individuals within a social network related to each other, impacting on relationships between two individuals within and group as well as influencing the overall harmony of a group. Differences in coping and experience impacted on how those within a social network were able to support each other.

Participants' relationships with the person who died in the years leading to their death impacted on the emotions they felt after the death, impacting on the way they were able to interact with other group members. Pre-existing relationships with each other also had an impact. There tended to be a polarisation in relationships, where pre-existing tensions were amplified by the loss, weakening relationships, and strong relationships were improved through effective support.

Effective support also depended on individual coping styles matching, as individuals tended to offer the kinds of support that they themselves wanted, which didn't necessarily suit others in their group. There were also barriers to open communication within social networks. Individuals were often concerned about adding to another group member's emotional burden by sharing their feelings and could feel uncomfortable introducing the loss into conversation, either because it didn't feel natural or because they were worried about bringing others' mood down. Meaning-making, centred or whether anyone or anything was to blame for the loss, had the potential to cause considerable distress and divisions within groups. In this sample, blood relatives tended to blame the person who died's partner for the loss to some extent.

These polarised relationships and narratives of blame formed in the weeks and months after the loss and rarely changed, meaning that these had a long-term impact on group dynamics.

After the loss, a hierarchy of grief according to kinship established within groups, where group members were seen as more or less impacted by the loss than others. Groups focused their support accordingly, with most support directed at those who were deemed to be most vulnerable (typically parents). Social networks also identified an individual or individuals who were deemed to be most vulnerable to negative outcomes as a result of the loss; this was often related to their place in the hierarchy, but also due to pre-existing mental health conditions. This became a role in which other group members focused support on these individuals. Conversely, there was a coping role which formed and individuals in this role offered practical support to the rest of the group whilst receiving little support themselves. This hierarchy and the associated roles generally formed implicitly and helped groups cope overall, but a small number of individuals did not feel

comfortable in the role that they felt they had to take on, and felt their own needs were not adequately met.

Specific roles didn't expand to the wider social network or the community. However, they did have common supportive functions. Friends in the wider social network could often be effective emotional supporters as the barrier of concern about the burden of emotion didn't exist with them, having not been personally impacted by the loss. Whilst groups didn't seem to want or need much support from the wider community, they valued attendance at the funeral or memorial events.

To facilitate the development of initial content for the public resource, in table 10 I present the most consistent findings from this chapter and how these findings translate into advice that may be helpful to members of friend and family groups bereaved by suicide.

Table 11: Key and consistent findings from chapter 5 and corresponding advice

Result	Advice
Relationships between some group members may strengthen after the loss, others may weaken.	Be prepared for and accepting of these changes. Relationships that strengthen are likely to be ones where effective support can take place between the individuals.
Group members may have different narratives of the loss, including differences in who or what they feel is to blame.	Be accepting of different narratives, but limit discussion of the death with those who have different narratives as these are likely to be difficult conversations.
People may cope with the loss in different ways.	Be understanding of how people grieve. Accept that the things others do as part of their grieving process might not be what you would do.
Group members may hide emotions to try to protect others from additional emotional burden.	Try to create an open atmosphere where groups members feel comfortable sharing their thoughts and feelings. Be assured that others will often want to talk about the loss if it is brought into conversation.
A hierarchy of grief may be established.	Be aware that your social group may focus support on specific individuals. If you don't feel you are getting enough support from them, look to supportive friends or extended family.

Chapter 6: Results of resource development work

This chapter describes the work undertaken to develop ideas for the format and content of the proposed public resource in light of the results of the qualitative study and existing resources for people bereaved by suicide.

6.1. Justification for development

The systematic review (chapter 2) showed that social support is likely to have at least a modest positive effect on wellbeing after a sudden or violent loss. It is possible that the limited positive association found is due to the fact that it is difficult for friend and family groups to support each other after this type of traumatic event. It is likely that multiple group members will be significantly impacted by the loss and are not likely to have experienced a suicide loss before, so therefore do not have experience in how best to offer support or interact with each other.

The results of the qualitative study reflect this, with participants expressing uncertainty about how best to support their friends and family, as well as describing improvements in certain relationships and damage to others. Results also draw out clear positive and negative elements of typical support after a loss to suicide as well as challenges to communication. Whilst some of the challenges to effective support within groups may be difficult to overcome (such as group member's different support preferences), other challenges (such as not feeling able to be honest about feelings) may be improved through better awareness and understanding of needs and experiences within groups. A resource aimed at friend and family groups could therefore be helpful in preparing people for and normalising the social challenges associated with suicide bereavement, as well as helping them to recognise and understand the needs of others impacted by suicide, hopefully leading to more effective support.

Whilst resources often have sets of advice based on "dos and don'ts", the findings of this study suggest that there are many factors that influence how a social network responds to a loss and that influence what an individual perceives as good support. In using this data, then, it is more beneficial to help people understand and prepare for what might happen and to prompt them to think about ways to cope rather than create a simple set of actions to follow.

Participants in the qualitative study frequently mentioned using formal support to help them cope with their bereavement, but very rarely mentioned informational or educational resources, except to say that information about how to cope with bereavement was difficult to access. It may be that existing resources (table 12) are not circulated widely enough so as to be accessible in the timeframe in which they would be most useful.

6.2 Existing resources and the gap in information

There are a range of informational resources in the U.K. that are designed to help people cope with bereavement, with some resources focused on suicide bereavement. In table 12, I have presented the resources that are either related to suicide bereavement or provided by a prominent organisation and noted the types of information that each one includes. Resources typically contain signposting information to other practical sources of support, and advice about how to support others through bereavement, but are typically not evidently based on research and have limited information about the actual personal experience of bereavement.

The Support After Suicide Partnership website (Samaritans, 2020) is perhaps the most comprehensive source of information and support about suicide bereavement available in the U.K., serving as hub for resources and local and national charities that offer support after a suicide loss in its capacity as an umbrella organisation for these third sector organisations.

A resource included on this website as well as a number of others is Help is at Hand (Public Health England, 2015), a digital and print booklet for those bereaved by suicide containing a range of information about the official processes that take place after a suicide, how to offer support and descriptions of typical feelings and experiences. This resource is one of few that have been evaluated; service users, bereavement charity volunteers and mental health service workers were interviewed about the resource and reported it to be useful (Hawton et al., 2012). Study participants highlighted that there was a need to have it as soon as possible after a bereavement but felt that it was not well-promoted by relevant organisations. The Survivors of Bereavement by Suicide website also has a similar information resource on their website (Survivors of Bereavement by Suicide, 2019) but also includes a brief section about how suicide bereavement may impact on relationships within the family group, focusing on tips for communication and being understanding of the situation.

A more recently published booklet is Finding the Words (UCL & Support After Suicide Partnership, 2019), based on a U.K. based qualitative study of people bereaved by suicide. This provides detailed information about how best to support people bereaved by suicide, and reflects a number of the key findings from this study in relation to the provision of social support.

The NHS, as well as a number of other bereavement and mental health charities have web pages about bereavement on their website (Cruse Bereavement Care, 2020; Marie Curie, 2020; Mind, 2019; NHS, 2019; Papyrus UK, 2020); typically containing some information about the practical processes that must happen after a death (e.g. registration, inquest), what kinds of feelings and thoughts to expect, and advice for how to cope. A number of resources provide advice about how to support somebody who is bereaved, generally focusing on how to offer emotional support. The amount of information presented on these websites is varied, but is generally limited to a few paragraphs and can have limited suicide-related information if created by a broader mental health/bereavement charity such as Cruse. These sites often link back to the broader Help is at Hand and SASP resources.

Of the resources that exist, there is a gap in the information that is publicly available that aligns with the focus of this project. My qualitative study has demonstrated that suicide bereavement can have a considerable impact on relationships, and that this impact relates to social support. Therefore, it is valuable to prepare people for the challenges they might face with their social group and suggest ways to cope with the impact of these challenges on support provision. Whilst one resource does provide information on this, it is brief and unclear if based on scientific research. Additionally, where resources include information aimed at helping people to support bereaved friends and family, they typically separate out this information from advice on coping, making a binary distinction between supporters and people who are bereaved and making the assumption that supporters are not impacted themselves. In line with the group focus of this study, I would argue that it is important for resources not to make this distinction and to acknowledge the challenges of providing support whilst coping with one's own grief, as well as the importance that each group member plays in the overall ability of the group to cope, regardless of how impacted they themselves are.

Table 12: Categories of information provided by U.K. bereavement resources

	Includes specific information on suicide bereavement	States that information is based on research	Information about practical processes related to loss[1]	Information about what the bereavement experience can be like[2]	Information about bereavement experience based on relationship type	Information about what physical feelings or emotions to expect	Advice about how to look after self during bereavement	Information about impact on familial relationships	Advice about how to support somebody who is bereaved	Signposts to further information or helplines or charities
Booklet										
Finding the words	✓	✓	✗	✗	✗	✗	✗	✗	✓	✓
Help is at Hand	✓	✗	✓	✓	✓	✓	✓	✗	✓	✓
Survivors of Bereavement by Suicide	✓	✗	✗	✗	✗	✓	✗	✓	✓	✓
Web page										
NHS	✗	✗	✗	✗	✗	✓	✓	✗	✗	✓
Mind	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓
Papyrus	✓	✗	✗	✗	✗	✗	✗	✗	✗	✓
Website										
Cruse	✓	✗	✓	✓	✓	✓	✓	✗	✓	✓
Marie Curie	✗	✗	✗	✗	✗	✓	✗	✗	✓	✓

Support After Suicide Partnership	✓	✗	✓	✓	✗	✗	✗	✗	✓	✓

1: "Practical processes" include tasks such as registering the death, organising the funeral, going through the inquest process.

2: "Experience" includes experiences such as responses from community, finding messages from the person who died, media interest

6.3 Content

Having considered the resources currently available to the UK public, there are no currently existing resources that focus on the interpersonal impact of suicide loss, and given the novelty of this research project, this is the first opportunity to create an evidence-based resource focused on this topic. In light of the data produced in this project, the most appropriate focus for this resource was believed to be preparing people for how their social network might change as a result of being impacted by suicide loss and to normalise the changes in relationships and tensions that may be incurred by a loss. Whilst resources often have sets of advice based on "dos and don'ts", the findings of this study suggest that there are many factors that influence how a social network responds to a loss and that influence what an individual perceives as good support. In using this data, then, it is more beneficial to help people understand and prepare for what might happen and to prompt them to think about ways to cope rather than create a simple set of actions to follow.

The resource will be targeted towards those who have been bereaved in the past 3 months, as the focus of the resource is on preparing people for changes in their social network and so would be most useful to people at the start of their bereavement. Although data was collected from participants bereaved more than 18 months prior to their interview, participants talked about their experiences retrospectively and so were able to describe the changes in their social landscape that took place in the initial months after the loss. The results of the qualitative study suggest that people who have been bereaved recently have the most intensive support needs, and also that changes in networks often occur during the immediate bereavement period. Content will cover both immediate and longer term changes and although aimed at those recently bereaved, will be relevant to those who have been bereaved for longer, in recognition of the fact that sometimes people are not ready to or don't know how to access resources of this type in the immediate bereavement period. Content will be written in a way that it is inclusive of people at any stage of their bereavement.

It is proposed that the resource begins with an explanation of its purpose and the research on which it is based, followed by three sections: vignettes, descriptions of potential interpersonal impact and advice about how to cope, and signposting. Examples of the first two sections are presented at the end of this chapter; whilst not intended to be finalised content, they demonstrate how the results of the qualitative study can be used and how information might be presented.

The resource is intended to exist in two formats; a booklet and a web page or collection of web pages, so that the information can be found by people searching for support online and be given to people in a physical format by professionals that they may come into contact with during the

immediate bereavement period. With this in mind, the resource is intended to be something that readily makes sense and is helpful even if read with very little context.

Booklets or text-based web pages are the most common method used to deliver health information and make for easy dissemination. This is also the simplest way to convey information, which is crucial given that the resource is intended for people who have recently been bereaved by suicide and so are likely to still be in shock and trying to cognitively process their loss. With this in mind, the resource must be comprehensive but not so long that it is off-putting to a reader with limited time and energy.

Example content was written in short and simple sentences using the active voice, using sensitive language and words and phrases that are currently accepted as being the most appropriate when talking about suicide (e.g. "attempted suicide and "completed suicide"). Information was presented in brief paragraphs and clearly marked sub-sections, allowing for easy and accessible reading. Any advice was presented as a suggestion (rather than authoritarian language), acknowledging that not all advice and experiences are applicable for every individual and every group, and avoiding the implication that individuals have a duty to help others regardless of their capacity for support.

6.3.1 PPI consultation

PPI group members were consulted about the content and format of the resource in the context of the results of the qualitative study. Members made a number of recommendations, which are presented in table 13.

Table 13: Key recommendations resulting from PPI discussion

Content	Presentation of information
Should be helpful to both those who are bereaved and those who are not but want to learn how to support somebody who is bereaved	Ensure use of language is sensitive and cannot cause offence
Should be aimed at people who have recently been bereaved so that they have the information when they need it, even if not immediately applicable	Ensure case studies are diverse and represent a range of family and friend systems
Should include signposting to a range of resources, including media (e.g. books, TV programmes) that normalise or educate in a relaxed/accessible way	Information presented in easy-to-read language
	Must find a balance between honest information and being overly negative/discouraging

6.3.2 Vignettes

The resource will contain several vignettes (short stories or scenarios based on fictional events and characters) that describe social groups who have been bereaved by suicide; for this resource they are based on the case studies developed in the qualitative study and designed to normalise the social impact of suicide bereavement.

Normalisation is a framework that is widely used for wellbeing interventions, typically to help people learn to cope with symptoms of a mental or physical health disorder and to reduce the distress that they bring about (Dudley et al., 2007; Morrison & Barratt, 2010). It has particular value for groups whose social support and peer support might be lacking due to fairly unique life experience (Von Mensenkampff et al., 2015). Given that suicide bereavement is a relatively unique experience with a sudden onset, and that research finds that those bereaved by suicide perceive more stigma than those bereaved in other ways (Pitman et al., 2014), normalisation is likely to be particularly important for this group.

In the qualitative study, participants frequently highlighted the value of sharing with and learning from peers and feeling like somebody else understood their experience. Other research on peer support has also found that interacting with people who have had the same experience is important to people bereaved by suicide, and that peer support helps to normalise experience and decrease feelings of isolation (Bartone et al., 2017). Reading descriptions of different social groups could therefore legitimise the reader's experiences and highlight that certain changes are to be expected and not a failing on their part, particularly for those who don't feel able to or comfortable accessing peer support and who may not otherwise have much contact with others bereaved by suicide.

Vignettes are a common tool for presenting information in health research and interventions. They allow for important information to be presented within a context relevant to the target group and allow readers to engage with sensitive information in a way that does not feel too personal but at the same time feels relatable (Crafter, de Abreu, Cline, & O'Dell, 2015; Gourlay et

al., 2014; Ribordy, Camras, Stefani, & Spaccarelli, 1988). Vignettes in this resource will illustrate some of the key previously identified relationship changes and support techniques. It will provide real life context for the information and advice presented in the sections of the resource that follow them.

I developed the example vignette (section 7.6.1) by basing it on case studies written up as part of the qualitative study, using common experiences and events that participants talked about in their interviews. Details were changed and different groups' and individual's experiences were amalgamated to protect anonymity of participants and to create an example that demonstrated a number of key issues and events.

6.3.3 Potential interpersonal impact and advice

This section will cover common tensions within groups and suggest ways to manage them. This section is intended to be written in such a way that it does not convey responsibility to help others, and to imply that the events described are common but not universal. Content in this section is again designed to normalise and explain the changes that come about after a loss to suicide, and encourage readers to accept these new social norms whilst equipping them with ways to cope and support their loved ones.

To create this content (section 6.4), I returned to the coding frameworks created during the analysis of the qualitative data. I focused on the most consistent changes that I found across the social networks included in my sample, coping techniques mentioned by participants and the elements of social support that were consistently interpreted as positive and negative, leaving out more ambiguous data where opinion could differ between participants depending on circumstance. I then separated this data out into information about change and examples of good and bad practice, rewrote it into simpler language and grouped it appropriately.

6.3.4 Signposting

As this resource only covers very specific information about social relationships, it is important to include information about where to get help with other issues related to bereavement.

As the focus of the resource is not to be a signposting resource in itself, this section will be brief and focus on referrals to other organisations or resources that can offer a broad range of advice and support. For example, the Help is at Hand booklet is available online and in print, and has an extensive signposting list for specific needs at the end of the resource. The Support After Suicide Partnership (SASP) website is a hub through which smaller local support organisations can be found and contacted.

There is also a potential for signposting to more informal resources, such as bereavement-related podcasts, programs or books or online support forums, that may not typically be signposted to, but might contribute to the normalisation of experience.

6.4 Example content

6.4.1 Vignette

Tom died by suicide 6 months ago. He was 24 years old and is survived by his parents, Jane and Paul, his sister Louise and his aunt Debbie, as well as close friends from university, work and his rugby club. Tom's death felt very sudden to everyone. Looking back, a few friends and family can remember conversations with Tom where he mentioned that he was struggling, but nothing seemed out of the ordinary.

Immediately after the loss, Jane and Paul were visited frequently by friends and extended family. Whilst at times it could be overwhelming to have so many people in and out of the house, they appreciated the company and the input on what best to do for Tom's funeral. They were also touched by neighbours on their street who took it in turns to cook meals for them in the first few weeks after the loss.

Jane and Paul have found it difficult to talk about Tom's death with each other. Paul feels angry towards the GP for not picking up on Tom's mental health challenges at his last check up, but Jane does not feel that the health services could have done anything to help him. This difference of

opinion has led to some tense conversations and so each now tries not to bring it up with the other, although both enjoy sharing happy memories of Tom with each other and do their best to be supportive and understanding when the other is having a difficult day. Paul has talked a lot about the death with his sister Debbie, and Jane has a close group of friends who often call or visit to see how she is.

Louise has always been close to her parents, but has found it hard to talk to them about how she feels about losing her brother. She has done her best to support them and can tell how much they are grieving, although they try not to let her know how difficult they are finding things. She doesn't want to add to their grief by sharing hers. Paul wishes he could talk to his daughter more about what has happened, but as he sees her to be coping well, he doesn't want to bring anything up that would upset her. Louise has access to a therapist through work and has been having counselling once a week which she finds helpful. She wants to recommend it to her parents but isn't sure how they would feel, as they didn't talk much about mental health when she was growing up.

Debbie makes sure that she sees Jane and Paul once a week and is always on the lookout for activities that she can invite them to in order to give them things to do. She is worried how they will cope with Tom's birthday next month, and wants to try and get the family together on the day.

Tom's friends had a fundraising event for a mental health charity in Tom's memory at the Rugby Club a month after he passed away and continue to keep in touch with Jane and Paul. They love to hear about their stories of Tom and to hear about how their lives are progressing, although it does remind them of the milestones Tom will never achieve. Jane and Paul particularly appreciate the chance to talk about Tom with his friends as some of their own friends have now stopped asking about him or mentioning the death, so he doesn't often come up in conversation. Although they would still like the chance to talk about him and how they're feeling, they don't feel as though they can bring him up in conversation in case they make other people feel uncomfortable or sad.

6.4.2 How might my relationships with my friends and family change?

There is no right or wrong way for you and your friends and family to grieve. The ways you are affected might surprise you, and might not be obvious straight away. You might find that your relationships with some of your friends and family change, either positively or negatively. This is something that's common in friend and family groups but can be difficult to get used to. It doesn't necessarily mean that anyone is doing anything wrong, it's just that it's a really difficult situation to cope with. Here are some things that might happen within your friend and family group:

You might have a different understanding of what happened, and what led to the death happening.

When somebody chooses to end their life their friends and family often have a lot of questions about what happened that will never be resolved, because only the person who died has the answers. You and your friends and family will each have a unique perspective of the death because you all had a unique relationship with your loved one, and you all have your own personal life experiences that influence the way you understand the world.

Your own perspective on what happened might be quite similar or quite different to that of your friends and family. This could make it easier to talk to certain people about the loss, and harder to talk to others because of how you each understand what happened. It's common to feel that someone or something could have prevented the loss, and friends and family members might feel angry towards each other or towards medical staff if they felt something could have been done to help the person who died. Whilst it might feel like there's a clear cause or trigger, we know from research that generally there will be lots of different stresses and difficulties that lead to a person ending their life, not just one thing.

You might grieve differently from each other

Grief is different for everyone, and so the things that give people comfort can be different. Some people might be very open about their grief, and others might prefer to grieve more privately. You might not feel comfortable with the way that others around you are grieving as their actions don't

feel comforting to you, but it's important to try and be accepting of the things that help each person. These differences might mean that there are different opinions about how best to memorialise your loved one, or what to do with their belongings.

It might be that you do certain things as a group to remember your loved one (such as have dinner together on their birthday) and other things privately (such as looking through photos and videos of them) so that you can grieve in the way you need to whilst being respectful of others' needs.

You might also feel like others are more or less impacted by the loss than you; for example, a friend of somebody who died might feel that this person's parents have been more impacted by the death due to the closeness of their relationship. This might be true, but it doesn't mean anyone's grief is invalid; everyone has lost someone important to them and is learning to live without them in their life. You might find that you and your friends and family focus on supporting the people who are more impacted, which can be really helpful for them. It can, however, sometimes be the case that people would prefer not to have lots of attention, or it could make the people seen as "less impacted" feel like they can't show that they're having a tough time too.

You might want different kinds of support
Grieving differently means that people will probably have different things that they need help with. This will partly depend on what relationship they had with the person who died, and what role that person had in their life. For example, those who lived with the person who died might appreciate help running errands and managing their household while they get used to doing the practical jobs that they used to share with their loved one. A parent who has lost their partner might particularly value help with childcare.

Support needs will also depend on how each person prefers to cope with things. There might be certain people who you do and don't feel comfortable talking to about what's happened depending on how they've responded to you sharing your troubles in the past, or you might not feel like talking to anyone at all. You might find it helpful to take on lots of practical tasks as they distract you from thinking about things too much, or everyday tasks might seem a bit overwhelming for a while.

You might find that different friends and family members "move on" at different times

Whilst you will never "get over" your loss, you will learn how to live with what has happened. There isn't a definite end point to grief, but there will be a point at which you and your friends and family return to work or education and the other activities you did before your loss. Others might return to these things before or after you do, because you will probably each feel ready for this return at different points, and there will be different responsibilities that you have to keep.

Similarly, as the months pass you will probably spend less time talking about the loss with your friends and family, and you might find that some have less of a focus on what's happened sooner than you are comfortable with. It can feel like they have forgotten about the person who died. Whilst this can be hard, remember that not seeing others grieve outwardly doesn't mean that the loss doesn't matter to them anymore.

6.4.3 What things could I do to help myself and my friends and family cope?

We have described above some of the challenges that you and your friends and family might face. Below, we give you some suggestions of things to be aware of and things to do to help your friend and family group to get through this difficult time.

You will probably have friends and family who are finding it difficult to cope with the loss. There are things that you can do to support them, but only if you feel able to. You might feel like it is your responsibility to help them, but it's also important to make sure that you look after yourself and that your helping of others isn't negatively impacting your wellbeing. If you don't feel able to help others, that's OK. You could direct them to this resource or the other resources signposted at the end of this booklet so that they can access that help that they would like for themselves.

Be accepting of how others are grieving and coping

We know that people grieve differently, and that they can have an understanding of the loss that's different to how others understand it. This can sometimes make it difficult for people to be around each other. Emotions will probably be running high, and people might say things to each other that they don't mean or don't realise is hurtful. Try to be accepting of how other people are feeling and grieving, even if you think they are wrong or if what they're doing is upsetting. There is no right or wrong way to grieve.

If you do find it difficult to be around certain people because of the way that they are grieving, try to focus your contact time with them to periods when you do feel able to be accepting and patient. You could set boundaries with each other about what things you do and don't want to talk about, and try to find things you could do together that you both find comforting. They're sad and missing your loved one just like you, just expressing this in a different way. Sometimes people find it helpful to talk to a friend or family member who didn't know the person who died, because they aren't going through their own grieving process and have more space to take on another person's emotions.

Be aware of what kind of help you need, and who you could ask for this help. Similarly, be aware of what you can do to help others

Given that we each find different kinds of help valuable, it's helpful to understand what it is that each of your friends and family need. Don't assume that because one person finds something helpful, another will too. The relationship that you had with your friends and family before the loss will also influence the support you will each feel comfortable giving and receiving. For example, if you had an emotionally close relationship with a friend before the loss, it's likely that they will feel comfortable talking to you about how they feel about the loss. If there are certain friends or family who seem like they're coping well with everything, it's still worth asking them if there's any way you can support them.

Be aware of this for yourself; you might have certain friends or family who you feel comfortable talking to and sharing your feelings with. There might be others who you wouldn't want to have an emotional conversation with, but are reliable and would help you with practical things if you were struggling, or who are good at cheering you up. Some people can find it helpful to have someone who isn't a close friend or family member to talk to, as they might not personally affected by the loss and so don't have strong emotions about what's happened.

Be proactive

You've probably experienced that it can be hard to ask for help sometimes, and people bereaved by suicide often say that they're not sure who to reach out to and what the boundaries are for support. If you can, think about what your loved ones might need at this time and help them with that. For example, you could prepare a meal for them that's easy to cook, or you could call and ask them to go for a coffee with you if you have a free morning. These kinds of gestures can be really meaningful to the person you're supporting, even if they turn down your offer.

It can be difficult to know if your friends and family want to talk about the person who died and the nature of their death. It might also feel awkward to bring the topic up with somebody, as you don't know how they might react; you might be worried that by talking about it you'll make that person feel worse. In fact, people mostly appreciate the opportunity to talk about their feelings.

Let others know that you're willing to talk about what's happened and acknowledge the loss the first time you speak to them after it's happened. They can always tell you that they'd rather not talk if they don't want to, knowing that you would be there for them in the future. You don't have to say anything profound, just that you're sorry and that you're there for them. If you have been bereaved by suicide in the past, it could be helpful to share your experiences to help your friend and family know what to expect. Asking detailed questions about the death or trying to relate it to your own experience of a different type of loss is often not very helpful.

You might be feeling worried about the mental wellbeing of your friends and family, and possibly concerned that there might be another suicide. Within your group, if you all can create an atmosphere where you're open with each other about how you're feeling, that might help you worry less about others, and be confident that they would get help for themselves if they needed it.

Check to see if needs are still the same as time passes
In the days and weeks after a loss, you and your loved ones might find that you particularly appreciate practical help and having people around as you come to terms with the shock of what's happened, and have a busy time dealing with practical needs such as organising the funeral. You might feel ready to talk about what's happened, or you might need some time to think through things on your own.

Over time, you might find that people need less practical help as they get used to life without the person who died, but might need more support talking through what's happened as they come to terms with it; it can take a long time to fully process a loss to suicide.

In the long term, it's important that people continue to remember the person who died and recognise the part they played in their loved one's lives. People who have been bereaved by suicide more than a year or so often say that they don't have much opportunity to talk about their loved one and it can feel a bit like everyone else has forgotten them. This remembrance could

be shown by marking birthdays and anniversaries of the death date, or sharing stories about the person who died and talking about things that remind them of them.

Chapter 7: Discussion of qualitative study

In this chapter I will discuss the results of the qualitative study, first summarising key results presented in chapters 4 and 5, and setting these in context of existing bereavement and social support research. I will then discuss the strengths and limitations of the study and the recommendations that can be made for both research and clinical practice based on these results.

7.1 Summary of key findings

The aim of this qualitative study was to better understand the experiences of giving and receiving of social support for people bereaved by suicide, having established in the systematic review presented in chapter 2 that good social support is positively associated with better wellbeing after a sudden or violent loss. This qualitative study also aimed to understand how loss to suicide impacts relationships within family and friend groups and how this impact relates to support. I conducted semi-structured interviews with 26 participants across 13 social groups to explore these topics. I analysed resulting data at the individual level, exploring the experiences of the 26 participants separately, and then at the group level, examining similarities and differences in experiences both within and between social groups. The findings of this study are summarised below.

Individuals in the close personal network of the person who had died often experienced notable changes in their priorities and attitudes toward others after their loss. This was particularly apparent as increased prosocial behaviour, including heightened concern for the wellbeing for others in their social network (such as more actively checking in on them), and a desire to help their community.

It was apparent that individual support needs changed over time (illustrated in figure 8), with different types of support felt to be most appropriate at different stages of the bereavement. In the days and weeks following a death, practical support was most widely mentioned as valued. Beyond that point, emotional support became more important over time as people tended to feel more able to process emotions after the initial shock was over. In the long-term, companionship and opportunities for continued remembrance of the person who died came to be the most important type of support.

Figure 8: Most effective support types in relation to time

Beyond this temporal dimension, there were a number of elements of support that were felt to influence its perceived helpfulness. Being proactive and persistent with support was described as important, although small and simple one-off acts off support were also valued. It was also important that support suited the recipient's personality and situational needs. For emotional support, participants wanted friends and family to accept the personal changes they had gone through, to facilitate discussion of emotions, and to be able to support them without becoming overtly overwhelmed or upset. Supporters with this capacity were often those who had not had a close personal connection with the person who died. However, participants also appreciated being around others also impacted by the same loss who implicitly understood their emotions and so sometimes preferred emotional support from their close personal network. These two sets of supporters seemed to be performing different functions; initially those within the close personal network work were important for meaning-making. However, after the initial period supporters who didn't have their own grief to contend with and who had more capacity for emotional support became more important. Negative support experiences often related to inappropriate responses where others (intentionally or unintentionally) reacted to discussion about the loss in a way that was offensive or intrusive, or avoidance, in which the topic was not acknowledged. The withdrawal of support could also be experienced as difficult if it was abrupt or perceived to be too soon after the loss.

There were also clear challenges to the provision of effective support. Supporters often felt a responsibility to help, but felt poorly equipped to do so and found that there were practical challenges to offering support. As well as the practical resources and the emotional capacity that was needed, participants were unsure how best to help in what was generally a novel situation for them. Supporters were concerned about making things worse for their friend or family member and tended to be aware of their strengths and practical capacity in terms of support when describing the role that they played for their social network. Those receiving support could also create barriers by withdrawing from certain people or certain social interactions in the expectation that they would be negative, making it more difficult for supporters to help.

Within social networks, clear grief hierarchies emerged after a loss to suicide, where group members were seen to be more or less impacted than others. Groups adapted their support accordingly and clear roles formed; those deemed vulnerable and those at the top of the hierarchy who were the focus of support within the group, and those who outwardly coped with the loss well who were primarily practical supporters. In each group these roles tended to form naturally, with little personal agency over taking on that role, but often suited individual's support needs and preferences. At the network level, these different roles and coping styles facilitated group coping. However, at an individual level a minority of participants found them to be detrimental. Some network members had to take on roles that didn't suit their coping preferences or didn't meet their needs. In addition, participants within groups who had different coping styles could find it difficult to communicate effectively and support one another. Group support was also influenced by the age of participants, with those at different stages of life tending to draw support from different network sub-groups.

Individuals often found that their relationships became stronger or weaker after their loss, depending on their qualities prior to the loss. Solid, supportive relationships often improved,

whereas relationships that had existing challenges and tensions often became more strained. This polarisation had trends within networks, with some having a general strengthening of relationships and increased harmony (more congruent coping and support between individuals), and others more fall-outs within the close personal network and general decrease in group harmony (less congruent coping and support between individuals).

These fall-outs were frequently related to the way that individuals had come to an understanding of the loss. In constructing a narrative of what had happened, blame for the death was often assigned to an organisation or individuals. Where people's narratives differed, or if blame was placed on a group member, this caused considerable tension within the group. Where network members had matching narratives or did not have strong feelings of blame, they found it easier to support each other through the bereavement period, although blame seemed to be connected to experiencing longer-term distress. Similarly, individuals with similar coping styles found it easier to support each other, being able to offer the support they themselves would want. It was common for network members to be wary of expressing their emotions about the loss to others, not wanting to burden them and not knowing what level of disclosure was appropriate.

Experiences of formal support were mixed. In contrast to social support, support through health services was seen as difficult to access, and a minority of participants had experience of it. Peer support services through charities were commonly accessed for the receipt of emotional support, although some participants had concerns about its effectiveness in improving wellbeing and felt that it only suited those who were open and comfortable speaking in groups. Those who did find peer support beneficial found value in connecting with and receiving support from others with similar experiences.

7.2 Findings in the context of previous research

7.2.1 Individual level results

7.2.1.1 Positive and negative supportive acts

Findings reflect the typical categorisation of types of support (emotional, tangible, informational and companionship; Wills, 1991) and demonstrate the importance of the different functions of supportive acts, and when different support types are needed. Although participants were sometimes not able to clearly verbalise what "support" meant to them, the acts that they described always fell into one of the four categories. These results also reflect the dual process model, in that the support that participants valued helped them cope with restoration oriented stressors as well as loss oriented stressors. The change in this over time (section 7.2.1.2) fits with the idea that the balance between the two types of stressors shifts over the course of a bereavement (Richardson, 2007).

The supportive acts that participants found helpful, and the acts that participants found unhelpful were consistent with other studies of social support after loss to suicide. Common findings include the value of practical support (Dyregrov & Dyregrov, 2008), proactive support and emotional availability (Dyregrov, 2011) and the detrimental impact of avoidance and insensitivity (Grad, Clark, Dyregrov, & Andriessen, 2004). My findings also match those of research on bereavement more widely. One large scale quantitative survey of people bereaved by any cause found types of helpful support included reliable alliance and social integration, whereas unhelpful support related to insensitivity, absence of anticipated support and lack of empathy (Aoun, Breen, White, Rumbold, & Kellehear, 2018).

No other published studies have explored the complexity of identifying who in the social network is most effective at providing support after suicide bereavement. Participants in this study seemed to value support from those within their close personal network during the immediate bereavement period as a way to share grief and come to an understanding of the loss together. This facilitation of meaning-making can be understood as a social process whereby we need others to confirm our beliefs to make them feel more objective (Park, 2010). However, emotional support within the close personal network often became challenging as group members tried to protect each other and became concerned about the burden of emotion on others. An Australian study of bereaved parents similarly found that participants could be preoccupied with the wellbeing of family members (Entilli, Ross, De Leo, Cipolletta, & Kõlves, 2021). The study highlighted the particular value of support from friends, as group members who were relatively removed from the loss. This mirrors research findings in the context of cancer, where friends were identified by cancer patients as the most common type of identified supporter (Hauken et al., 2019), demonstrating their value as a social contact who is less caught up in the stressful life event than relatives.

In this study, friends seemed to be uniquely positioned to offer effective emotional support at this point, having a positive relationship maintained by choice with the bereaved person and likely having the emotional capacity to be a supporter, not having been personally impacted by the loss.

In line with my findings related to peer support (discussed in section 6.2.3 below) and the findings of other studies examining peer support (Bartone et al., 2019; Wagner & Calhoun, 1992) participants found it particularly helpful if they had friends who had previous experience of suicide bereavement who could help them normalise their experience and empathise with them from the perspective of somebody who had been through a similar experience. Ultimately, it seemed as though those outside of the close personal network were often better positioned in the long-term to provide support than those within the close personal network.

This study identified that the structure of a social network is strongly influential in the quality and amount of social support an individual will receive (Wrzus et al., 2013). In this study, participants at different life stages seemed to have different numbers of available supporters and different types of key supportive relationships (e.g. younger adults drew on support from larger friendship groups than older adults). A minority of participants in my dataset were men and so it is not possible to draw detailed conclusions about the relationship between gender and social support.

Although gender is regarded as a key influencer of social network structure (Haines & Hurlbert, 1992), male participants did not seem to be more or less dissatisfied with their available support than women, although there was a tendency for participants to indicate that male social network members used emotional support less so than female group members.

7.2.1.2 Timing of support

Few other studies have been able to chart changing patterns of needs for support in the period following the loss using categorisation of support as this one did. Authors of a qualitative study of parents bereaved by military death additionally comment that research tends to examine emotional support over other types of support (Rolls & Harper, 2016); their study documented participants' perceived positive impact of practical support, although did not comment on the timing of support. Other work has identified the value of companionship as ongoing, long-term support (Aoun et al., 2019), and of supporters being persistent and offering continuing support beyond the immediate bereavement period (Dyregrov, Kristensen, & Dyregrov, 2018; Scott et al., 2007) and, in the context of suicide, the importance of maintaining a connection with the person who died (Maple, Edwards, Minichiello, & Plummer, 2013).

7.2.1.3 The experience of providing support

Research about social support after suicide loss typically focuses on the perception of the receipt of support, with less known about the experiences of supporters. In chapter 1 I reviewed two qualitative studies of support after suicide bereavement (Dyregrov, 2006; Wagner & Calhoun, 1992) that examined the experiences of giving and receiving support, but these studies failed to consider the interpersonal context of support by considering these experiences together. Dyregrov's study focused on the experiences of supporters, finding that support could be emotionally demanding, with supporters unsure of how best to support and concerned about doing the wrong thing; my study confirmed these findings. In addition to these results, participants in my study also highlighted that being a supporter presents practical challenges in terms of dedicating resources to supportive acts.

By using a methodological approach focused on groups, I was able to avoid categorising participants into the binary roles of providers of support or receivers of support, as was the case in the studies referenced above (Dyregrov, 2006; Wagner & Calhoun, 1992). This approach allowed for the exploration of the experience of having to cope with one's own grief whilst coping with the grief of others in the close personal network, and attempting to support them, which will be considered further in following sections.

7.2.2 Group level results

Analysing data from multiple participants at the group level in order to compare and contrast their experiences was a key element of the novel contribution to knowledge provided by this thesis. Additionally, I was able to examine the impact of loss on a wide range of family and friends, not just those typically seen as most vulnerable. Rather than using this approach to identify who was

most at risk and therefore most in need of intervention as suggested by Stroebe and Schut (2015), I was able to consider the unique experiences of each individual, even those within the same social settings (Gilbert, 1989).

Considering multiple accounts of the same loss provided me with a richer understanding of group adaptations and responses than accounts from single participants, and allowed for a certain level of verification of data that previous studies in this area have not had. Whilst some bereavement studies have examined interpersonal impact (Hooghe et al., 2013; Lehman et al., 1989; Lietz, 2006), they have only considered specific elements of it, or included it as part of wider examination of bereavement impact. These studies will be considered here in the context of where the findings of my study supported, contradicted and expanded on current knowledge.

7.2.2.1 Group harmony

In the results section, I identified harmony within a group as a marker of how well that group was coping with their loss. Harmony was impacted by how well group members could communicate with and support each other. It manifested itself through patterns in the strengthening and weakening of relationships due to matches or mismatches in coping styles and meaning-making as well as pre-loss relationships. Most bereavement research focuses on how individuals cope with loss, measuring individual-level wellbeing outcomes. Only a limited body of literature explores coping at the group level during bereavement (not specific to suicide bereavement), often focusing on the resilience of groups (Lietz, 2006) or measuring specific outcomes related to individual relationships, such as marital satisfaction (Lehman et al., 1989). A number of these studies find that meaning-making and the social construction of a narrative of loss is important to the resilience of family groups and place it centrally in bereavement experience, in the same way that that meaning-making was important to the participants in my study (Hooghe & Neimeyer, 2013; Nadeau, 1998). Their findings therefore are consistent to mine, in that meaning-making was important to the participants in my study.

One study with a similar focus to the one described in this thesis examined the changes in relationships after bereavement due to a road traffic crash (Breen & O'Connor, 2011). Although some participants were derived from the same families, the authors did not appear to compare their experiences directly in order to confirm differences in perspectives, but presented findings for the group as a whole similar to those in my study. Group members were reported as having found that grieving in different ways from others was challenging, and that relationships strengthened and weakened through the same mechanisms of polarisation that I noted with my participants. They also described permanent changes in supportive networks, with an initial sense of togetherness, but a dwindling of support and distancing of group members. Unlike my study, they found that relationships "deteriorated and collapsed" more often than they improved and did not explore how the way in which group members coped impacted on relationships.

Whilst there are very few published studies that focus on suicide bereavement at the family or group level, one study has explored pre-loss dynamics and the impact of suicide loss on family functioning (Ratnarajah, Maple, & Minichiello, 2014). This had more of a focus on family history

and considered longer-term dynamics than I did in this study, exploring how intergenerational patterns of behaviour influenced grief responses. Similar to my findings, this study found that suicide loss could magnify pre-existing tensions within the group, and that individual relationships changed after the loss. It also found that shared narratives of loss were important for individual's meaning-making, although did not explore what happened when narratives differed or compare the different perspectives of group members, as I was able to do with this dataset.

7.2.2.2 The hierarchy of grief

Social norms differ from culture to culture and place certain expectations on the bereaved as to how they should act; who should grieve and in what way (Harris, 2010). It is usually argued that there is a binary distinction between enfranchised and disenfranchised grief, where enfranchised grief is socially mandated, whereas disenfranchised grief is not (Doka, 1999). This categorisation typically occurs due to the culture's perception of the cause of death that occurred, or the type of relationship (e.g. a mother grieving her child compared to a nephew grieving an uncle with whom he had no contact). The expectation is that enfranchised grief is universally positive for individuals and disenfranchised grief is universally negative. In my study, participants did not seem to fit clearly into these two categories. Instead, within each group, they lay along a continuum of perceived impact that fit in with social norms. This concept of a continuum of impact rather than a binary categorisation matches with the idea of a continuum of suicide bereavement presented in Chapter 1 (Cerel et al., 2014).

This evidence of grief hierarchy supports theoretical ideas that hierarchies of grief are a helpful lens through which to view bereavement, both at the social network level and the community level (Harms et al., 2015; Zehfuss, 2009). Robson and Walter (2013) highlight that whilst the concept of disenfranchised grief is useful in some specific contexts, such as somebody grieving the loss of their partner in an undisclosed relationship, a hierarchy of grief is a more useful concept for understanding more typical losses. Their paper presented broad categories for hierarchy essentially the same as the one presented in this thesis, my study being the first to outline a hierarchy of grief for social groups bereaved by suicide.

Robson and Walter (2013) established their grief hierarchy through a study in which participants organised fictional sets of family members into a hierarchy, with blood relatives placed higher than relatives through marriage, and primary relatives over secondary relatives. Fictive kin (those who are deemed close enough to be family but who are not related through blood or marriage) were equally ranked with relatives by marriage but not blood relatives. Spouses and parents were typically ranked as highest in the grief hierarchy. In my study I did not have enough data to find a consistent placement for spouses across groups. As spouses are usually regarded as next of kin, most outsiders to a social network would see a spousal relationship as an important one, however, as my study found that spouses were often blamed and ostracised by close personal networks, their placement within the hierarchy may be a complex issue.

Another important finding was that participants in this study did not always feel comfortable in the position their social network had placed them in the hierarchy. Whilst having a hierarchy in

place is an effective coping mechanism for the whole group as it allows support resources to be allocated appropriately and according to need, it may be detrimental to a minority of individuals who don't feel like their place in the hierarchy is right for them.

7.2.2.3 Roles

My findings identified two key roles within the close personal network beyond the hierarchical placements of group members: the role of vulnerability and the role of coping. These specific roles are not described in other group-focused studies of suicide bereavement, but have been described in a family-focused study of bereavement through road traffic crashes did find that (Breen & O'Connor, 2011) group members fulfil specific supportive needs for the group.

There are a significant number of studies that examine vulnerability in suicide bereavement and identify risk factors for negative wellbeing outcomes (Stroebe et al., 2005), particularly in the case of risk to mental health and attempted suicide (Sveen & Walby, 2008). The relatively implicit process of social groups identifying vulnerability matches empirical research about risk factors, finding that kinship and pre-existing mental health conditions are predictors of higher risk of negative wellbeing after suicide loss (Pitman, Osborn, King, & Erlangsen, 2014; Spiwak et al., 2020).

In my study roles were also connected to personal coping methods, in the sense that copers often preferred not to use emotional support whereas those deemed vulnerable received much more emotional support. Bereavement research that focuses on coping styles and strategies typically make distinctions between problem-focused coping (reducing levels of strain) and emotional coping (either avoidant; not acknowledging the loss, or active; directly dealing with the loss) (Drapeau et al., 2016; Johnson, Lund, & Dimond, 1986; Lawrence, Jeglic, Matthews, & Pepper, 2005). The "copers" in my dataset often tended toward problem-solving coping focused on reducing stress for the group, whereas those who were most vulnerable tended toward active emotional coping.

7.2.2.4 Blame

In my study, blame was a prominent feature of interviews as a specific aspect of the meaning-making process. Whilst participants often constructed narratives and came to an understanding of the loss together, there could be differences in narratives. This meaning-making could therefore be a disharmonious and distressing interpersonal process, a phenomena recognised by family systems approaches to bereavement (Castelli Dransart, 2013; Nadeau, 2004). Conflicting narratives within groups caused long-term damage to relationships as individuals' beliefs were challenged by others.

Blame is a common feature in suicide bereavement research and is viewed as one of the key factors that impacts on a social network after suicide loss (Cerel et al., 2008). Some research focuses on perceptions of blame emanating from outside the close personal network (Range, 1996). Whilst some participants in my study did experience avoidance from the wider social

network and community, there were no reported instances of blame from those groups. Other research focuses on self-blame and blame from within the close personal network, finding that both are common amongst those bereaved by suicide (Entilli et al., 2021; Jordan, 2001; Testoni, Francescon, De Leo, Santini, & Zamperini, 2019), some research suggesting more so than other forms of bereavement (Pitman, Stevenson, Osborn, & King, 2018). Whilst self-blame was not common in my sample, blaming others in the close personal network was, and seemed to be a source of considerable distress for participants. It is possible that if my study and interview questions had been more focused on individual coping, this may have elicited more reports of self-blame. However, the interpersonal focus did allow me to identify a pattern of blood relatives collectively blaming partners for the loss, something that has not been noted elsewhere.

7.2.2.5 Stigma

Stigma is often associated with blame in suicide research, with stigmatising attitudes including blaming the person who died or their friends and family for the loss. Quantitative studies tend to identify a heightened sense of rejection from the community as being more prominent in suicide bereavement than other types of bereavement, and that this stigma is detrimental to wellbeing (Cvinar, 2005; Kõlves et al., 2020; Pitman et al., 2014; Sveen & Walby, 2008). Stigma is also implicated in the association between suicide bereavement and risk of suicide attempt (Pitman et al., 2016).

As stated above, participants in my study did experience withdrawal and avoidance from others, but few experienced overt acts of stigma and this was typically not a central issue in interviews. Stigma was therefore a less a prominent issue than in other studies of the impact of suicide bereavement (Pitman et al., 2014; Sveen & Walby, 2008). Whilst participants did sometimes withdraw from others on the basis of anticipated or perceived stigma, these instances weren't clearly connected to the cause of death, rather the bereavement in general. It is possible that those bereaved by suicide may be particularly sensitive to stigma given the history of blame and stigma associated with suicide (Cvinar, 2005) and so are prone to self-stigmatisation, something suggested in a small body of recent research (Hanschmidt, Lehnig, Riedel-Heller, & Kersting, 2016; Pitman et al., 2018).

7.2.3 Formal support

Whilst formal support services were not the main focus of my thesis, I included questions about formal support in the qualitative interview topic guide as a way to understand the differences between formal and informal support, and how they might work together.

My findings support existing research that suggests in the UK, social support is more widely accessed than formal support for people bereaved through suicide (Pitman et al, 2014). It is therefore crucial to understand and improve social support as the main type of support the majority of people bereaved by suicide will receive. In this study all participants could identify at least one friend or family member who had been a help to them, whereas only a small number

had had positive experiences of peer support or help from statutory services in relation to their bereavement.

Participants in this study reported a mixture of positive and negative experiences of formal support from healthcare services and peer support organisations, as well as support for returning to work and in the workplace. The apparent lack of guidance that appears to be in place within workplaces and the healthcare system as to how to support people bereaved by suicide means that experiences for bereaved individuals are highly variable. Other research similarly reports inconsistencies in support from healthcare staff, both in the UK and internationally (Feigelman, Sanford & Cerel, 2020; Foggin et al., 2016; Wainwright et al., 2020), and within the workplace (Gibson, Gallagher, & Jenkins, 2010). Participants rarely mentioned instances of informational support from friends and family, and did not cite this as something that they were missing from their social network. However, it was commonly mentioned in reference to formal support, suggesting that those bereaved by suicide do not expect bereavement information about their loss from friends and family, but may do so from those who they expect to be informed and trained in healthcare and bereavement. This was the same for participants in a study sampling those who had experienced all types of bereavement found this same pattern in their questionnaire responses (Aoun et al., 2018).

Of the types of formal support available, participants had most commonly heard of or tried peer support, in line with existing literature that shows that this is a common support service for people who are bereaved (Pitman et al., 2017). For this group of participants, the value of peer support appeared to be that it allowed for people to connect and share experience with others who understood the kind of loss that they were going through, but weren't from within their social network and so didn't have the same kind of communication barriers. This is evidenced by the fact that even participants with effective support within their close personal network attended support groups to receive this emotional and informational support in a different way. These results add to the idea that emotional support can be valued more when it comes from outside the close personal network and that peer support, whether as a managed group activity, or through an existing friend with their own previous experience of suicide bereavement, is a valuable tool for support.

Evaluations of peer support groups for suicide bereavement are consistently positive (Bartone et al., 2019). However, selection bias is a problem in such studies, where samples consist of people who are actively using peer support groups and therefore must draw some value from it. My own study interviewed a wider range of participants in terms of use of support groups, including some who had attended a group only once or twice, and those who would not consider attending a group, thereby offering a less biased reflection on the strengths and flaws of peer support. It seems that peer support groups, when managed to ensure safe and structured conversation, are beneficial to wellbeing, but only for those who are comfortable with this type of group interaction.

A summary of key findings in relation to existing literature about suicide bereavement literature is presented below in table 11.

Table 14: Key findings in relating to existing suicide bereavement research

Confirmatory findings	Contradictory findings	Novel findings
People find all types of support (practical, emotional, informational, companion) useful (Dyregrov & Dyregrov, 2008).		Different types of support are most effective at different times, with a linear progression through practical, informational, emotional and companionship support.
Supporters can find it difficult to know what support is best, whilst those receiving support can pre-emptively withdraw from social contact (Dyregrov, 2006).		Supporters experience practical challenges to providing support, including time and geographical distance. In the long-term, supporters from outside the close personal network are often best placed to offer emotional support.
	Rather than enfranchised/disenfranchised grief, groups have a continuous hierarchy of grief (Doka, 1999).	Specific "coping" and "vulnerable" roles naturally form within social networks after the loss.
Relationships are polarised by the loss (Ratnarajah et al., 2014).		Polarisation of relationships can relate to differences and similarities in coping style
Meaning-making is an important part of the bereavement process (Shields et al., 2017).		
	Self-blame was not common (Sveen & Walby, 2008).	Blaming someone or something for the loss can be distressing, particularly if there are disagreements about this within the social network. Blood relatives often blame partners.
	Active stigma from communities was not common; avoidance of the subject (passive stigma) was more common (Pitman et al., 2014).	
Experiences of formal support (e.g. GPs, counselling, line managers) are mixed and often tempered by limited training for professionals (Gibson et al., 2010; Wainwright et al., 2020).		
Peer support groups are valued for the ability to connect with and learn from others with similar life experience (Andriessen, Lobb, et al., 2018).	Peer support groups are not consistently viewed as positive (Bartone et al., 2019).	

7.3 Strengths and Limitations

The study was the first of its kind to use a novel, group-focused qualitative approach to gain a nuanced understanding of the social support that occurs within a social network after a loss to suicide. The use of novel methodology allowed for a more detailed understanding of how relationships can be impacted by bereavement than has previously been achieved in interpersonal bereavement research; a key strength of this study is therefore the inclusion of multiple perspectives of a bereavement experience from within a single social network, and the comparison of whole networks against other whole networks. This study demonstrated that individuals can have very different experiences of the same loss and that social support is highly complex and individualised.

7.3.1 Strengths and Limitations of the study sampling approach

This study did have some challenges in relation to sampling that lead to limitations in the sample. The study had a relatively low rate of initial contacts becoming participants, (see chapter 4, table 8), and although social media posts have a large potential audience, low numbers of eligible participants responded to requests for participants. It is possible that advertising could have been improved to make inclusion and exclusion criteria more clear. Necessary adjustments to the recruitment strategy partway through the recruitment stage of the study have been described in the methods section. Whilst this change in strategy was successful in recruiting enough participants for a meaningful sample, it would have been optimal if each of the 13 groups was represented by two or more participants, to allow for more comparison of perspectives.

In chapters 1 and 2, I noted that studies in this area often use convenience sampling and have samples that are limited in diversity of age, sex and ethnicity, with participants often older, more female and White. Studies also often recruit through peer support organisations, leading to samples of help-seekers whose needs and methods of coping are likely different to those who do not seek help. Whilst a number of participants in this study were recruited through charities and peer support organisations, snowball recruitment and advertising on social media ensured a mixture of help-seeking and non-help-seeking participants and broadened recruitment methods beyond convenience sampling. This resulted in a sample that was diverse in age range, and had a slightly more even gender split than is typical, but still did not completely mitigate the homogeneity that is prevalent in research in bereavement research.

A key limitation of this sample was the lack of ethnic diversity. Research shows that different cultures have different beliefs about death and different grieving rituals to others (Rosenblatt, 2013). The social landscape within groups from different ethnic backgrounds may therefore not be the same as the ones described by participants in my sample. For example, due to differences in appropriate expressions of grief, it may be that those in ethnic minorities face different barriers to communication than the avoidance and concern about emotional burden in my findings.

Whilst attempts were made to involve participants from ethnic minorities, all participants were White British and so this sample is a poor reflection of the ethnic and cultural diversity that exists

in England (UK Government, 2018). Ethnic minorities are less likely to participate in mental health research than ethnic majorities, and face a number of unique barriers to participation including beliefs about psychiatry, stigma, trust, and lack of cultural awareness on the part of researchers (Brown, Marshall, Bower, Woodham, & Waheed, 2014). I attempted to mitigate some of these barriers by working with community organisations, being flexible in interview times and locations, as well as reimbursing travel expenses. However, as a white researcher myself, I am an outsider to ethnic minorities in the UK so am unaware of all the cultural differences and sensitivities around bereavement, nor do I have first-hand experience of the barriers to participation that ethnic minority participants face. Additionally, I am based in an academic department of psychiatry at an institution with a legacy of eugenics (University College London, 2021) and so may be perceived as a representative of a field that is mistrusted, impacting on my ability to connect with participants and potential participants. These issues likely contributed to the homogenous sample found in this study I was unable to mitigate enough barriers to enable wider access to my study. Ideas for increasing access to research will be discussed in the next section.

Similarly, the voices of friends and partners are not particularly well represented in this sample. Whilst no limitations were set on relationship to the person who died, the majority of participants were blood relatives. During the process of snowball recruitment a minority of participants put forward friends for participation, and only one group's initial participant was a friend rather than a family member. It is possible that this reflects the hierarchy of grief, where both family members and the friends themselves place themselves lower down in the hierarchy. As a result, they may not be seen as a priority for research and support, and across bereavement literature there is limited research that focuses on friends (Liu, Forbat, & Anderson, 2019). It may also be that friends are less likely to be invested in participating in research about the loss than more deeply impacted family members.

Conceptualisations of methodological validity that are appropriate to qualitative research are trustworthiness, rigour and quality (Golafshani, 2003). Lincoln and Guba (1985) suggest that these can be judged through credibility (how recognisable the report of participants' experiences would be to other with similar experience), transferability (how applicable findings would be to another group), dependability (clarity of a researcher's decision-making process) and confirmability (the degree to which findings can be corroborated by others); these markers are commonly used by qualitative researchers (Pandey & Patnaik, 2014).

As discussed above, results of this study may not be highly transferable to other cultural groups given the lack of ethnic diversity in the sample. They may, however, be broadly applicable to other types of sudden bereavement as some of the demands placed network members and strains on relationship could be similar. Throughout the study, consultation with PPI group members has contributed to both credibility and confirmability as group members with lived experience have been able to assess whether my interpretation of results fits with their own experience and advise me to consider new areas that I may have missed. Results of this study are broadly in line with what other similar research has found, although it is important to acknowledge that having read much of the literature before beginning my research, there is a possibility that I implicitly tended towards results that confirmed my expectations rather ones that conflicted with what I knew. However, I tried to mitigate this through consultation with my PPI group and supervisory panel, as

well as keeping a reflexive diary which contributed to the dependability of the research, allowing me to reflect on each decision made during the design, data collection and analysis stage of the project and have my reasoning challenged by others to ensure clear and logical thought processes behind decision-making. Particular attention was given to documenting the process of group-level data analysis, as this was a novel method of analysis and no existing framework for analysis could be followed.

Careful consideration and consultation with the PPI group also lead to the inclusion criteria of participants bereaved more than 18 months and less than 8 years; it was felt that it would be unethical to ask those who were recently bereaved to explore their experiences in depth, and those bereaved for more than 8 years might have forgotten their initial experiences. Although these cut-off points may have resulted in some recall bias, the large window allowed for different temporal perspectives of loss and meant that all of the participants had gone through the initial lasting changes that occur in social networks after a loss.

There was also an indirect benefit to snowball sampling, which is the only feasible sampling strategy in dyadic or multiadic research. I was able to interview network members who perhaps would not have volunteered for participation without prompting by another group member, and who did not initially identify as being deeply impacted by the loss, but who, during the interview, would reveal strong emotions and beliefs about their experience.

7.3.2 Strength and limitations of interview approach

Dyadic analysis, the approach that this study was based on, is often used in conjunction with joint interviews with pairs of participants (Morgan et al., 2013; Paradiso de Sayu & Chanmugam, 2016). However, this approach was not suitable for such a sensitive research topic, as participants often spoke about each other and sometimes revealed private information that other participants wouldn't know. Although this level of honesty was valuable and interviews with three or four participants would have been logistically difficult to arrange, it did mean that I was not able to capture participants discussing their experiences of each other's support (or lack of it). Group discussion could also have elicited useful information about how group narratives form and to see grief hierarchies in action.

The HMT (Antonucci, 1986) was developed to produce quantitative measurements of social network qualities, but has since been adapted by researchers to elicit qualitative data (a detailed description of the tool is presented in appendix 7. Although I initially introduced this tool as a way to capture quantitative data to complement the qualitative interviews, piloting showed that it was not suitable for this purpose, given the small sample size and the different ways that pilot participants chose to interpret and use the maps. However, I found through piloting that it was a highly effective tool for prompting discussion and thought from participants. It allowed study participants to ease into the interview in their own time, and gave them a chance to start thinking about who was important to them and why, and how this had changed since the loss. It also created a framework for the beginning of the interview, as we could work through names on the maps one by one, talking about who they were and why their closeness might have changed over

time, if it had. Through this I was able to identify key relationships and ensured that I explored these with the participant over the course of the rest of the interview.

Whilst useful, this section of the interview did often take up a considerable amount of time. Due to the 120-minute time limit I had set, I did on occasion have to end interviews before it felt like participants had said everything they wanted to say. It can be argued that this takes the ownership of the interview from the participant as it impedes on their control over their narrative (Faulkner, 2005). However, I ultimately decided that with such a sensitive interview topic, any longer would require too much emotional labour from both myself and the participant, and I was aware of my own limitations in terms of how long I could actively listen and manage a conversation.

Overall, presenting myself as an insider researcher was helpful for this group as participants seemed to appreciate speaking to someone who they saw as a peer. Participants were often interested in who I'd lost and how long ago; my initial concerns that not having lost a family member would mean that they viewed my experience as different were unfounded.

Although I took precautions to ensure that the data collection phase of my study did not cause unmanageable emotional labour by restricting interviews to one per day and ensuring that I had access to clinical supervision, transcribing data was an unexpected challenge. Due to data protection needs as well as the emotionally demanding and sometimes graphic nature of interviews, I chose to transcribe all data myself rather than use an external transcription company. Listening to audio recordings without the need to focus on guiding conversation and responding appropriately that I had had during interviews inevitably lead to more emotional impact and more resonance with my own experience of suicide loss. Ultimately, I restricted the amount of time I spent each day transcribing data, and only transcribed data when I was in a shared office at UCL with people I could interact with to reset my frame of mind if a section of an interview was significantly negatively impacting on my mood. There was, however, a clear benefit to carrying out transcriptions myself in that it facilitated my immersion in the data, allowing me to take the time to consider different interpretations of the data and emerging patterns within it. Although time-consuming, the transcription process was a useful first step in data familiarisation and initial stages of analysis.

7.3.3 Strengths and limitations of a novel method of analysis

Given that an analysis at the group level followed a novel process, I will consider in detail here. Comparing and contrasting experiences within and across groups was crucial to effectively answering the research questions and bringing about the unique contribution to scientific knowledge provided by this thesis. Descriptions of widely used qualitative analysis methods do not account for the comparison of data within subgroups of a dataset and so a novel process had to be developed. Papers describing the methodological process of dyadic analysis (Eisikovits & Koren, 2010; Van Parys et al., 2017) were used as a reference when developing this method of analysis. However, as no guidelines exist for analysis of groups involving more than two participants, there may be other approaches that could be taken. For example, a completely linear process with distinct individual and group level stages, or a process that treated analysis within groups and

analysis between groups separately. As the number of participants in each group increased (the maximum I had was 4 participants in one group), so did the complexity of the group level analysis, and so with larger groups an alternative approach may be necessary in order to fully capture individual's comparable experiences. Ensuring rigour for this type of analysis was also difficult; double coding wasn't possible in this instance due to time constraints and due to the fact that I was the only researcher fully immersed in the data provided by all participants across groups. Instead, I relied on in-depth discussions with my supervisors during the development of the group-level coding framework, and consultation with my PPI group once initial themes were generated.

Taking this approach to analysis brought an added complexity to the interpretation of the data as well as the analytic process. An inevitable incompleteness to the dataset was apparent; there may have been conflicting views that I could not capture because I couldn't interview all network members. In some groups there were key group members who were not asked to participate, or had declined to do so, but were mentioned often by other group members. I had to take this third-party account of them and their experience as the only available truth. This limitation was particularly apparent in the case of partners who had been blamed by blood relatives for their actions pre and post-loss as I captured only one side of what could have been quite a conflicting story. Where I did have multiple perspectives of the same event, or participants who referenced each other, it was quite a conscious process to give equal weighting to each of their accounts and accept not knowing which was objectively more accurate. My reflexive diary helped with this; after interviews I noted how I felt about what participants presented me with and reflected on whether I felt more or less aligned with their experiences compared to another participant in their group. Ensuring that I was conscious of any of these biases helped me to be more objective once I began group-level analysis.

Reflexivity is critical to any piece of qualitative work (John & Stonebridge, 1993; Mauthner & Doucet, 2003), but was especially so for this project. I had to be aware that there were times when I connected with one participant more than another from their network, potentially influencing my preference for one account over the other. This required a reflexive process over and above what is typically required in a qualitative project, positioning myself within each participant group as well as within the group of participants as a whole.

Other qualitative researchers have commented on the particular importance of reflexivity when researching sensitive topics (Band-Winterstein, Doron, & Naim, 2014; Fletcher-Brown, 2020). Fitzpatrick and Olsen (2015) reflect on the challenges of emotion in interviews, and being unsure of how much emotion was appropriate to display when participants were talking about distressing topics and were visibly upset. This was a challenge that I faced, and one that was heightened by my own experience of suicide loss as participant's experiences often resonated with my own. I was sometimes impacted by participants' emotions or the things they and I felt it was important to show this to some extent in order to empathise with them, but I also didn't want participants to feel like I couldn't cope with the emotional weight of their story and to hide things from me thinking it would be too distressing. Reflecting on these heightened emotions after interviews was useful for my analysis; allowing me to separate out sections of the interview that were emotive simply because they elicited memories and feelings around my own loss, and sections that were

emotive because of the participant's strong feelings and therefore potentially important codes and themes.

Similarly, there were additional ethical considerations in terms of ensuring that no information about one network member was revealed to others. There were times when it would have been useful to ask a participant about an event or belief mentioned by another participant in their group; however I couldn't always do this without being too intrusive or revealing something that somebody else had told me. In these instances I had to accept an account from a single participant, knowing that there might have been another perspective or additional knowledge. Further reflections on my role as an interviewer are presented in Appendix 13.

This need to conceal information also brings about challenges for publication of this data, where a balance must be struck between publishing results that are novel and provide enough context for them to be verifiable and understandable, but that don't put the anonymity of participants at risk. Other researchers publishing data from dyadic analyses have found that the balance between data integrity and participant anonymity is challenging (Forbat & Henderson, 2003; Lever Taylor, 2019; Ummel & Achille, 2015). I used an approach similar to others, anonymising data until I reached the point that I felt it would compromise its meaning, and I will redact case studies from the publicly available version of this thesis. I also allowed participants to check their transcripts and remove anything they were uncomfortable with having said, and made it clear to participants that I would do my best to protect their anonymity in publications, but that I could not guarantee they would be unidentifiable to those who knew them as I cannot know what each participant's defining experiences and characteristics are to their friends and family. Although this had the potential to make participants wary of being completely honest in their interviews, this kind of compromise is necessary in qualitative research (Saunders, Kitzinger, & Kitzinger, 2015). It seems likely that for my study, some form of co-production process with participants where they contribute to write-ups and decide what they are comfortable putting into the public domain with an understanding of what the key discoveries are may be a plausible and ethically safe option.

7.3.4 Key learning from this project

As a researcher with lived experience of the sensitive topic being researched, using a relatively novel method of analysis, there were several issues to contend with that have not had much coverage in existing literature and that I had not considered when initially designing the study.

As described, there are additional ethical challenges to group-level analysis compared to individual level analysis. There were also additional challenges to analysis of the 3 or 4 person groups compared to typical dyadic analysis. At a basic level, confidentiality became more challenging as group sizes increased and in interviews it became more difficult to keep track of what individual participants had and hadn't told me. Analysis also became exponentially more difficult as I tried to balance each participant's account within a group.

In dyadic analysis, a pair of participants are often chosen for a purpose, e.g. a mother and child talking about an issue relating to raising children, partners talking about their relationship with each other. My social groups did not have a definite cut off-point. Considering my largest social group with four participants, it felt as though I had reached the point of data saturation in terms of contextual information about the events of the loss, but not about the impact on relationships and group functioning. It felt as though a saturation point for data at this level would be almost impossible to reach, as I centred social groups around the person who died, but through my experience of recruitment, it is unlikely that each group member would agree to research participation to produce a complete account of the group's experience. Whilst I began this project with a predetermined maximum of ten participants in each group, it may be more feasible to reduce this cap to five participants per group.

As a researcher with lived experience, I learnt that reflexivity is particularly important in order to challenge one's own beliefs about the experience in question that can be very fixed, and are easy to introduce into interpretations of the data. For example, I began the project having had poor experiences of formal peer support and was therefore biased against it. During data collection and analysis I found that a number of participants found their peer support groups beneficial, and that I needed to ensure that these positive experiences were fairly represented despite my own feelings. I found that consultation with PPI members was critical to achieving a less personal interpretation of data. I also learned that the emotional challenges of a research project are not always at the point at which they are expected, and there is a need to have supportive wellbeing safeguards in place for all stages of the project and to be aware of the impact that being invested in a long-term project can have.

7.4 Recommendations for future research

The results of this study point to several key areas for future qualitative and quantitative research. Given that this is the first qualitative study of suicide bereavement to focus on both the social impact of suicide bereavement and resulting social support, it was necessary for interviews to cover a broad range of topics and explore the most prominent issues related to support and impact. As a result, some specific topics require more investigation to build on some of the findings presented here.

7.4.1 Understanding change over time

Having established a pattern for different types of support having value at different stages of the bereavement process, further confirmatory research on this would be beneficial, through longitudinal assessments of perceptions of support at discrete intervals over the initial years of bereavement. Studies should also focus on better understanding individual differences in coping strategies and their use by those bereaved by suicide. Whilst wider bereavement literature does consider coping styles, (Drapeau et al., 2016; Johnson et al., 1986; Lawrence et al., 2005), there is no current consensus on which styles are most protective against negative wellbeing and not much known about the application of these to suicide bereavement, given the additional

challenges to meaning-making and cognitive processing of loss that it presents. Wider trauma-focused research suggests that whilst emotion-focused coping can be effective in the short term, it may ultimately be detrimental (Braun-Lewensohn et al., 2009), and problem-solving coping styles could be more effective in the long-term (Hooberman, Rosenfeld, Rasmussen, & Keller, 2010). Improving understanding of support styles would allow for better tailoring of both formal and informal support to individuals.

7.4.2 Sampling

Given the limitations of sampling that have impacted on the transferability of results, future research should work to engage and investigate the experiences of participant groups not reached here, particularly those from different cultures and at different life stages. In this study, a small number of participants were younger adults without their own family units who included more friends than family in their hierarchical network maps (see case study 302, 501 and 901) and did not have the same kind of social experience as older adults with different social network make-ups. Research has typically focused on close family units, discounting friends and colleagues and therefore perpetuating the idea that close personal networks tend to consist of fairly homogenous family groups. There were a number of groups in which there was a rift between partners of the person who died and blood relatives causing considerable distress. If this is a common occurrence, partners are likely to be a particularly vulnerable group, having lost a key member of their close personal network to suicide and losing other members of their wider network due to blame and differences in meaning-making.

A crucial next step in this area of research is to explore the experiences of social networks who are not of white ethnicity in order to understand whether conclusions drawn here are transferable to networks of people of other ethnicities. There is currently a dearth of research that captures the experiences of suicide bereavement in ethnic minority groups in European and North American countries, and as described in section 1.2.4, being of an ethnic minority can have a considerable impact on access to social support. A similar U.K.-based study to the one described in this thesis could be carried out, with qualitative interviews conducted with network members from ethnic minority groups, exploring both the support and change in relationships that occurred within groups, but also whether minority status had an impact on support outside the immediate network and whether cultural differences impacted on support or relationships within the group. Such a study could also examine whether formal support services such as bereavement-focused therapies are suited to those from ethnic minorities, and if not, how they can be adapted. This has been previously identified as a gap in grief literature (Ali, 2015).

Overcoming the barriers to involving ethnic minorities in research typically requires focused and pre-planned design and recruitment efforts, including working with community organisations (Waheed, Hughes-Morley, Woodham, Allen, & Bower, 2015). An effective approach to involving those from ethnic minorities who are bereaved by suicide could be to work to involve minority communities in the design, data collection and analysis of research (Bergold & Thomas, 2012). Involving "community researchers" (McQuiston, Parrado, Martínez, & Uribe, 2005) from the outset of a study would give ownership of this project to these communities, ideally increasing trust in the research and encouraging participation, as well as ensuring that research questions are

ones that are applicable to people in these communities, and that resulting data is interpreted in a way that is representative of their experience. There are a number of UK- based groups for ethnic minorities that are focused on mental health (including organisations involved in advertising the study presented in this thesis) who could be approached about facilitating involvement of community researchers for a new study. This study would need to factor in sufficient time and financial resources for training and supporting these researchers.

7.4.3 Formal support

Evaluation of formal support services would also be valuable. Given the current limited provision of support services in the UK and the reliance on third sector organisations, little is known about those who do and don't access support services and what services are effective in improving wellbeing. As peer support is a widely available support service in the UK and often believed to be effective by those who use it (Bartone et al., 2019; Maass et al., 2020), further evaluation should take place to ensure that it is structured in a way that it improves wellbeing safely and effectively. In the wider context of mental illness, it has been observed that peer support groups are typically not theory-driven or designed to achieve a particular goal and so their structure, content and mechanisms for positive change are not well-defined (Lloyd-Evans et al., 2014). Research could aim to explore and precisely describe which specific elements of suicide bereavement support groups do bring about benefits to wellbeing, and how they do so, in turn allowing for thorough evaluation of different models of peer support programmes.

7.4.4 Quantifying the relationship between social support and wellbeing

As discussed in Chapter 1 and 2, there is a general deficit of good quality longitudinal research that explores the relationship between wellbeing after suicide loss and social support, which should be a priority for quantitative research. More studies are required to quantify the directional relationship between social support and wellbeing, and to understand the mechanism by which it works. As my qualitative study illustrates, and as is noted in chapter 2, widely used quantitative measurement tools are often not sensitive to factors such as the timing or source of support. Self-report measurement tools that are able to capture variations in types of support and distinguish between functional and structural support (for example, the Coppel Index of Social support; Coppel, 1980), or perhaps tools similar to diagnostic clinical interview tools are likely to be the most appropriate for quantitative social support research.

7.4.5 Priorities for interventions

As described in chapter 1, postvention work is focused on reducing the resulting increased suicide risk for people bereaved by suicide, and so this is a key outcome in any intervention aimed at improving wellbeing in people bereaved by suicide. The systematic review presented in chapter 2 found studies frequently measured depression and PTSD and found high rates of both in participants bereaved by suicide, and so these are also important outcomes, particularly for any interventions based on social support.

Results of the review in relation to complicated grief were inconsistent. As this relatively new concept is becoming more widely recognised as a diagnosable disorder, and is one that relates to suicide loss in a different way compared to other types of loss (Tal et al., 2017), further research should aim to better understand the relationship between suicide loss and complicated grief. In particular, studies should focus on identifying factors that clearly decrease the risk or severity of complicated grief and understanding the mechanisms by which they do this. Despite the limited existing research on complicated grief, valid and reliable quantitative assessment tools exist to measure it as an outcome, such as the Inventory of Complicated Grief (Prigerson *et al*., 1995).

Findings from the qualitative study suggest that stigma could be a less important outcome than previously thought (Pitman et al., 2014), but other social outcomes such as loneliness or isolation could be important outcomes for intervention studies. It is plausible that the concern for other network members and the hypervigilance reported by a number of participants in this study would relate to anxiety, and studies have already shown that elevated anxiety is associated with suicide bereavement (Mitchell, Sakraida, Kim, Bullian & Chiappetta, 2009). Intervention studies could aim to explore, understand and then reduce the social anxiety related to a bereavement by suicide.

7.4.6 Understanding the impact of COVID-19

Finally, the current COVID-19 pandemic may have had an impact on suicide and the way social networks are able to grieve. Whilst data from the initial months of the pandemic suggests that suicide rates have not significantly increased in high income countries (John, Pirkis, Gunnell, Appleby, & Morrissey, 2020), the longer-term impact on suicide rates is still unclear, and studies show rates of mental distress have risen in connection to the pandemic and the restrictions in movement in place to stop the spread of the virus (Pierce, Hope, Ford et al, 2020). The economic impact of the pandemic may also increase suicide rates; this was the case during the last economic recession in 2008 (Barr, Taylor-Robinson, Scott-Samuel, McKee, & Stuckler, 2012; Chang, Stuckler, Yip, & Gunnell, 2013). Those bereaved by suicide during this pandemic will have had to cope with their loss without the usual social support available as a result of social distancing and quarantine measures that have been in place across much of the world. These measures, whilst necessary for public health, will have reduced the amount of social contact mourners are able to have and limited the ceremonies such as memorials and funerals that typically take place after a loss. They will have also negatively impacted on the formal support available (such as peer support groups unable to meet in-person). Researchers should work to understand the impact of these restrictions on the grieving processes, and whether they present an increased risk to wellbeing that can be mitigated either now or during potential future health crises.

7.5 Recommendations for practice and policy

Overall, the findings of this study show that the social landscape within which a death by suicide takes place and the social support that follows it, is extremely important to those who are bereaved and should be accounted for in clinical practice and policy decision-making.

7.5.1 Improved information and guidance

In this study, supporters felt ill-equipped to provide support in what was typically a novel situation, and many of the barriers and challenges to support seemed to relate to a lack of confidence in how to communicate and what action to take. Therefore, dissemination of information about how to interact with and support people bereaved by suicide is crucial, and psychoeducational resources for bereaved groups have already been shown to be effective (Dyregrov & Kristensen, 2020; Senneseth, Dyregrov, Matthiesen, Pereira & Hauken, 2019). My study can add to these existing resources by presenting evidence-based information designed to normalise and support individuals through the social experience of suicide bereavement. In Chapters 4 and 5, I noted the key results that could be translated into clear advice for people bereaved by suicide. These related to communication, support needs and the timing and type of support. In Chapter 7, I outline the process for developing a resource that focuses on communicating this information, aiming to prepare people bereaved by suicide for what may happen within their social network and advising on how to help their group through the experience using the results from this study.

7.5.2 Therapeutic interventions with an interpersonal focus

As described in chapter 1, therapeutic interventions for individuals bereaved by suicide have had mixed results (Andriessen, Krysinska, Hill et al., 2019). These interventions typically focus on the individual and don't account for the interpersonal challenges noted in this research, or the individual variance in support needs. Cognitive Behavioural Therapy-type interventions that help individuals understand their loss and the feelings of other network members could be valuable in alleviating distress. The results of this study identified a number of clear challenges to communication (such as mismatches in coping styles, concern about emotional burden, pre-emptive withdrawal from social contact) that therapists could work through with service users. Narratives of the loss and implicit hierarchies and roles could also be explored and challenged, increasing awareness of their benefits and challenges. This interpersonal focus could help participants come to terms with the subjectivity of their understanding of what happened and equip them to manage difficult social situations resulting from their bereavement.

One therapeutic intervention that may be particularly suited to suicide bereavement is Interpersonal Psychotherapy (Markowitz & Weissman, 2004). Results showed that groups coped well when individuals played different functionally supportive roles and collectively met the majority of each individual's needs, and significant fall-outs within the group were challenging. Interpersonal therapy is a brief intervention typically used to reduce depressive symptoms through resolving a key interpersonal issue (such as struggling with bereavement or a key familial relationship) in order to improve the individual's social life and help them cope with their depression. Given the social challenges of suicide bereavement, this type of therapy could be applied to individuals experiencing disharmony within their social network, or who were finding it difficult to access social support.

Alternatively, group therapy rather than individual therapy could be used to improve interpersonal relations within networks, focusing on relationships that have been negatively impacted by the loss. This could then improve the overall resilience of the network after a suicide loss (Kissane, Bloch, McKenzie, McDowall, & Nitzan, 1998). Family systems therapy, for example, focuses on treating the family as a single unit, and resolving issues within this context. This therapy is based on family systems theory (Broderick, 1993) in which families are seen as units in which individuals influence each other's behaviour. In a theoretical framework for clinical practice using a family systems perspective, Walsh and McGoldrick (1998) suggest three tasks for resolution of grief:
-Recognition of the loss, where emotions are shared and tolerated between family members.
-Reorganisation where the role of the person who died must be taken on by other family members and the family must generate a new sense of identity.
-Reinvestment of family members in the new family; finding a way to stay connected with the person who died whilst moving forward as a new family unit.
There are examples of each of these tasks present across this dataset, suggesting that families naturally attempt these tasks to varying degrees of success, and so expert support with these could be invaluable.

7.5.3 Improved access to formal support

As with any healthcare matter, public health bodies have a responsibility to help those bereaved by suicide. My study results illustrate the challenges that exist to social support and the potential isolation that can occur through blame or weakening of relationships after a loss to suicide.

Participants' experiences suggest that professional services in England may need to be improved, with a focus on improving access to early intervention and informational support. Whilst some NHS Trusts have programmes to support people who have been bereaved by suicide, and there are third sector organisations across the UK who have varying levels of local and national support services, there is no consistent care package available to UK citizens who lose a loved one to suicide. Government guidance exists that details best practice for suicide bereavement support, recommending a network of support from different organisations, but relies on third sector organisations which have limited capacity and reach, and on community groups not specifically designed for suicide bereavement support (Public Health England, 2016). Examples of good practice include third-sector organisations in Cornwall, Merseyside and Teeside who are able to offer practical and emotional support through signposting systems through coroners and the police. These services are typically evaluated positively, but struggle with low referral rates (National Suicide Prevention Alliance, 2018). Critically, Public Health England only provides guidance and examples of best practice for local authorities, rather than the training, funding and staff required to practically implement an evidence-based care package. In 2019, the government announced funding for suicide bereavement support services in England, intended to link in with local services (Department of Health, 2019). It is not yet clear if this money has been allocated, and there is continued reliance on third sector services who have inconsistent coverage across the UK, and different beliefs about best practice for support.

Creating a pathway to care that is consistently applied throughout the UK at an early point in bereavement (for example, GPs are informed of possible suicides and make contact with next of

kin, or funeral services signpost to healthcare services) would increase the number of people bereaved by suicide who had some contact or offer of professional support without having to seek it out. As a result, everyone in the country would have access to the same level of support and increase trust and awareness of this support would likely increase, as something was that consistently embedded in health care services. Follow-up contact 3-6 months after the bereavement, when those who are bereaved have begun to process the loss and when social support has waned, many be particularly helpful for those who would benefit from therapeutic interventions.

A consistent, national approach to suicide bereavement could also include a campaign to increase public awareness of suicide bereavement and the challenges it presents. The public resource proposed in the next section is aimed at helping social networks cope with their loss, but basic information for wider communities about how to sensitively acknowledge a loss and provide brief, basic support (for example for a colleague in the workplace) may increase confidence and decrease the passive stigma and avoidance that participants in my study experienced.

Although peer support groups are primarily run by charities, government-backed training for leaders of these groups in how to manage risk and moderate discussion could help to improve the quality of groups and ensure consistency across the country. As some participants did not use peer support groups due to their dislike of public speaking or group settings, it may be helpful to signpost them to online peer support forums. Using text-based communication allows for a greater level of anonymity and can be less intimidating than speaking in a group, as well as allowing for one-to-one conversations with others. Whilst limited existing research evaluates the merits of these forums for suicide bereavement and bereavement more generally, it does indicate that they are valued and beneficial to users (Bartone et al., 2019; Schotanus-Dijkstra et al., 2014).

7.5.4 Recommendations for professionals

The findings of this thesis have relevance for professionals, such as those working in frontline healthcare, policing or funeral services, who are likely to encounter people bereaved by suicide. Recommendations about proactive contact from healthcare professionals have been made in previous sections. This support should be offered not only to the immediate family of the person who died, but also to friends, partners and extended family; even though they are not at the top of the hierarchy of grief, their experiences in this study suggest that they may also benefit from formal emotional support. It could also be of value to identify the "coper" in an impacted network in order to provide them with any available practical help.

As professionals in the UK report low confidence in providing specific support for those bereaved by suicide (Foggin et al., 2016; Tiatia-Seath, Lay-Yee, & Von Randow, 2017), information after about how to support them should be provided by employing organisations. This may be as basic as awareness of resources that they can signpost to, or access to booklets such as "Help is at Hand" (a resource designed to help those bereaved by suicide, or who may be supporting someone bereaved by suicide; Public Health England, 2015) which they could disseminate, but

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could be as extensive as specialist training courses, such as the PABBS training that is offered privately to UK-based healthcare professionals (Suicide Bereavement UK, 2021).

I described in the section 7.5.2 options for therapeutic interventions that focus on interpersonal issues caused as a result of bereavement; any healthcare professional supporting somebody who is bereaved by suicide should be aware of the significant potential impact of the loss on the availability of their support network and signpost as necessary, either to peer support groups that can provide formalised social support, or to therapeutic services. Given the belief of participants in this study that suicide bereavement is unique to other types of bereavement and the preference to interact with others who have an understanding of suicide and suicide bereavement, it could be beneficial for counsellors or psychologists who can specialise in this area to make this clear to potential clients. For example, on the British Association for Counselling and Psychotherapy website, registered therapists are able to specify that they have expertise in bereavement; a small number of these specify expertise in suicide bereavement (British Association for Counselling and Psychotherapy, 2021). In section 7.4.5, I outlined some of the key outcomes for interventions aiming to reduce the negative impact of suicide bereavement, which clinicians should be aware of when supporting people who have been bereaved by suicide, in particular suicidal ideation, depression, PTSD, complicated grief, loneliness and related constructs, and anxiety.

7.6 Continuation of resource development

7.6.1 Future work

Within the scope of this PhD, it was only possible to set out an initial plan for the resource through carrying out some preliminary consultancy work and reflection on the real-life application of the results of the qualitative study.

This example content has been reviewed by three PPI group members, but does require more consultation and development. A full resource would contain several more vignettes representing different kinds of friend and family groups and circumstances (e.g. a group consisting of primarily friends rather than family, groups from ethnic minority backgrounds). The expectations and advice sections may require additional content; whilst the clearest and most consistent findings from my research are included, there may be other important changes or supportive acts noted in other research that could be added. Content may also need to be reframed depending on the specific focus for the resource that is ultimately chosen and edited for length, as it's possible that there is too much information here to be easily absorbed. In discussion with PPI group members, it was recognised that there must be a balance between being honest about the negative experiences people may have, and not presenting information that is overly daunting and discouraging. Whilst I attempted to strike this balance, it may be that further consultation reveals more about what information is appropriate and helpful, and what isn't.

Given the potential for this public resource to be a useful tool to the thousands of people across the U.K. who are bereaved by suicide each year, it felt prudent to plan on the resource being a project in its own right that deserved more time, funding, and external input than could be achieved within this PhD project. I have created demonstrative examples of resource content which have been reviewed by PPI group members, but content needs to be developed and reviewed further in order to be appropriate for public release. It is also important to note that this resource is not the only possible practical output from the data generated from this research. For example, there may be value in using it to create briefing documents for counsellors or GPs who come into contact with people bereaved by suicide, but typically don't have any specific training on what their unique needs may be.

Development and support is required in four key areas:

1. *Funding*

Additional funding is required to support the payment of individuals and organisations involved in the production and distribution of the resource. This could come from research funding bodies in the form of a postdoctoral grant to develop and evaluate the resource. Funding could also come from bereavement/mental health charities for this to either be an independent project, or a more collaborative endeavour in which they provide not only monetary funding, but also expertise, branding, and a platform through which to disseminate the resource.

2. *Consultation*

As described, some initial consultation has taken place. However, further input from postvention experts and experts in public resource design are required, and backing from a government body (such as Public Health England) or an appropriate charity would add legitimacy to the project. Consultation is needed with a number of groups; communication experts to advise on the presentation of the content, and both those with lived experience and government agency or third sector experts to advise on further development of the content and focus of the resource.

Given that my PhD project has been focused on involving those with lived experience at each stage of the project, I also believe it is important to co-produce this material with others who have been bereaved by suicide to ensure that it effectively meets needs. The co-production of services is widely accepted as good practice within mental health research and provision (Osborne, Radnor, & Strokosch, 2016) and given the lack of cultural diversity in the qualitative dataset, it is important that the content be reviewed by those with different cultural and religious backgrounds. The PPI group for this project was successfully recruited through social media, so this could be used form a new group for ongoing work, with parameters around recruitment to ensure more equal representation. Funding applications would include the cost of reimbursing PPI group members for time and expenses. Alternatively, funding bodies and universities (including UCL) often have separate funding pots available to support researchers in working with PPI groups.

3. *Design*

A professional designer is needed to ensure that the layout of the resource is engaging, accessible and appropriate to the subject matter being covered. Larger mental health and bereavement charities have in-house design teams who are often experienced at designing resources and could advise or carry out design work. Alternatively, it may be possible to collaborate with a postgraduate design student interested in working on the resource as part of a dissertation or coursework or in a voluntary capacity.

4. *Dissemination*

Given that this project has highlighted issues with access to formal support, it is important to have a platform through which the resource can be distributed widely and easily found. Hosting the resource on a public health or charity website that is well-known to the public and has a high volume of traffic would increase the chances of people finding the resource online. Large print runs of the physical resource would allow copies to be distributed directly to services, such as funeral homes, police departments and hospitals, where professionals are likely to have contact with people who have very recently been bereaved and can give them the resource. This would also give professionals who are not necessarily trained in bereavement support an easy tool with which to support their service users. Distribution could run directly through Public Health England or could be advertised to services through charity links, conferences, newsletters etc. who could then request copies.

Discussion is currently underway to explore possible collaborations with third sector organisations who could support development and dissemination of the resource. Additionally, potential sources of funding from research and health funding bodies are being identified as they become available and initial grant applications are being considered.

5. *Evaluation*

Quantitative evaluation of a resource for people bereaved by suicide would have considerable practical challenges. As a relatively rare and traumatic event, recruitment for studies would be difficult, and ethically challenging if participants had been very recently been bereaved. An existing suicide bereavement resource has been evaluated through individual interviews and focus groups (Hawton et al., 2012). A similar qualitative approach to evaluation could be taken with this resource. As ideally this resource would be offered to people bereaved by suicide by professionals

with whom they came into contact, permission could be sought on behalf of researchers for follow-up contact to be made several months after receiving the resource. Researchers could provide those willing to participate with a brief survey about the resource, examining the extent to which they had found it beneficial, with questions on topics such as the extent to which vignettes reflected their own experience, if they used any of the advice provided or if they felt it had made the changes in their networks easier to cope with. Follow-up qualitative interviews could then be offered to a subset of respondents, with researchers ensuring that they interviewed a balance of those who did and didn't find the resource beneficial. The resource could be appraised as "successful" if most questionnaire respondents found it beneficial to some extent, with qualitative data used to make further improvements to it.

Chapter 8: Conclusions

Overall, this project has shown that social support is an important tool in helping people by bereaved by suicide cope with their loss and that it is a complex interpersonal process. Support within social networks is impacted by and impacts on relationships within these groups, which often undergo changes in functioning after a loss to suicide. Guided by a PPI group throughout, this project has been centred on asking research questions that are relevant to the population, using sensitive research design, and producing results that are useful to those bereaved by suicide.

My systematic review of quantitative studies of social support after bereavement found that better perceived social support is associated with a reduced severity of negative wellbeing outcomes such as PTSD and depression. Considered studies of those bereaved by suicide alone, it illustrated that there is a comparative lack of knowledge in this area, but that there is a consistent positive association between support and improved wellbeing, with each of the four studies finding at least a partial positive association between the two.

To my knowledge, this project included the first study to examine the social impact of suicide bereavement, and the support processes that take place within friend and family groups. I used a novel method of analysis to examine the experiences of 26 participants across 13 different social networks, enabling me to account for multiple perspectives of bereavement experience from within a single social network, and to compare whole groups against other groups. Using a qualitative methodology illustrated the complexity of support not captured by quantitative measures of support and highlighted the importance of treating it as an interpersonal process. Results showed that social support must be highly individualised to be effective, as needs and preferences vary depending on personal coping styles, time since loss and who is offering the support. At the group level of analysis, it was found that groups, as a whole, naturally adapt to cope with a loss by assigning specific functions and roles to members, but that individual relationships are challenged by mismatches in narratives, support and communication which can have a lasting negative impact.

Further research must focus on a better quantitative understanding of the bidirectional relationship between social support after loss to suicide and wellbeing. It should also aim to explore the effectiveness of coping styles and how they relate to support needs, and to capture the experiences of participants not well-represented in my sample; ethnic minorities and partners and friends of the deceased. Results illustrate the potential value of therapeutic interventions focused on the group level, the potential value of safely-managed peer support and the need for additional informational support and public education about the experience of suicide bereavement.

The lack of consistent and easily accessible formal support services for those bereaved by suicide emphasises the need for effective informal social support to allow social network members to help each other cope with the loss in the absence of external support. The data produced in this study

allowed me to consider what issues were most prevalent for social networks dealing with suicide bereavement, and what information would be most useful to them. I concluded that it would be most helpful to create a text-based resource that would help individuals to normalise and recognise the impact of suicide loss on relationships within their social network as the qualitative study found that across groups there were numerous lasting positive and negative changes in relationships that were unavoidable but likely easier to cope with if they were prepared for and acknowledged.

A clear plan for further development of my public resource exists, and when complete, will be a practical application of these study findings that has the potential to help the large number of people bereaved by suicide in the UK each year.

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Appendices

Appendix 1: Published systematic review paper

[redacted]

Appendix 2: PRISMA checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	Under all sections, abstract
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	Paragraphs 4-5, introduction
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	Paragraph 6, introduction
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	Under "study selection", methods

Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	Under "study inclusion" and "study selection", methods
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	Under "study selection", methods
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Appendix 1
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	Under "study selection", methods
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	Under "study selection" and "data extraction", methods
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	Appendix 3
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	Under "quality appraisal", methods
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	-
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	Under "summary of findings", methods

Appendix 3: Search Strategy

MEDLINE

1. bereavement/
2. grief/
3. (bereave* or grief or griev* or mourn*)
4. widowhood/
5. (widow* or suicide survivor* or suicide loss*)
6. 1 or 2 or 3 or 4 or 5
7. Social support/
8. Social environment/
9. Social adjustment/
10. Financial support/
11. practical support* or financial support* or monetary support* or financial gift* or monetary gift*)
12. (emotional support* or psychological support*)
13. peer support* or informal support* or online support*)
14. (social support* or social adjustment* or social environment* or social network* or support system*)
15. Family/
16. Friends/
17. (friend* or companion* or relative* or famil*)
18. 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17
19. quality of life/
20. (well being or wellbeing or well-bring or quality of life or life satisfaction)
21. mental disorders/
22. exp mental disorders/
23. mental health/
24. exp mental health/
25. complicated grief or complicated grieving or prolonged grief or prolonged grieving)
26. Suicidal ideation/
27. Suicide, attempted/
28. (suicidal ideation or suicide attempt* or suicidal thought*)
29. Social isolation/
30. Social stigma/
31. Loneliness/
32. (isolat* or stigma* or loneliness or lonely)
33. 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 30 or 31 or 32
34. 6 and 18 and 33

Cochrane

"emotional support*" or "psychological support*" or friend* or companion* or relative* or famil* in Title Abstract Keyword OR "peer support*" or "informal support*" or "online support*" in All Text OR "social support*" or "social adjustment*" or "social environment*" or "social network*" or "support system*" in All Text OR family in Keyword OR friends in Keyword

CINAHL

TX ("practical support*" or "financial support*" or "monetary support*" or "financial gift*" or "monetary gift*" or "emotional support*" or "psychological support*" or "peer support*" or "informal support*" or "online support*" or "social support*" or "social adjustment*" or "social environment*" or "social network*" or "support system*" or friend* or companion* or relative* or famil*) AND TX (bereave* or grief or griev* or mourn* or widow* or "suicide survivor*" or "suicide loss*") AND TX ("quality of life" or well being or wellbeing or well-being or "life satisfaction" or "mental disorders" or "mental health" or complicated grief or "complicated grieving" or "prolonged grief" or "prolonged grieving" or "suicidal ideation" or "suicide attempt*" or isolat* or stigma* or loneliness or lonely)

IBSS

((bereave* OR grief OR griev* OR mourn* OR widow* OR "suicide survivor*" OR "suicide loss*") AND ("social support" OR "social environment" OR "social adjustment" OR "financial support" OR "practical support" OR "monetary support*" OR "financial gift" OR "monetary gift" OR "emotional support" OR "psychological support" OR "peer support" OR "informal support" OR "online support" OR "social adjustment" OR "social network" OR "support system" OR famil* OR friend* companion* OR relative*) AND ("quality of life" OR "well being" OR well-being OR wellbeing OR "life satisfaction" OR "mental disorders" OR "mental health" OR "complicated grief" OR "complicated grieving" OR "prolonged grief" OR "prolonged grieving" OR "suicidal ideation" OR "suicidal thought*" OR "suicide attempt*" OR "attempted suicide" OR isolat* OR stigma* OR loneliness OR lonely)) AND peer(yes) AND rtype.exact("Clinical Trial" OR "Clinical Trial, Phase I" OR "Controlled Clinical Trial" OR "Abstract" OR "Clinical Trial, Phase II" OR "Article" OR "Articles") AND stype.exact("Scholarly Journals")

Psychinfo

1.(TS= (bereave* OR grief OR griev* OR mourn* OR widow* OR "suicide survivor*" OR "suicide loss*")) *AND* **DOCUMENT TYPES:** (Article)

2. (TS= ("quality of life" OR "well being" OR wellbeing OR well-being OR "life satisfaction" OR "mental disorder*" OR "mental health" OR "complicated grief" OR "complicated grieving" OR "prolonged grief" OR "prolonged grieving" OR "suicidal ideation" OR "attempted suicide" OR "suicide attempt" OR "suicidal thought*" OR loneliness OR lonely OR isolat* OR stigma*)) *AND* **DOCUMENT TYPES:** (Article)

3. (TS=("social support*" OR "social adjustment" OR "social environment*" OR "financial support*" OR "practical support*" OR "monetary support*" OR "financial gift*" OR "monetary gift*" OR "emotional support*" OR "psychological support*" OR "peer support*" OR "informal support*" OR "online support*" OR "social network*" OR "support system*" OR famil* OR friend* OR comparison* OR relative*)) *AND* **DOCUMENT TYPES:** (Article)

4. 1 AND 2 AND 3

Appendix 4: Data extraction template

1. Reference

2. Title

3. Year

4. Country

5. Study type

6. Sample size

7. Sample demographics

8. Inclusion/exclusion criteria

9. Period of loss

10. Type of death

11. Social support measurement

12. Reference for social support validation

13. Type of social support measured

14. Length of follow-up

15. Analysis model used

16. Results

17. Evidence to support hypothesis (yes/no)

18. Reported limitations

19. Reported strengths

20. Limitations

21. Strengths

Appendix 5: Quality appraisal scales

5.1 NOS for cohort studies

Selection (one star per category)

1) Representativeness

a) truly representative of the average suddenly bereaved individual in the community *

b) somewhat representative of the average suddenly bereaved individual in the community *

c) selected group of users eg nurses, volunteers

d) no description of the derivation of the cohort

2) Selection of non exposed cohort (*excluded for use as non-applicable to this review*)

a) drawn from the same community as the exposed cohort *

b) drawn from a different source

c) no description of the derivation of the non exposed cohort

3) Ascertainment of exposure

a) secure record (eg surgical records) *

b) structured interview *

c) written self report

d) no description

4) Demonstration that outcome of interest was not present at start of study

yes . *

no

Comparability (two stars can be given here)

1) Comparability of cohorts on the basis of design/analysis

a) study controls for _____ (select the most important factor) wellbeing outcome at initial timepoint

b) study controls for any additional factor (criteria could be modified to indicate specific control for a second important factor.)

Outcome (one star per category)

1) Assessment of outcome

a) independent blind assessment

b) record linkage

c) self-report

d) no description

2) Was follow-up long enough for outcomes to occur?

a) yes (select an adequate follow up period for outcome of interest)

b) no

3) Adequacy of follow up of cohorts

a) complete follow up - all subjects accounted for *

b) subjects lost to follow up unlikely to introduce bias - small number lost - > _____ % (select an adequate %) follow up, or description provided of those lost) *

c) follow up rate < _____% (select an adequate %) and no description of those lost

d) no statement

5.2 Adapted NOS for cross-sectional studies

Selection

Representativeness of the sample
a) Truly representative of the average in the target population. * (all subjects or random sampling)

b) Somewhat representative of the average in the target population. * (non-random sampling)

c) Selected group of users.

d) No description of the sampling strategy.

Sample size (*operationalised as whether studies had carried out a power analysis*)

justified and satisfactory *

not justified

Non-respondents

a) Comparability between respondents and non-respondents characteristics is established, and the response rate is satisfactory. *

b) The response rate is unsatisfactory, or the comparability between respondents and non-respondents is unsatisfactory.

c) No description of the response rate or the characteristics of the responders and the non-responders.

Ascertainment of the exposure

a) Validated measurement tool. **

b) Non-validated measurement tool, but the tool is available or described.*

c) No description of the measurement tool.

Comparability (can get 2 stars)

The subjects in different outcome groups are comparable, based on the study design or analysis. Confounding factors are controlled.

a) The study controls for the most important factor (time since loss). *

b) The study control for any additional factor. *

Outcome

Assessment of the outcome

a) Independent blind assessment. **

b) Record linkage. **

c) Self report. *

d) No description.

Statistical test

a) The statistical test used to analyze the data is clearly described and appropriate, and the measurement of the association is presented, including confidence intervals and the probability level (p value). *

b) The statistical test is not appropriate, not described or incomplete.

Appendix 6: Ethics application

note to applicants: it is important for you to include all relevant information about your research in this application form as your ethical approval will be based on this form. Therefore anything not included will not be part of any ethical approval.

You should read the Ethics Application Guidelines and have them available as you complete this form.

APPLICATION FORM

SECTION A	APPLICATION FOR ETHICAL REVIEW: HIGH RISK

A1	Project Title: People bereaved by suicide and support from their family and friends: understanding social network interactions and their impact	
	Date of Submission:	Proposed Data Collection Start Date: 01/10/18
	UCL Ethics Project ID Number: 12381/001	Proposed Data Collection End Date: 01/10/20
	Is this application for continuation of a research project that already has ethical approval? *For example, a preliminary/pilot study has been completed and this is an application for a follow-up project? If yes, please provide the information requested below.*	
	Project ID for the previous study:	

A2	Principal Researcher	
	Please note that a student – undergraduate, postgraduate or research postgraduate cannot be the Principal Researcher for Ethics purposes.	
	Full Name: Brynmor Lloyd-Evans	Position Held: Senior lecturer
	Name and Address of Department: Division of Psychiatry	Email: b.lloyd-evans@ucl.ac.uk
		Telephone: 02076799428
		Fax:

Declaration To be Signed by the Principal Researcher

I have met with and advised the student on the ethical aspects of this project design *(applicable only if the Principal Researcher is not also the Applicant).*

I understand that it is a UCL requirement for both students & staff researchers to undergo Disclosure and Barring Service (DBS) Checks when working in controlled or regulated activity with children, young people or vulnerable adults. The required DBS Check Disclosure Number(s) is:

I have obtained approval from the UCL Data Protection Officer stating that the research project is compliant with the Data Protection Act 1998. My Data Protection Registration Number is: Z6364106/2018/08/99

I am satisfied that the research complies with current professional, departmental and university guidelines including UCL's Risk Assessment Procedures and insurance arrangements.

I undertake to complete and submit the 'Continuing Review Approval Form' on an annual basis to the UCL Research Ethics Committee.

I will ensure that changes in approved research protocols are reported promptly and are not initiated without approval by the UCL Research Ethics Committee, except when necessary to eliminate apparent immediate hazards to the participant.

I will ensure that all adverse or unforeseen problems arising from the research project are reported in a timely fashion to the UCL Research Ethics Committee.

I will undertake to provide notification when the study is complete and if it fails to start or is abandoned.

SIGNATURE: [signature redacted]   DATE:

A3	Applicant(s) Details *(if Applicant is not the Principal Researcher e.g. student details):*	
	Full Name: Hannah Rachel Scott	
	Position Held: PhD student	
	Name and Address of Department: Division of Psychiatry	**Email:** hannah.scott.17@ucl.ac.uk
		Telephone: 02076795240
		Fax:
	Full Name:	
	Position Held:	
	Name and Address of Department:	Email:
		Telephone:

		Fax:

A4	Sponsor/ Other Organisations Involved and Funding

Sponsor: ☒ UCL ☐ Other institution

If your project is sponsored by an institution other than UCL please provide details:

Other Organisations: If your study involves another organisation, please provide details. *Evidence that the relevant authority has given permission should be attached or confirmation provided that this will be available upon request.*

Funding: What are the sources of funding for this study and will the study result in financial payment or payment in kind to the department or College? *If study is funded solely by UCL this should be stated, the section should not be left blank.*

A5	**Signature of Head of Department** [or Chair of your Departmental Research Ethics Committee]

(This must not be the same signature as the Principal Researcher)

A. **I have discussed this project with the principal researcher who is suitably qualified to carry out this research and I approve it.**

I am satisfied that *[please highlight as appropriate]:*

(1) **Data Protection registration:**

- **has been satisfactorily completed**
- **has been initiated**
- **is not required**

(2) **a risk assessment:**

- **has been satisfactorily completed**
- **has been initiated**

(3) **appropriate insurance arrangements are in place and appropriate sponsorship [funding] has been approved and is in place to complete the study.** X **Yes** ☐ **No**

(4) **a Disclosure and Barring Service check(s):**

- **has been satisfactorily completed**
- **has been initiated**
- **is not required**

Links to details of UCL's policies on the above can be found at: http://ethics.grad.ucl.ac.uk/procedures.php

**If any of the above checks are not required please clarify why below.

This project will not involve any controlled or regulated activity with children, young people or vulnerable adults.

PRINT NAME:

SIGNATURE: DATE:

**It is essential that Sections B1 and B2 are completed in simple understandable lay language that a non-expert could understand or you risk your project being rejected

B1	Please provide a brief summary of the project in <u>simple lay person's prose</u> outlining the intended value of the project, giving necessary scientific background. *(max 500 words)*.

Postvention (reducing the risk of somebody dying by suicide as a result of being bereaved by suicide themselves) is a priority in the Government's national suicide prevention strategy. Being bereaved by suicide can have a negative impact on a number of different aspects of an individual's life and significantly increases the risk of them attempting suicide.

Whilst formal support is available for those who have experienced a loss to suicide, research shows that a fairly low proportion of those affected actually access this support, due to a lack of availability in practice, lack of knowledge of its existence or reluctance to engage with formal support organisations.

Therefore, it is crucial to consider and improve the social support (help provided informally by friends and family) available to those who are bereaved by suicide as this is the primary source of help that most people have access to. Social support is widely regarded in academic literature as being a buffer against the negative impact of stressful life events, but the limited research that specifically addresses the relationship between social support and suicide bereavement is less conclusive, likely because of the traditionally taboo nature and perceived stigma of the topic.

Previous research focuses primarily on a single person who has been bereaved and their perspective of received support, failing to take into account the experiences of the people who offer them the support. Given how challenging it is to talk about suicide and to cope with the aftermath, it is likely that both parties have difficulties in knowing how to communicate with the other, leaving the bereaved unable to ask for the support that will help them, and the supporter unclear as to how to help.

Ours is the only study that the researcher knows of that will ask for multiple different perspectives of the same event and analyse the data collectively to examine the contrasts and overlaps in people's opinions of what happened and how they felt about others' actions.

Exploring this topic qualitatively and gathering in-depth information about people's thoughts and feelings about their bereavement is the only way to gain a full understanding of what works best and what doesn't work when supporting people bereaved by suicide, and thus the only way to improve best practice.

| B2 | Briefly characterise in <u>simple lay person's prose</u> the research protocol, type of procedure and/or research methodology (e.g. observational, survey research, experimental). Give details of any samples or measurements to be taken *(max 500 words)*. |

Up to 40 participants will be recruited from up to 10 different social networks (groups of friends and family). Participants will either have been bereaved by suicide or be a friend to/family member of somebody who has been bereaved by suicide. Those who initially respond to advertisements will be invited to ask their friends and family to participate, who may also have been impacted by the same bereavement, or who didn't know the decedent but were a source of support for the individual who was bereaved. At least 2 people from each network will participate.

Each participant will take part in one face-to-face interview session with the researcher. First, the participant and researcher will spend time building rapport, giving the participant an opportunity to talk about their experience of bereavement. Participants will also provide age, gender and ethnicity data so that the researcher can draw conclusions about how representative the sample is of the general population.

Next, participants will complete a social network mapping exercise (appendix 1), based on the hierarchical mapping technique (Antonucci, 1986). Participants will be asked to create two hierarchical network maps: one representing the time period immediately before their bereavement (retrospective map) and one representing their current network (present-day map). On each map, participants will place stickers representing their 10 people from their personal network, with each of the 3 concentric circles representing a level of closeness. Once all the stickers have been placed, participants will be asked to note the type of relationship they have with each participant (e.g. colleague, friend, brother-in-law) and whether or not each person listed knew the decedent. This mapping exercise will enable participants to visually represent their network and consider it as a single entity, setting the tone for the interview.

An audio-recorded semi-structured interview will then take place (schedule attached as appendix 2) which will reference the maps as well as asking about changes in social networks, the interplay between formal and informal support and beliefs about how best to support others through bereavement. The researcher will follow the questions on the interview schedule and use prompts to help participants think about everything in depth.

Participants will be fully debriefed at the end of the session, provided with potential support resources and offered a follow-up contact if necessary. Participants will also be allowed to choose if they would like a copy of their de-identified transcript. These participants will be able to request the removal of any information from the transcript should they not want it to be published.

Interview data will be analysed qualitatively to identify themes from the data and any overlaps or contrasts between individuals and networks. Map data will be analysed to produce relevant quantitative data about participants' networks, such as size, closeness, differences over time, that will provide context for the qualitative data.

Attach any questionnaires, psychological tests, etc. (a standardised questionnaire does not need to be attached, but please provide the name and details of the questionnaire together with a published reference to its prior usage).

B3	Where will the study take place (please provide name of institution/department)?

If the study is to be carried out overseas, what steps have been taken to secure research and ethical permission in the study country?

Is the research compliant with Data Protection legislation in the country concerned or is it compliant with the UK Data Protection Act 1998?

The study will take place primarily at the Division of Psychiatry, UCL. Interviews will be conducted across England at participants' homes or public spaces of their choosing.

B4	Have collaborating departments whose resources will be needed been informed and agreed to participate?

Attach any relevant correspondence.

n/a

B5	How will the results be disseminated, including communication of results with research participants?

Participants will indicate on their consent form whether they wish to be contacted with the details of any publications the result from the study. Results are expected to be published in three forms:

As part of a PhD thesis which will be archived in the UCL open access repository upon completion.

As part of peer-reviewed publications in suitable academic journals. It is planned that these publications will be open-access.

As part of a free public resource designed to help family and friends support each other through a loss to suicide, based on the results of this study and other relevant research. This resource will be published online and offered to relevant suicide prevention charities to distribute across their networks if they wish.

Participants will be able to request that they be kept informed of publications. These participants will be sent a report at the end of the project including details of any publications that have been released at that time and details of where future publications are likely distributed.

B6	Please outline any ethical issues that might arise from the proposed study and how they are be addressed. *Please note that all research projects have some ethical considerations so do not leave this section blank.*

The sensitive topic of the study is considered, as it has the potential to cause distress to those participants who have been bereaved by suicide and are recalling their experience. A number of decisions have been made regarding the design of the study to ensure that participants are comfortable and to minimise the likelihood of distress. These decisions have been made with taking into account the literature about sensitive interviewing and input from a Patient and Public Involvement (PPI) group with lived experience of bereavement by suicide to ensure that best practice is employed. The PPI group also provided guidance during the development of the interview schedule and the mapping exercise.

10-15 minutes of rapport-building conversation will take place prior to the start of the interview. Conversation will be fairly relaxed to establish a level of familiarity and may not necessarily be related to the bereavement. However, part of this time will be an opportunity for participants to tell their story, if they wish, and to talk about the person they lost and their wider experience of bereavement, as previous research has indicated that participants find this to be a useful experience and value having the space to reflect on their thoughts and feelings about the person they lost and the circumstances of their death.

The researcher will manage the conversation to endure that the participant does not speak in-depth about topics related to the interview schedule and then have to repeat themself during the interview. The interview itself will last no longer than 90 minutes to prevent fatigue.

There will be an emphasis on confidentiality to reassure the participant that they can speak about sensitive issues knowing their friends and family members who are also participating will not be told of anything they have said. However, given the nature of the topic, there is a low risk that participants may disclose mental health problems or suicidal ideation that have safeguarding implications. If a participant indicates suicidal ideation or thoughts of harming self or others during the interview or any following communications, a risk protocol will be initiated (attached as appendix 3). In consultation with a supervisory clinician, a standard pathway will be followed to decide upon appropriate action.

SECTION C	DETAILS OF PARTICIPANTS

C1	Participants to be studied

C1a. Number of volunteers:	40
Upper age limit:	100
Lower age limit:	18

C1b. Please justify the age range and sample size:

The sample size is deemed to be appropriate given the broad scope of the study, taking into account the nature of the topic as well as the expected quality and richness of the data.

Adults of all ages will be invited to take part in the study. Age is an important factor in the qualitative and quantitative components of a social network and so it is important not to restrict to a certain age range.

C2	If you are using data or information held by a third party, please explain how you will obtain this. You should confirm that the information has been obtained in accordance with the UK Data Protection Act 1998.
	n/a

C3	Will the research include children or vulnerable adults such as individuals with a learning disability or cognitive impairment or individuals in a dependent or unequal relationship? ☐ Yes ☒ No How will you ensure that participants in these groups are competent to give consent to take part in this study? *If you have relevant correspondence, please attach it.*

C4	Will payment or any other incentive, such as gift service or free services, be made to any research participant? ☒ Yes ☐ No If yes, please specify the level of payment to be made and/or the source of the funds/gift/free service to be used. Reasonable travel costs will be reimbursed if participants have travelled to be at the interview. Please justify the payment/other incentive you intend to offer. Not paying for travel costs has the potential to deter low-income participants from being involved in the study and therefore bias the recruited sample.

C5	Recruitment

(i) Describe how potential participants will be identified:

Potential participants will self-identify as being bereaved by suicide (significantly impacted by the death by suicide of somebody they knew) or being friends with/related to somebody bereaved by suicide. The researcher will not make any judgements about inclusion based on their perception of the closeness of potential participants' relationship or the impact on suicide on them.

Once potential participants have approached the researcher about the study, a telephone conversation will take place to ensure that participants meet the other eligibility criteria for participation, listed below:

Inclusion:

Participants aged 18 years or above who have been bereaved by suicide or who have experience of supporting somebody who has been bereaved by suicide.

Participants who are in the same social network (group of family, friends, colleagues) as at least one other participant.

Exclusion

Participants who experienced bereavement by suicide under 18 months ago, or more than 8 years ago.

Participants who were bereaved when they were under 16 years old.

Participants who are unable to give their own consent for participation.

Participants who are currently participating in another research project related to their bereavement.

(ii) Describe how potential participants will be approached:

No cold calling will be made on the part of the research team: participants will initially respond to adverts (see below) and then snowball recruitment will be employed, with initial participants recruiting their friends and family. These secondary-recruited participants will either contact the researcher themselves or give written permission for the researcher to have their contact details and get in touch with them.

The potential social pressure of participants recruiting other participants is acknowledged, but any alternative is non-compliant with data protection laws. It will be made clear to participants that it is not their role to recruit their friends and family, simply ask if they are willing to speak to the researcher about potential involvement.

(iii) Describe how participants will be recruited:

Advertisements (example attached as appendix 4) will be placed in public spaces where advertising is permissible (e.g. library notice boards), on social media, shared through organisations focused on suicide prevention and through previous participants in related UCL research who have agreed to be contacted about future research.

Attach recruitment emails/adverts/webpages. A data protection disclaimer should be included in the text of such literature.

C6	Will the participants participate on a fully voluntary basis?	☒ Yes ☐ No

Will UCL students be involved as participants in the research project?   ☒ Yes ☐ No

If yes, care must be taken to ensure that they are recruited in such a way that they do not feel any obligation to a teacher or member of staff to participate.

UCL students may be involved in the study as it will be publicised on campus, but their participation will be as a member of the public rather than as a student.

Please state how you will bring to the attention of the participants their right to withdraw from the study without penalty?

The information sheet and consent form (appendix 5) both make it clear to participants that they are able to withdraw from the study with any negative consequences. This will be reiterated by the researcher when discussing the study with participants prior to the start of data collection.

C7 CONSENT

Please describe the process you will use when seeking and obtaining consent.

All potential participants will be given an information sheet (appendix 5) and have a phone conversation with the researcher before they are asked to consent to participation. Once potential participants have a good understanding of what the study entails, they will be provided with a consent form (appendix 5) and asked to sign a physical copy of this form at the start of the interview session, which will only proceed if participants agree to all conditions.

Consent to record and store special category data, namely ethnicity, is explicitly listed on the consent form. Participants will be enabled to choose to participate or not to participate entirely freely, and individuals who lack the capacity to consent for themselves will not be eligible for participation.

A copy of your participant information sheet(s) and consent form(s) must be attached to this application. For your convenience proformas are provided in Appendix I. These should be filled in and modified as necessary.

In cases where it is not proposed to obtain the participants informed consent, please explain why below.

C8 Will any form of deception be used that raises ethical issues? If so, please explain.

n/a

C9	Will you provide a full debriefing at the end of the data collection phase?	☒ Yes ☐ No

If 'No', please explain why below.

C10	**Information Sheets And Consent Forms: Appendix 5**

A poorly written Information Sheet(s) and Consent Form(s) that lack clarity and simplicity frequently delay ethics approval of research projects. The wording and content of the Information Sheet and Consent Form must be appropriate to the age and educational level of the research participants and clearly state in simple non-technical language what the participant is agreeing to. Use the active voice e.g. "we will book" rather than "bookings will be made". Refer to participants as "you" and yourself as "I" or "we". An appropriate translation of the Forms should be provided where the first language of the participants is not English. If you have different participant groups you should provide Information Sheets and Consent Forms as appropriate (e.g. one for children and one for parents/guardians) using the templates provided in Appendix. Where children are of a reading age, a written Information Sheet should be provided. When participants cannot read or the use of forms would be inappropriate, a description of the verbal information to be provided should be given. Where possible please ensure that you trial the forms on an age-appropriate person before you submit your application.

SECTION D: DATA STORAGE AND SECURITY

D1	**Will the research involve the collection and/or use of personal data?**
	
	☒ Yes ☐ No
	
	If yes, is the research collecting or using:
	
	   − **sensitive personal data as defined by the UK Data Protection Act (racial or ethnic origin / political opinions / religious beliefs / trade union membership / physical or mental health / sexual life / commission of offences or alleged offences), and/or**
	
	   − **data which might be considered sensitive in some countries, cultures or contexts?**
	
	If yes, state whether explicit consent will be sought for its use and what data management measures are in place to adequately manage and protect the data.
	
	Explicit consent will be sought to use special category data through the consent form. Digital data will be stored in the UCL data safe haven and physical data stored securely on the UCL campus. Any identifiable information will be deleted or destroyed at the end of the project

D2	<u>**During the Project**</u> **(including the write up and dissemination period)** **State what types of data will be generated from this project** (i.e. transcripts, videos, photos, audio tapes, field notes, etc). • Physical paper maps of participants' past and present social networks and demographic information. • Digital audio recordings of qualitative semi-structured interviews, used to create transcripts of interviews. **How will data be stored, including where and for how long?** This includes all hard copy and electronic data on laptops, share drives, usb/mobile devices. Identifiable audio files will be stored in the UCL Data Safe Haven. These files will be deleted at the end of the project. Pseudonymised transcript files will be encrypted and stored on the researcher's N drive on the UCL network. Paper copies of social network maps and demographics forms (appendix 1) will be stored in a locked cupboard which is accessible only to the researcher, in Wing B in the Division of Psychiatry (6th floor, Maple House) which has secure access points. These will be used to create anonymised aggregated social network and demographic data which will be digitised, encrypted and stored on the researcher's N

drive on the UCL network. Paper maps and forms will be confidentiality destroyed within 3 months of the interview date.

Upon project completion (expected March 2021), data will be archived at the UK Data Service according to guidance from the ESRC who are funding the PhD.

Who will have access to the data, including advisory groups and during transcription?

Members of the research team: the researcher and their primary and secondary supervisors, as well as the external transcriber will have access to all of the data.

Additional members of the supervisory panel and the PPI group will have access to the de-identified data.

D3	**Will personal data be processed or be sent outside of the European Economic Area (EEA)*?**
	If yes, please confirm that there are adequate levels of protection in compliance with the DPA 1998 and state what arrangements are below.
	*Please note that if you store your research data containing identifiable data on UCL systems or equipment (including by using your UCL email account to transfer data), or otherwise carry out work on your research in the UK, the processing will take place within the EEA and will be captured by Data Protection legislation.
	No

D4	**After the Project**
	What data will be stored and how will you keep it secure?
	Audio recordings and maps will be destroyed before the end of the project. Contact details for participants will be destroyed at the end of the project.
	Following guidance from the ESRC who are funding the project, de-identified data (transcripts and aggregated demographic and social network data) will be stored securely at the UK data archive. This data will be deleted from UCL drives.
	Where will the data be stored and who will have access?
	The de-identified data will be stored at the UK data archive (www.data-archive.ac.uk) and be accessible by registered users of the service.
	Will the data be securely deleted?

	If yes, please state when will this occur: Any data held on UCL storage facilities will have been deleted by 31/03/2021.

D 5	**Will the data be archived for use by other researchers?** ☒ **Yes** ☐ **No** If **Yes**, please describe provide further details including whether researchers outside the EEA will be given access. The UK data archive allows registered users from any country to access data deposited in their archive. Prior to depositing the data in the UK data archive, the researcher will agree controlled access conditions with the storage service to ensure that GDPR is not breached and personal data is not transferred outside of the EEA, and seek advice on the appropriate level of detail to be included in the deposited data.

SECTION E: DETAILS OF RISKS AND BENEFITS TO THE RESEARCHER AND THE RESEARCHED

E1	**Please state briefly any precautions being taken to protect the health and safety of researchers and others associated with the project (as distinct from the research participants).** A standard UCL lone worker policy will be employed when the researcher is conducting interviews off-campus. The researcher will work with a nominated line manager to ensure safety by providing them with the location of the interview and phoning them to check in and out at times of departure and arrival and the location. They will provide an estimate of what time they expect the interview to finish, and the line manager will take action if they have not called to confirm departure within an hour of that time. No more than two interviews will be scheduled per day to prevent fatigue, and the researcher will have the chance to debrief with a member of the team after any interviews that they may have found challenging.

E2	**Will these participants participate in any activities that may be potentially stressful or harmful in connection with this research?**	☒

Yes ☐ **No**

If **Yes**, please describe the nature of the risk or stress and how you will minimise and monitor it.

The focus of the interviews is participants' personal experience of bereavement by suicide and asks them to reflect on a difficult time, which has the potential to be a stressful or upsetting. Is it expected that this risk primarily relates to participants who knew the person in their network who died, and that there is a minimal risk of distress to the participants who did not know the person who died.

Participants will be reminded at the start of the interview that they can pause or stop the interview entirely at any stage if they wish.

The researcher is a trained Samaritan listening volunteer and is adept at having sensitive conversations and has extensive experience in talking to others about bereavement by suicide. Questions will therefore be asked sensitively, potentially stigmatising language will be avoided and empathy will be offered whilst maintaining a sense of professionalism. Members of the project's PPI group who have been bereaved by suicide have input on the interview schedule and mapping exercise to ensure that they are appropriate for people with similar lived experience.

The researcher will monitor participant's emotional responses to questions and offer the participant a break if they seem to be distressed.

Each participant will all fully debriefed at the end of the interview, and any participants who have been distressed during the interview will be offered a follow-up call the following day so that they can debrief further if they wish.

Further considerations relating to the sensitive nature of the study are listed in section B6 and E5.

E3	**Will group or individual interviews/questionnaires raise any topics or issues that might be sensitive, embarrassing or upsetting for participants?**

If **Yes,** please explain how you will deal with this.

Bereavement by suicide is deemed to be a sensitive topic and so there is the potential for the participants who have been bereaved by suicide to feel upset when thinking about their experience. Considerations referenced throughout this document are designed to minimise distress and safeguard against any negative outcomes should participation cause any upset.

E4	**Please describe any expected benefits to the participant.**

Prior to the semi-structured interview, participants will have the chance to talk about their experience and the person they lost, which is something commonly reported by those bereaved by suicide to be something that they value. Research into the experiences of individuals taking part in studies about their bereavement also finds that this is generally a positive experience and allows people to feel as though they have made a positive contribution towards helping others in the same position.

Participants will be able to choose if they wish to receive the resource or academic publications once they have been created, and to receive a copy of their interview transcript by post to reflect on.

E5	**Specify whether the following procedures are involved:**

Any invasive procedure(s) ☐ Yes ☒ No

Physical contact ☐ Yes ☒ No

Any procedure(s) that may cause mental distress ☒ Yes ☐ No

Please state briefly any precautions being taken to protect the health and safety of the research participants.

A risk protocol (appendix 3) has been developed with input from a practising clinician with experience in the field of suicide bereavement (Dr. Alexandra Pitman) which will be initiated if there is any cause for concern.

All participants will receive a list of contact details for organisations that can offer support (appendix 6) and a copy of Help is at Hand, a booklet developed to help those facing an unexpected loss. Participants will also be offered a follow-up call the day after the interview to check in on how they feel after the discussion.

Further considerations relating to the sensitive nature of the study are listed in section B6 and E2.

E6	Does the research involve the use of drugs? ☐ Yes ☒ No	

If **Yes**, please name the drug/product and its intended use in the research and then complete Appendix II

Does the project involve the use of genetically modified materials?   ☐ Yes   ☒ No

If **Yes**, has approval from the Genetic Modification Safety Committee been obtained for work?   ☐ Yes   ☐ No

If **Yes**, please quote the Genetic Modification Reference Number:

E7	Will any non-ionising radiation be used on the research participant(s)? ☐ Yes ☒ No
	If **Yes**, please complete Appendix III.

E8	Are you using a medical device in the UK that is CE-marked and is being used within its product indication? ☐ Yes ☒ No
	If **Yes**, please complete Appendix IV.

CHECKLIST

Documents to be Attached to Application Form (if applicable)	Tick if attached
Section B: Details of the Project	
• Questionnaire(s) / Psychological Tests	☒
• Relevant correspondence relating to involvement of collaborating department/s and agreed participation in the research i.e. approval letters to gatekeepers seeking permission to do research on their premises/ in their company etc.	☐

Section C: Details of Participants

- Parental/guardian consent form for research involving participants under 18 ☐

- Participant/s information sheet ☒
- Participant/s consent form/s ☒
- Advertisement ☒

Appendix : Information Sheet(s) and Consent Form(s) ☒

Appendix II: Research Involving the Use of Drugs

- Relevant correspondence relating to agreed arrangements for dispensing ☐
  with the pharmacy

- Written confirmation from the manufacturer that the drug/substance has ☐
  has been manufactured to GMP

- Proposed volunteer contract ☐
- Full declaration of financial or direct interest ☐
- Copies of certificates: CTA etc… ☐

Appendix III: Use of Non-Ionising Radiation ☐

Appendix IV: Use of Medical Devices ☐

Updated 17.10.2017

Personal network map (past)

Please place up to 10 people in the

circles.

Inner circle: those in your life who you

are closest to.

Middle circle: those who are not as

close but are still important to you.

Outer circle: those not already placed

but who are close enough that they

should be included in your

personal network.

ME

265
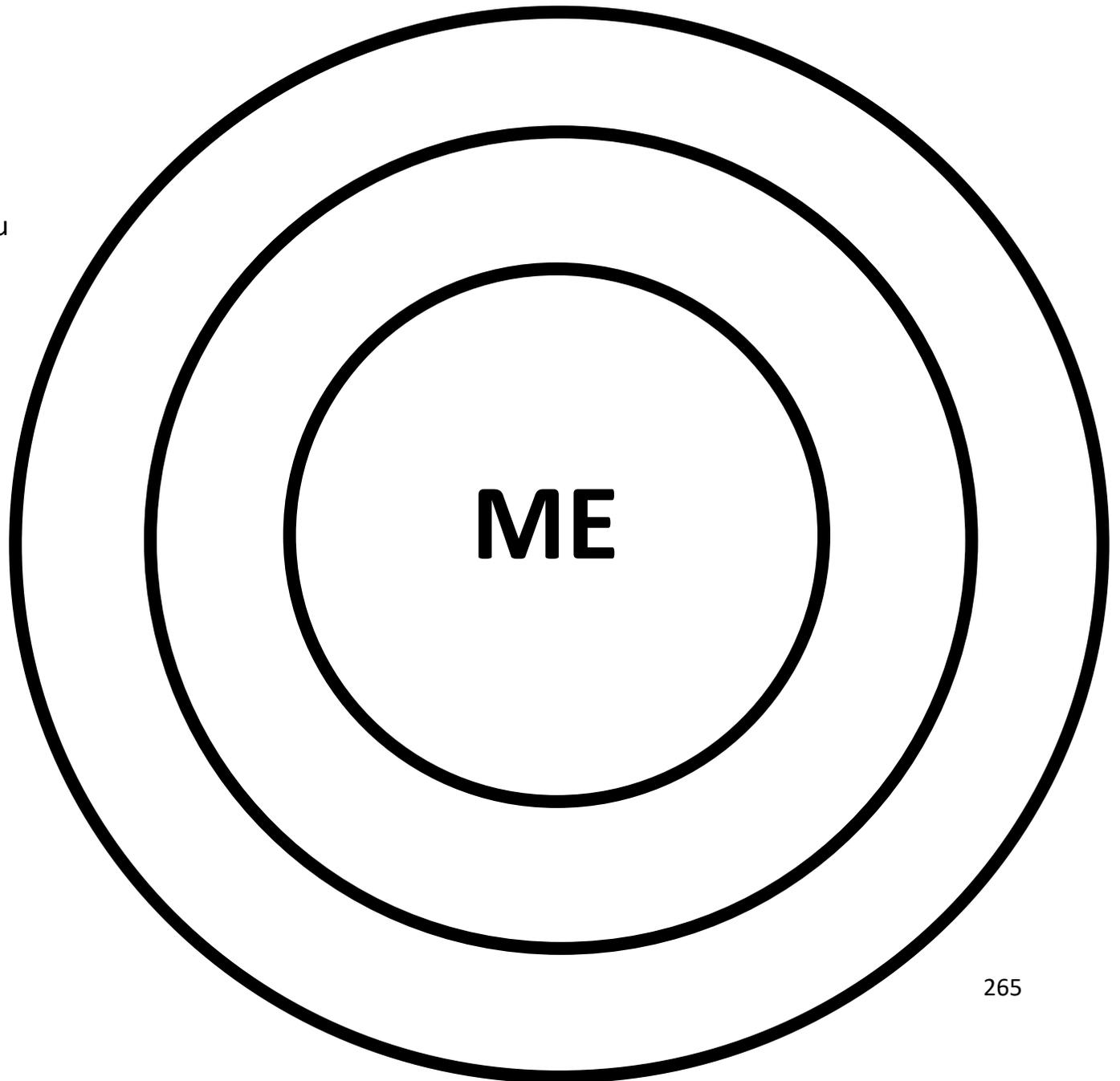
Personal network map (present)

Please place up to 10 people in the circles.

Inner circle: those in your life who you are closest to.

Middle circle: those who are not as close but are still important to you.

Outer circle: those not already placed but who are close enough that they should be included in your personal network.

ME
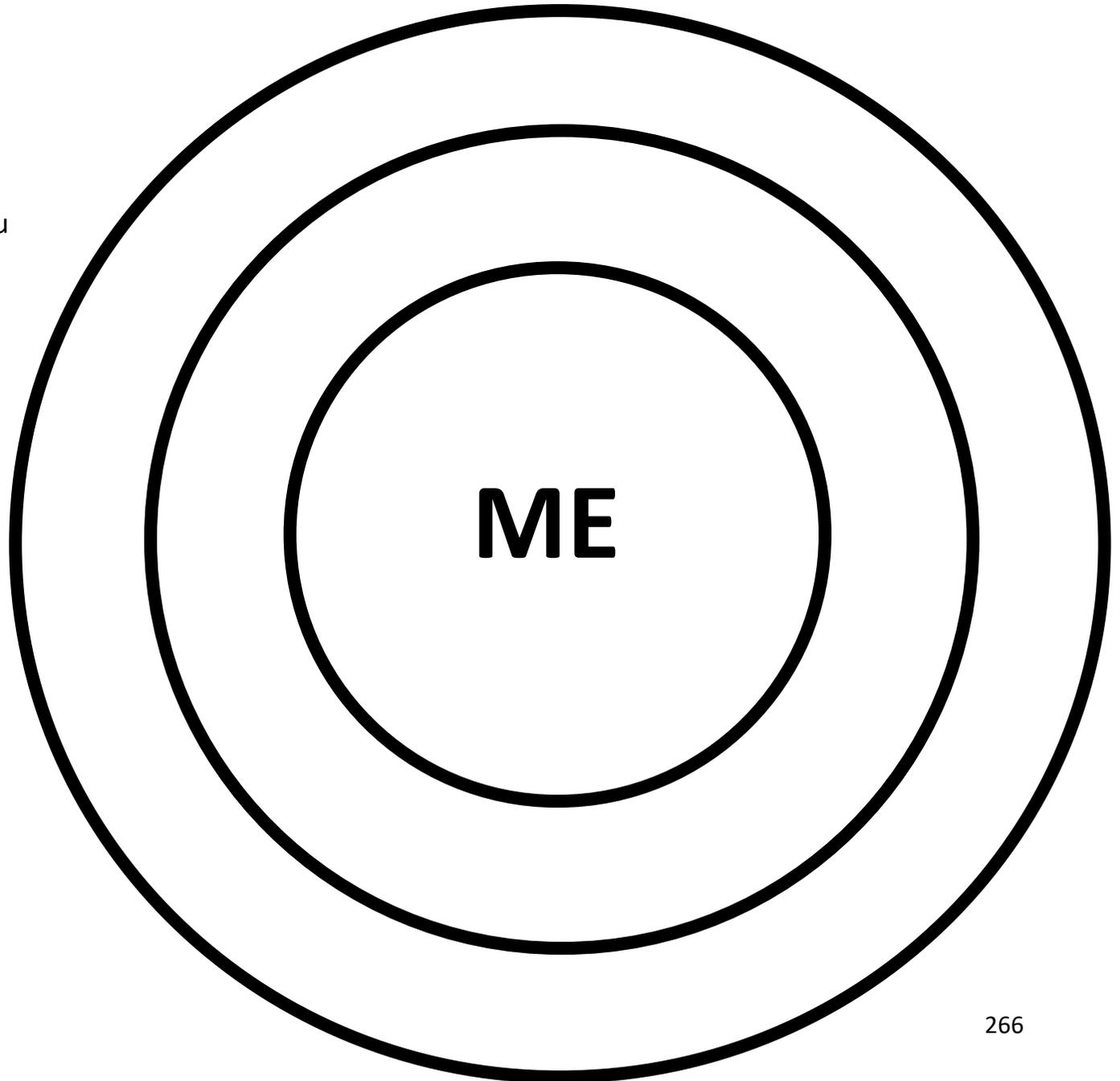
Participant ID: _____

Gender:_____

Age (years):_____

Ethnicity (*circle applicable group*):

White

Mixed/multiple ethic groups

Asian/Asian British

Black/African/ Caribbean/Black British

Other ethnic group

Interview Schedule

Some participants may not have known the person from their social group who died, or will have not known them well, so questions have been designed to apply to both people who have only offered support in this context and those who may have offered and received it.

Opening

The interview questions will be preceded by a period of rapport building and time spent drawing hierarchical maps. This time will not be audio recorded. Instead, when asking the questions below, information mentioned prior to the audio recording will be referred back to in order to provide context for the recording. The researcher will verbally confirm, or ask if it hasn't already been covered:

- Who it was the participant has lost to suicide.
- What their relationship with that person was.
- How long it has been since that person died.

The interview will also explain the concept of social support so that the participant is clear on what they are referring to throughout the interview. Example script:

"In this interview we're going to talk about social support. Social support is the help given to a person by their friends, family and wider community and can come in many different forms. Social support can be emotional (such as listening empathetically), tangible or practical (such as giving financial help, or helping with domestic tasks), companionship (such as shared social activities that make someone else feel included) or informational (such as giving advice) support.
  In this context, it might have been directly related to the bereavement (such as a family member helping with funeral arrangements) or indirectly related to the bereavement (such as a colleague helping with your workload while you took some time off)."

Questions

Questions marked with * will be skipped if the participant did not know the person in their network that died.

Understanding the participant's supportive relationships

1. Looking at the maps you drew earlier, there may be changes in who you've included in the past and present, and how close you feel to them. Could you tell me more about these changes?

> Prompts (*asked about each person in turn*):
>
> - Why do you think you and x might be closer/more distant?
>
> - What makes you feel closer to/more distant from x?
>
> - What made you realise you're not as close/closer to x now compared to before?

- How has your friend and family group changed as a whole since x died?

2. Thinking about each of the relationships that were impacted by the loss of X, could you tell me more about the support between the two of you?

Prompts (*asked about each person in turn*):

-Can you tell me more about the support you have given?

-Can you tell me more about the support you have received?

-Are there any experiences of support between the two of you that particularly stand out to you?

Differences in support

3.* What was the support like between you and those who did know x compared to the support between you and those who didn't know x?

Prompts:

- Did one group offer you more support than the other?

- If there were any differences in how you interacted with those who did or didn't know x, what were they?

- Did you feel more comfortable accessing support from one group more than the other?

-How did you talk to people about the support you each wanted?

4. Has the support between you and your friends and family changed since the first few days and weeks of the bereavement up until now? If so, how?

Prompts:

-What things do they do differently?

-When did you notice the change?

-Why do you think these things might have changed?

-Has the support changed in frequency?

-Do people offer different kinds of support now compared to previously?

-How do you feel about these changes?

Professional support

5.*After a bereavement, people often consider accessing formal support (such as counselling or peer support groups) to help them cope with the loss. If this was something you considered, can you tell me your thoughts about it?

Prompts:

-Was this something that was offered to you or that you sought out?

-What was it that caused you to think about getting formal support?

-What was it that made you decide to access it/not access it?

-What was appealing/unappealing about the service?

6. *How did the formal support you received influence the social support between you and your friends and family, it at all? (*skip if participant didn't access formal support*)

Prompts:

-Did it offer anything different to the support you were receiving from friends and family?

-Did it build on any aspects of support your friends and family gave?

-How, if at all, did it change the support you wanted from friends and family?

- How, if at all, did it change the support you offered to friends and family who have also

been impacted by the loss of x?

Perspectives on best practice for support

7. What help that you haven't received, if any, from friends and family during the bereavement would you like to have?

Prompts:

-Is there anything specific that you wish they did?

-Is there anything that somebody did that you wish more people had done?

-Is there anything you wished you had at particular time points in the bereavement?

8. Thinking about your experience, what do you believe are the best ways for friends and family to support each other through a loss to suicide?

Prompts:

-What are the things that helped you most?

-What are the things that helped you least?

-What would make it easier to offer support to friends and family who are bereaved?

-What advice would you give to other friend and family groups in the same position as you?

Closing

9. Is there anything else you haven't mentioned already that you think would be relevant, or anything you'd like to clarify or say more about?

Risk Protocol

If participants are deemed to be at risk due to suicidal thoughts, contact with the GP will be made following discussion and ideally with full consent from the participant. If the participant refuses permission for the researcher to inform the GP, then the researcher will immediately consult the Supervisory Clinician (XX) who will consider the participant's situation and, if necessary, assess the participant. If it is concluded that there is a significant risk, the participant's GP will be notified with or without the participant's consent. If the risk is severe and urgent, the Supervisory Clinician/researcher will contact the emergency services without first assessing the participant. In these cases, the decision will be explained to the participant as soon as possible.

It is explained to participants in the study's information sheet that the researcher may need to pass on information about potential risk of harm, and the consent form requests their GP contact information, so enacting this protocol would not be a surprise to participants. Researchers must initiate the risk protocol each time a participant expresses suicidal thoughts or thoughts of harm to self or others at any point of contact with the researcher.

Use of the risk protocol will be undertaken with appropriate supervision. The Primary Study Supervisor has overall responsibility for risk assessment and management for this study. The Primary Study Supervisor is responsible for:

    i)   ensuring that supervision for risk issues is accessible and readily available

    ii)   ensuring that any researchers involved in this study are adequately trained in the use of the risk protocol prior to participant contact

    iii)   ensuring that researchers are aware of who can provide supervision (i.e., the Supervisory Clinicians) and how supervisors can be contacted

Action

Before conducting the interviews, researchers should ensure that the contact details for Study Supervisors, Supervisory Clinicians and the participant's GP details are current.

Throughout the interview, the researcher will be aware of any indications of potential risk including suggestions that they may harm themselves or others, or indications that they are struggling to cope with their life, such as phrases like *"I'm not sure if I can cope any more"* or *"I wish it would all end"*.

If the researcher notices any of these indicators, they will pause the interview at an appropriate point and return to any comments made by the participant to explore them further. The researcher will ask appropriate questions to assess how immediate the risk is to the participant or others. This will involve assessing whether the participant has made any plans for action, and how immediate these plans are.

Appendix 3: Risk protocol

Example phrasing:

"I'm struck by how difficult you've found the loss of x. Bereavement, particularly bereavement by suicide can be really challenging to cope with, so it's understandable that you've been having some difficult thoughts. Earlier, you mentioned that *summarise what participant said*, could you tell me more about that?"

"You've spoken about your thoughts to harm yourself/somebody else; can I ask if you have made any plans to do so?"

"When have you thought you might do this?"

Depending on the participant's responses to the researcher's questions, one of three actions will be taken:

1. **If the participant has thoughts about harming themselves/somebody else but no plans:**

Non-urgent action will be taken.

The researcher will suggest that the participant contacts their GP and remind them of the list of support organisations that has been provided to them.

Example wording:

"From what you've said, it seems like you're finding it difficult to cope with your bereavement with the support you currently have. I'd recommend speaking to your GP about what's happened and how you're feeling so that they can arrange professional support for you, if it's appropriate and if that's what you want. At the end of the session, I'll give you a list of resources and charities who help those who have been bereaved; this gives you information about how you can access support groups, phone lines and online resources that you might also find useful."

2. **If the participant has significant plans to harm themselves/somebody else that are not immediate:**

Non-urgent action will be taken.

The researcher will explain to the participant they will pause the interview to confer with the supervisory clinician. They will then call the supervisory clinician to inform them of the situation and to confirm further action is appropriate. If the clinician believes contacting a medical professional is appropriate, the researcher will aim to gain the participant's permission before doing so but will make contact even without.

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If GP contact details are provided by the participant on the consent form, the researcher will call them. On telephoning, if the participant's GP is not available then the researcher should ask to speak to the duty doctor. If the participants' thoughts are about harming somebody else, the researcher will also call 101 (the non-emergency police phone line) to ensure they aware of the risk.

If no medical professionals at the practice are currently available, the researcher will call 111 (the non-emergency healthcare service line). The researcher should make it clear that no clinical risk assessment has been performed and that clinical responsibility for the study participants remains with the medical professionals.

If the participants' thoughts are about harming somebody else, the researcher will also call 101 (the non-emergency police phone line) to ensure they aware of the risk.

Example wording:

"From what you've said, it seems like you're finding it difficult to cope with your bereavement with the support you currently have. I'm going to make some phone calls to your GP to let them know how you are feeling so that they can arrange some help for you. I understand that this could be scary for you, but I will let you know what's happening as soon as I've spoken to them."

The risk protocol form (appendix 1) will be completed and stored securely to record that a risk protocol has been enacted.

3.   **If the participant has plans to harm themselves/somebody else that are immediate:**

Urgent action will be taken.

The researcher will explain to the participant they will pause the interview to confer with the supervisory clinician. They will then call the supervisory clinician to inform them of the situation and to confirm further action is appropriate. If the clinician believes contacting a medical professional is appropriate, the researcher will aim to gain the participant's permission before doing so but will make contact even without.

The researcher will call 999 to relay the information provided by the participant and act according to guidance from the emergency services. The researcher should make it clear that no clinical risk assessment has been performed and that clinical responsibility for the study participants remains with the medical professionals.

If the researcher is concerned about their personal safety, they will leave the location.

Example wording:

Appendix 3: Risk protocol

"From what you've said, it seems like you're finding it difficult to cope with your bereavement with the support you currently have. I'm going to make some phone calls to the emergency services to let them know how you are feeling so that they can arrange some immediate help for you. I understand that this could be scary for you, but I will let you know what's happening as soon as I've spoken to them."

The risk protocol form (Appendix 3.1) will be completed and stored securely to record that a risk protocol has been enacted.

Appendix 3: Risk protocol

Appendix 3.1: Risk protocol form

All risk clarification forms and correspondence relating to risk sent by research staff will be
checked by **Risk Clarification Form**

Date risk protocol enacted: **Participant ID:**

Risk Information:

Report which questions gave cause for concern and attach copy of risk assessment. Include
whether the participant has reported any of the following:

- *Current suicidal ideation*

- *Suicide plans*

- *Active preparations to take own life*

- *Plans to do harm*

- *Targeted individual*

Supervisor contacted: Y / N   **Date:**

Name of supervisor: **Time:**

Actions taken:

Appendix 3: Risk protocol

Additional relevant information:

Researcher Name: Date: Signature:

Supervisor Name: Date: Signature:

Appendix 4: Advertisement

[advertisement redacted]

Appendix 5: Information sheet and consent form

Participant Information Sheet For Adults

UCL Research Ethics Committee Approval ID Number: ___12381/001____

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: People bereaved by suicide and support from their family and friends: understanding social network interactions and their impact

Department: Division of Psychiatry

Name and Contact Details of the Researcher(s): Hannah Rachel Scott (Hannah.scott.17@ucl.ac.uk)

Name and Contact Details of the Principal Researcher: Dr. Brynmor Lloyd-Evans (b.lloyd-evans@ucl.ac.uk)

This study consists of interviewing groups of families and friends who have experienced a bereavement by suicide to help us understand how best people can support each other after a loss to suicide. This document provides an overview of what you would be asked to do if you participated, what measure we'd make sure you were comfortable at every stage of participation, and exactly how the data you provide would be stored and used. Please take as long as you need to read through it and ask the researcher if you have any questions. On the last page you'll see a diagram that summarises what will happen during the study and what will happen to the data you provide.

Invitation Paragraph

You are being invited to take part in a research project that forms part of Ph.D. Before you decided whether you would like to participate it is important that you understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether you wish to take part.

What is the project's purpose?

A large number of people in the U.K. are bereaved by suicide each year, and we know that it's a very difficult thing to cope with. A lot of people who have been bereaved by suicide might need some help to cope with their loss but don't access any formal support like therapy or support groups, and also can find it difficult to talk to friends and family members about how they're feeling.

Appendix 5: Information sheet and consent form

In this project, we want to better understand what the challenges are for groups of friends and family members who are experiencing a bereavement by suicide so that we can create guidance on how people can best help each other in this situation.

Why have I been chosen?

We want to interview people who have been bereaved by suicide, or who have experience of supporting a friend or family member who has been bereaved by suicide; you were approached to participate because either you have been bereaved by suicide, or you are close to somebody who has been bereaved by suicide

We will invite up to 9 of your other family and friends to be interviewed to represent the social network of the person you (or your friend/family member) lost to suicide. We are seeking to interview people from up to 10 networks: each with up to 10 family or friends of the person who died by suicide, or their family and friends.

If you have a friend or a family member who would also be interested in being involved in the study, we will ask you to invite them to participate as well; this is so that we can get a representation of your social network and compare people's experiences of the same loss.

For ethical reasons, we won't be inviting anybody who isn't able to give their own consent to take part, including children under the age of 18. We also won't invite people who have been bereaved for under 18 months to participate, or people who are currently participating in another research project about bereavement.

Do I have to take part?

It is entirely up to you to decide whether or not you want to take part and a decision not to take part would have no negative consequences. If you do take part, you will be asked to sign a consent form.

At any point, if you decided that you no longer wanted to participate, you could do so without having to give a reason and without it affecting any reimbursement offered. You would be asked what you wished to happen to the data that you had provided up to that point.

What will happen to me if I take part?

You will take part in one interview that will last no more than 90 minutes, where we will ask you about your experience of bereavement and about the support you gave to and received from your family and friends, and how your relationships have been impacted by the bereavement. We will also ask you to create two maps of your social networks to help you think about your relationships with the people you're close to. These interviews can either

take place in your own home, on the UCL campus where the research is based, or another quiet public space that you feel comfortable in. The interview will be audio recorded and these recordings will be transcribed and analysed along with the transcripts from other interviews so that we can draw from the collective information we have gathered.

We will be interviewing other people in your social group, but nothing you say will ever be repeated back to any other participant.

Even if one of your friends or family members is participating in this study, nothing you say will ever be repeated back to any other participant.

We understand that this can be a difficult thing to talk and think about and we will be sensitive. We are not here to judge you or to offer any advice, although we will provide you with information about support resources that you can access should you wish. The researcher interviewing you is experienced in having conversations about difficult topics and so will do her best to make you feel comfortable. She has been bereaved by suicide and so has a similar lived experience to the one you have faced.

Will I be recorded and how will the recorded media be used?

The interview will be audio recorded, so that the researcher can capture everything you say and transcribe this for data analysis. The audio recordings of your interview will be used only for transcriptions by either the research team or a professional transcriber.

 No other use will be made of them without your written permission, and nobody else will be allowed to access the original recordings. The recordings will be stored in the UCL Data Safe Haven and deleted within 3 months of the interview date.

What are the possible disadvantages and risks of taking part?

You will be asked to talk about your experience of suicide bereavement and its impact on your relationships with others. Sometimes this can be challenging to talk about in-depth and you may find it distressing to revisit some of the experiences that you've had. The interviews will be conducted sensitively, and you will be able to take breaks or stop whenever you wish.

At the start of the interview, we will provide you with contact details for organisations and resources that offer bereavement support for you to access if you wish, as well as a booklet called "Help is at Hand", a resource created to help those who have been bereaved by

suicide. You'll also have some time to debrief after the interview and have a number to call if you want to speak to the researcher about anything at a later date.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work and the information that you provide will improve the lives of others who are bereaved by suicide, by helping us understand what the best ways for people are to support their friends and families who have been bereaved by suicide. The information you give us will be the basis for peer-reviewed publications and conference presentations, which will inform the academic community and shape future research, and also be used to create a free public resource for anyone who has been bereaved by suicide.

Participants may also find it useful to have the space to talk about the person they lost and their experience of bereavement to help them reflect on their thoughts and feelings.

If any travel expenses are in incurred as a result of your participation, these will be reimbursed.

What if something goes wrong?

If at any point during or after your participation you feel uncomfortable with an aspect of your participation, you can talk to the researcher about it to try and find a resolution together.

If you wish to raise a complaint about something relating to your participation, you can do so by contacting Dr. Brynmor Lloyd-Evans (b.lloyd-evans@ucl.ac.uk). If your complaint has not been handled to your satisfaction, you can contact the chair of the UCL Research Ethics Committee (ethics@ucl.ac.uk).

If a serious incident happens during your participation or as a direct result of your participation, your researcher has guidelines on how to manage the safety of both of you. In case of serious emergency, you can call the emergency services on 999.

Will my taking part in this project be kept confidential?

Data will be collected and stored in accordance with the Data Protection Act 1998. The information you provide will be kept strictly confidential and be stored in compliance with the General Data Protection Regulation. Only members of the project team will have access to your data: the researcher, the project supervisors and the professional transcriber who is external to UCL but held to the same standards of data protection.

Appendix 5: Information sheet and consent form

When your audio recording is transcribed, your name and the names of other people you talk about will be replaced with a pseudonym (false name) and other identifiers will either be deleted or made to be less specific so that you aren't recognisable.

There is a small chance that you, or somebody who knows you well, might be able to recognise your quotes should they read them in a publication. For this reason, you'll be able to choose whether or not you're happy with short quotes being used for publication. You will also have the choice of whether or not you would like to read through the transcript once it has been completed to make sure that you are comfortable with what is written.

Transcriptions will be held in the UCL Data Safe Haven, and once the project is completed (October 2020), the transcription and digitised copies of the maps you've made will be securely archived at the UK Data Service.

Limits to confidentiality

Everything you say will be kept in confidence, unless you said something that made us worried about your safety or the safety of others; if this happened we might suggest that you seek support. If there were immediate, serious concerns about your or somebody else's safety, we might contact the appropriate services on your behalf even if we did not have your consent to do this. In any instance, we would make sure you knew that we were doing this.

What will happen to the results of the research project?

Once the data is analysed, it will be written as part of the researcher's PhD thesis, which will be publicly accessible once published at the end of the 2020. The study will also be written up for published in peer-reviewed academic journals during the project. You can choose whether or not you would like copies of these publications when they are completed.

Additionally, the information you provide will be used to create a free public resource aimed at groups of families and friends who have been bereaved by suicide and designed to help them support each other. You will not be identified in any report or publication.

Data Protection Privacy Notice

The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data and can be contacted at [data-protection@ucl.ac.uk. UCL's Data Protection Officer is Lee Shailer and he can also be contacted at data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk).

Appendix 5: Information sheet and consent form

Your personal data will be processed for the purposes outlined in this notice. The legal basis that would be used to process your personal data will be the provision of your consent. You can provide your consent for the use of your personal data in this project by completing the consent form that will be provided to you.

Your personal data will be processed so long as it is required for the research project, which ends in October 2020. We will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, please contact UCL in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

Who is organising and funding the research?

This research forms part of a Ph.D. project, sponsored by UCL. The project itself is funded jointly by the Economic and Social Research Council and the McPin Foundation.

16. Contact for further information

For further information, please contact Hannah via email at Hannah.scott.17@ucl.ac.uk or by telephone on 020 3108 4106.

Alternatively, you can contact primary supervisor Dr. Lloyd-Evans via email at b.lloyd-evans@ucl.ac.uk or by telephone on 020 7679 9428

Study flow

Recruitment

Potential participant responds to advertisement or is referred by a friend/family member.

Information sheet sent and screening telephone conversation carried out.

Potential participant eligible and willing to participate.

Potential participant excluded or declines to participate.

Participation

Audio recorded interview and social network mapping.

Analysis

Transcription and de-identification of audio recordings.

Anonymisation of map and demographic data.

Participants who opted in sent transcripts for review.

De-identified data is analysed.

Publication

Results published in academic journal.

Results published as part of PhD thesis.

Results used to create public resource.

Data storage

Contact details stored in data safe haven.

Potential participant eligible and willing to participate.

Potential participant excluded or declines to participate.

Contact details deleted.

Audio recordings stored in the data safe haven.

Paper maps, demographics and consent forms stored in locked cabinet on campus.

De-identified transcripts and anonymised map and demographic data stored in encrypted files on UCL N drive.

Audio recordings deleted and paper maps destroyed at the end of the project.

At project end, personal contact details deleted, de-identified data transferred to UK Data Service for long-term storage.

You will be given a copy of this information sheet to keep and a signed consent form to keep.

Appendix 5: Information sheet and consent form

Thank you for reading this information sheet and for considering participation in this research study.

Appendix 5: Information sheet and consent form

CONSENT FORM FOR ADULTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: People bereaved by suicide and support from their family and friends: understanding social network interactions and their impact

Department: Division of Psychiatry

Name and Contact Details of the Researcher(s): Hannah Rachel Scott (Hannah.scott.17@ucl.ac.uk)

Name and Contact Details of the Principal Researcher: Brynmor Lloyd-Evans (b.lloyd-evans@ucl.ac.uk)

Name and Contact Details of the UCL Data Protection Officer: Nicki White (n.g.white@ucl.ac.uk)

This study has been approved by the UCL Research Ethics Committee: Project ID number: __ 12381/001_____

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

Tick
Box

1. I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction and would like to take part in

   - *a social network mapping exercise*

   - *an individual interview*

2. I understand that I will be able to withdraw my data up to 4 weeks after my interview.

3. I consent to the processing of my personal information *(name, age, ethnicity, gender, audio recording of my interview, created maps)* for the purposes explained to me. I understand that such information will be handled in accordance with all applicable data protection legislation.

4. **Use of the information for this project only**

    Please tick each separate point below:

    (a) I understand that my data gathered in this study will be stored securely at UCL. Once my recording is transcribed, my name and those of others mentioned will be replaced with pseudonyms (false names). Other things that might identify me be will be removed or made to be less specific.

    (b) I understand that all personal information will remain confidential and all efforts will be made to ensure I cannot be identified, unless I disclose that I or somebody else may be at risk of serious harm, in which case information will be passed on to relevant agencies with or without my consent.

    (c) I agree for a pseudonym (false name) to be used in connection with any words I have said or information I have passed on, and for my data to be grouped with data from others in my social network.

    (d) I agree that for my audio recording to be transcribed by a professional transcription service that is held to the same rules of confidentiality as the research team.

    (*please select either e or f*)

(e) I agree to my pseudonymised data being used in publications to report general themes that have emerged from my interview, but not short quotes from my interview.

(f) I agree to my pseudonymised data being used in publications by the research team, which may include short quotes from my interview.

(*optional: if you would like a copy of your interview transcript, please tick below*)

(g) I would like to be contacted once my interview has been transcribed so that I can check it and confirm that I am comfortable with what has been recorded.

5. I understand that my information may be subject to review by responsible individuals from the University and the Economic & Social Research Council (study funders) for monitoring and audit purposes.

6. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. If I decide to withdraw, any personal data I have provided up to that point will be deleted unless I agree otherwise, and any agreed upon travel reimbursements will still be given to me.

7. I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.

8. I agree that no promise or guarantee of benefits have been made to encourage me to participate.

9. I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.

10. I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.

11. I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. Yes/No

12. I consent to my interview being audio recorded and understand that the recordings will be destroyed following transcription, and in that time will be stored securely and used only for this study.

13. I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.

14. I hereby confirm that:

    (a) I understand the exclusion criteria as detailed in the Information Sheet and explained to me by the researcher; and

    (b) I do not fall under the exclusion criteria.

15. I agree that my GP (if currently registered with one) may be contacted if there is concern that I am at risk of harm.
    Please write GP details below:

16. I am aware of who I should contact if I wish to lodge a complaint.

17. I voluntarily agree to take part in this study.

18. **Use of information for this project and beyond**

    All the data provided will be stored using UCL secure data storage facilities during the period of data analysis. Audio recordings will be deleted within 3 months of the date of interview and it is proposed that the anonymised transcripts and maps are archived in a secure storage facility at the UK Data Service. Anonymised and pseudonymised will published in a PhD thesis that will be stored in an open access repository.

    I would be happy for my data to be archived at the UK Data Service once the project has been completed. (*If you do not agree to this, your data will be destroyed upon project completion.)*

Appendix 5: Information sheet and consent form

I understand that other authenticated researchers will have access to my anonymised or pseudonymised data: these will be Dr. Brynmor Lloyd-Evans and Dr. Nicola Morant, UCL academics supervising the project.

If you would like your contact details to be retained so that you can be contacted in the future by UCL researchers who would like to invite you to participate in follow up studies to this project, or in future studies of a similar nature, please tick the appropriate box below.

Yes, I would be happy to be contacted in this way

No, I would not like to be contacted

_____   _____   _____

Name of participant   Date   Signature

_____   _____   _____

Researcher   Date   Signature

Where to get help coping with your bereavement

The resources listed below provide information and support for those experiencing bereavement, with some specialising in support for those bereaved by suicide.

U.K. Registered Charities

Support after Suicide Partnership

A partnership between a number of suicide prevention charities. Their website offers information about practical and emotional support as well as links to member organisations.

- Website: www.supportaftersuicide.org.uk

Cruse Bereavement Care

Offers support for those have been bereaved in any way. They run a variety of support services across the UK; specific details for each region can be found on their website.

- Website: www.cruse.org.uk
- Phone helpline: 0808 808 1677

Facing the Future

A service provided in partnership by Samaritans and Cruse that facilitates support groups across England and Wales for those bereaved by suicide.

- Website: www.facingthefuturegroups.org
- Phone: 020 8939 9560

Healthtalk.org

A website providing information about health issues, including videos of people talking about their experience of suicide bereavement, which can be found by typing "bereavement due to suicide" in the search bar.

- Website: http://www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics

The Compassionate Friends

Offers support for parents who have lost their child of any age, with specific resources for those bereaved by suicide. Runs online support forums, a helpline, and in-person support groups across the U.K.

- Website: https://www.tcf.org.uk/
- Phone helpline: 0345 123 2304

Samaritans

Offers a 24/7 emotional support service for people to talk about anything on their mind.

- Website: www.samaritans.org
- Phone helpline: 116 123
- Email support: jo@samaritans.org
- Text support: 077 2590 9090

Survivors of Bereavement by Suicide

Organises local support groups and a helpline during normal working hours for those bereaved by suicide.

- Website: www.uksobs.org
- Phone helpline: 0300 111 5065
- Email support: sobs.support@hotmail.com

International Support

International Association for Suicide Prevention

The IASP website can be visited to find information country-specific support by selecting "help" on the homepage and then "suicide bereavement".

- Website: https://www.iasp.info/

Formal Support

The British Association for Counselling and Psychotherapy

BACP has a website that allows you to search for registered therapists across the U.K. with its therapist directory.

- Website: https://www.bacp.co.uk

NHS

The NHS can provide mental health support; to find out more about this, call 111 or book an appointment with your GP

Appendix 7: Refining the Hierarchical Mapping Technique for use in this study

7.1 Rationale

Social network analysis [SNA] is a way of gaining a deep understanding of social groups; traditionally its main purpose has been to quantify social networks, but can also be used as a tool in qualitative investigations to prompt and structure conversations (Schepis, 2011). Hierarchical mapping technique [HMT; Antonucci, 1986] is a technique used in SNA, in which the participant places markers to represent members of their social network on three concentric circles indicating degrees of closeness. HMT has been used as an effective tool for both qualitative and quantitative research as it can be adapted to produce quantitative information about a social network, such as size, density and connectivity, or to elicit more explorative qualitative data (Reza, 2017; Webster, Antonucci, Ajrouch, & Abdulrahim, 2015).

HMT was chosen over other forms of social network analysis as it is a visual modification of the more traditional name generation exercise (where participants list people they know and then answer a set of questions about each) most commonly used in SNA. Banks (2018) argues that visual tools allow a participant to think about ideas that may be difficult to express verbally. So, the use of hierarchical maps allows participants to think about their relationships with others without having to attach verbal labels to them which may suggest a certain level of intimacy, such as "mother" or "colleague", both of which indicate very different levels of closeness that may not be representative of that individual's relationships with each.

For this study, it is proposed that each participant will create two maps: one based on the present, and one based on the past, prior to their bereavement to prompt them to think about how and why their network has changed since their loss. Several published studies have asked participants to draw two hierarchical maps to examine network change over time, and have found it be a reliable measurement tool, but have used longitudinal study designs and so the maps have been created at two separate time points (Ajrouch, Antonucci, & Webster, 2016; Julal et al., 2017). To the researcher's knowledge, no studies have asked people to create a retrospective map and so this method has not been validated.

Rather than relying on the maps as a quantitative data collection tool, the maps are will be used primarily as a way to get participants to think about their relationships with others in their network and to think about whether their suicide bereavement acted as a catalyst for strengthening or weakening relationships. Social network theories and empirical studies suggest that social networks are significantly altered by traumatic events and that certain characteristics of networks impact on an individual's ability to cope with the event (Hays & Oxley, 1986; Isaksson, Skär, & Lexell, 2005). It is hypothesised that there will be a considerable difference in the closeness of certain people's relationships before and after their bereavement due to the support that they felt they did or did not receive or the support that they felt they could or could not offer.

7.2 Development

An informal piloting process was used to arrive at the final version of the maps, to establish whether participants felt they were a useful tool in thinking about past and present social networks. Four separate friend groups participated in the pilot which was designed in the same way as Antonucci's original study with the researcher varying the number of years back the retrospective maps should be, and for two groups, asking them to compare the method against free-drawing a network.

In discussions about the technique, comments from the twelve participants indicate that the hierarchical maps are a valid way of collecting data and are perhaps easier than the free-drawing maps to complete. Participants did not find it difficult to understand the instructions or the concept of either map, although the free-drawing map did elicit more questions about how and where to place and connect people on the map. It took roughly 3-5 minutes to complete each map. Nobody found the exercise distressing or difficult and did feel that they had been able to accurately represent their friend and family group using the maps, although some had included family members out of a sense of obligation. Generally, it was not thought to be difficult to think back and complete retrospective maps and it was felt that the structured maps were easier to complete than free-drawing. The maps also confirmed there could be considerable variation in who was included in past and present maps, primarily for those who had experienced a significant life event during the time period.

Discussions with pilot participants lead to one change being made to the wording of the instructions. Originally, the inner circled was labelled as "those who you feel so close with that you can't imagine life without." Participants felt that this was insensitive phrasing given the topic of study, and so the label was changed to "the people in your life who you are closest to".

Appendix 8: Interview schedule

Some participants may not have known the person from their social group who died, or will have not known them well, so questions have been designed to apply to both people who have primarily offered support and those who have primarily received it.

Opening

The interview questions will be preceded by a period of rapport building and time spent drawing hierarchical maps. This time will not be audio recorded. Instead, when asking the questions below, information mentioned prior to the audio recording will be referred back to in order to provide context for the recording. The researcher will verbally confirm, or ask if it has not already been covered:

- Who it was the participant has lost to suicide.
- What their relationship with that person was.
- How long it has been since that person died.

The interview will also explain the concept of social support so that the participant is clear on what they are referring to throughout the interview. Example script:

"In this interview we're going to talk about social support. Social support is the help given to a person by their friends, family and wider community and can come in many different forms. Social support can be emotional (such as listening empathetically), tangible (such as giving financial help), companionship (such as shared social activities that make someone else feel included) or informational (such as giving advice) support.

In this context, it might have been directly related to the bereavement (such as a family member helping with funeral arrangements) or indirectly directly related to the bereavement (such as a colleague helping with your workload while you took some time off)."

Questions

Questions marked with * will be skipped if the participant did not know the person in their network that died.

Understanding the participant's supportive relationships

1. Looking at the maps you drew earlier, there may be changes in who you've included in the past and present, and how close you feel to them. Could you tell me more about these changes?

Prompts (*asked about each person in turn*):

- Why do you think you and x might be closer/more distant?

- What makes you feel closer to/more distant from x?

- What made you realise you're not as closer/closer to x now compared to before?

- How has your friend and family group changed as whole since x died?

2. Can you tell me about the support between you and your friends and family?

Prompts:

-Can you tell me more about the support you have given?

-Can you tell me more about the support you have received?

-Are there any experiences of support between the two of you that particularly stand out to you?

Differences in support

3.* What was the support like between you and those who did know x compared to the support between you and those who didn't know x?

Prompts:

- Did one group offer you more support than the other?

- If there were any differences in how you interacted with those who did or didn't know x, what were they?

- Did you feel more comfortable accessing support from one group more than the other?

-How did you talk to people about the support you each wanted?

4. Has the support between you and your friends and family changed since the first few days and weeks of the bereavement up until now? If so, how?

Prompts:

-What things do they do differently?

-When did you notice the change?

-Why do you think these things might have changed?

-Has the support changed in frequency?

-Do people offer different kinds of support now compared to previously?

-How do you feel about these changes?

Professional support

5.*After a bereavement, people often consider accessing formal support (such as counselling or peer support groups) to help them cope with the loss. If this was something you considered, can you tell me your thoughts about it?

Prompts:

-Was this something that was offered to you or that you sought out?

-What was it that caused you to think about getting formal support?

-What was it that made you decide to access it/not access it?

-What was appealing/unappealing about the service?

6. *How did the formal support you received influence the social support between you and your friends and family, it at all? (*skip if participant didn't access formal support*)

Prompts:

-Did it offer anything different to the support you were receiving from friends and family?

-Did it build on any aspects of support your friends and family gave?

-How, if at all, did it change the support you wanted from friends and family?

- How, if at all, did it change the support you offered to friends and family who have also been impacted by the loss of x?

Perspectives on best practice for support

7. What help that you haven't received, if any, from friends and family during the bereavement would you like to have?

Prompts:

-Is there anything specific that you wish they did?

-Is there anything that somebody did that you wish more people had done?

-Is there anything you wished you had at certain times in the bereavement?

8. Thinking about your experience, what do you believe are the best ways for friends and family to support each other through a loss to suicide?

Prompts:

-What are the things that helped you most?

-What are the things that helped you least?

-What would make it easier to offer support to friends and family who are bereaved?

-What advice would you give to other friend and family groups in the same position as you?

Closing

9. Is there anything else you haven't mentioned already that you think would be relevant, or anything you'd like to clarify or say more about?

Appendix 9: Risk protocol

If participants are deemed to be at risk due to suicidal thoughts, contact with the GP will be made following discussion with and ideally with full consent from the participant. If the participant refuses permission for the researcher to inform the GP, then the researcher will immediately consult the Supervisory Clinician who will consider the participant's situation and, if necessary, assess the participant. If it is concluded that there is a significant risk, the participant's GP will be notified with or without the participant's consent. If the risk is severe and urgent, the Supervisory Clinician/ researcher will contact the emergency services without first assessing the participant. In these cases, the decision will be explained to the participant as soon as possible.

It is explained to participants in the study's information sheet that the researcher may need to pass on information about potential risk of harm, and the consent form requests their GP contact information, so enacting this protocol would not be a surprise to participants. Researchers must initiate the risk protocol each time a participant expresses suicidal thoughts or thoughts of harm to self or others at any point of contact with the researcher.

Use of the risk protocol will be undertaken with appropriate supervision. The Primary Study Supervisor has overall responsibility for risk assessment and management for this study. The Primary Study Supervisor is responsible for:

iv)   ensuring that supervision for risk issues is accessible and readily available

v)   ensuring that any researchers involved in this study are adequately trained in the use of the risk protocol prior to participant contact

vi)   ensuring that researchers are aware of who can provide supervision (i.e. the Supervisory Clinicians) and how supervisors can be contacted

Action

Before conducting the interviews, researchers should ensure that the contact details for Study Supervisors, Supervisory Clinicians and the participant's GP details are current.

Throughout the interview, the researcher will be aware of any indications of potential risk including suggestions that they may harm themselves or others, or indications that they are struggling to cope with their life, such as phrases like *"I'm not sure if I can cope any more"* or *"I wish it would all end"*.

If the researcher notices any of these indicators, they will pause the interview at an appropriate point and return to any comments made by the participant to explore them further. The researcher will ask appropriate questions to assess how immediate the risk is to the participant or others. This will involve assessing whether the participant has made any plans for action, and how immediate these plans are.

Example phrasing:

"I'm struck by how difficult you've found the loss of x. Bereavement, particularly bereavement by suicide can be really challenging to cope with, so it's understandable that you've been having some difficult thoughts. Earlier, you mentioned that *summarise what participant said*, could you tell me more about that?"

"You've spoken about your thoughts to harm yourself/somebody else; can I ask if you have made any plans to do so?"

"When have you thought you might do this?"

Depending on the participant's responses to the researcher's questions, one of three actions will be taken:

4. **If the participant has thoughts about harming themselves/somebody else but no plans:**

Non-urgent action will be taken.

The researcher will suggest that the participant contacts their GP and remind them of the list of support organisations that has been provided to them.

Example wording:

"From what you've said, it seems like you're finding it difficult to cope with your bereavement with the support you currently have. I'd recommend speaking to your GP about what's happened and how you're feeling so that they can arrange professional support for you, if it's appropriate and if that's what you want. At the end of the session, I'll give you a list of resources and charities who help those who have been bereaved; this gives you information about how you can access support groups, phone lines and online resources that you might also find useful."

5. **If the participant has significant plans to harm themselves/somebody else that are not immediate:**

Non-urgent action will be taken.

The researcher will explain to the participant they will pause the interview to confer with the supervisory clinician. They will then call the supervisory clinician to inform them of the situation and to confirm further action is appropriate. If the clinician believes contacting a medical professional is appropriate, the researcher will aim to gain the participant's permission before doing so, but will make contact even without.

If GP contact details are provided by the participant on the consent form, the researcher will call them. On telephoning, if the participant's GP is not available then the researcher should ask to speak to the duty doctor. If the participants' thoughts are about harming somebody else, the researcher will also call 101 (the non-emergency police phone line) to ensure they aware of the risk.

If no medical professionals at the practice are currently available, the researcher will call 111 (the non-emergency healthcare service line). The researcher should make it clear that no clinical risk assessment has been performed and that clinical responsibility for the study participants remains with the medical professionals.

If the participants' thoughts are about harming somebody else, the researcher will also call 101 (the non-emergency police phone line) to ensure they aware of the risk.

Example wording:
"From what you've said, it seems like you're finding it difficult to cope with your bereavement with the support you currently have. I'm going to make some phone calls to your GP to let them know how you are feeling so that they can arrange some help for you. I understand that this could be scary for you, but I will let you know what's happening as soon as I've spoken to them."

The risk protocol form (appendix 1) will be completed and stored securely to record that a risk protocol has been enacted.

6. **If the participant has plans to harm themselves/somebody else that are immediate:**

Urgent action will be taken.

The researcher will explain to the participant they will pause the interview to confer with the supervisory clinician. They will then call the supervisory clinician to inform them of the situation and to confirm further action is appropriate. If the clinician believes contacting a medical professional is appropriate, the researcher will aim to gain the participant's permission before doing so, but will make contact even without.

The researcher will call 999 to relay the information provided by the participant and act according to guidance from the emergency services. The researcher should make it clear that no clinical risk assessment has been performed and that clinical responsibility for the study participants remains with the medical professionals.

If the researcher is concerned about their personal safety, they will leave the location.

Example wording:

"From what you've said, it seems like you're finding it difficult to cope with your bereavement with the support you currently have. I'm going to make some phone calls to the emergency services to let them know how you are feeling so that they can arrange some immediate help for you. I understand that this could be scary for you, but I will let you know what's happening as soon as I've spoken to them."

The risk protocol form (below) will be completed and stored securely to record that a risk protocol has been enacted.

Risk protocol form

All risk clarification forms and correspondence relating to risk sent by research staff will be checked by **Risk Clarification Form**

Date risk protocol enacted:	Participant ID:

Risk Information:

Report which questions gave cause for concern and attach copy of risk assessment. Include whether the participant has reported any of the following:

- *Current suicidal ideation*

- *Suicide plans*

- *Active preparations to take own life*

- *Plans to do harm*

- *Targeted individual*

Supervisor contacted: Y / N   **Date:**

Name of supervisor: **Time:**

Actions taken:

Additional relevant information:

Researcher Name: Date: Signature:

Supervisor Name: Date: Signature:

Appendix 10: Example coding

During the analysis process I kept notes of my development in thinking around codes and themes. In a recent paper, Braun and Clarke set out a range of procedural approaches to thematic analysis that exist; "coding reliability" in which the focus is on objective and deductive coding, "codebook", in which a structured coding framework and themes are developed early on in the analysis process, and "reflexive" in which analysis is entirely an interpretive reflexive process (Braun & Clarke, 2020). My approach had elements of both the "reflexive" and "codebook" approaches. Whilst I did develop a coding framework after an initial round of coding, this continued to develop throughout the analysis process as my interpretation of the data developed, particularly in the case of the more novel process of group-level coding.

The following is an excerpt from a single transcript (P1101) illustrating how transcripts were coded in the initial round of coding. This is followed by a description of the development of the codes that were included in this excerpt, providing examples of how initial codes developed and contributed to the final themes presented in the results sections of this thesis.

Transcript	Code
Well right after [youngest son] died, [eldest son] stayed with us but he wasn't in good shape for the first few days, he was in really bad shape. **Him and his girlfriend did a vigil**. So we're very close to him and we saw them a lot. Yeah and he's quite close to his mum. He's gone through a difficult time and he's in therapy. So yeah we talk to him a lot.	Commemorative acts
Then **he went through a phase of not wanting to come in the house. Didn't want to come to the house any more which was quite hard for us. And he used to walk out in the garden and he used to struggle with it. And he still says he feels uncomfortable in the house sometimes and I actually don't understand.**	Differences in coping
With [wife], we went through an interesting phase where we argued quite a bit to start with. I was quite angry with [decedent], a lot of the bad behaviour, we used to argue because she wanted to play that down and I thought we needed to acknowledge that he did all these bad things. And she didn't want to do that. I mean, I suppose we, we acknowledged the good times. She still gets upset, I think, acknowledging the good times.	Differences in coping
And I think for me, I think actually coming and being with those women [in a peer support group] was helpful because **those women were carrying the burdens, and they do. And that was the big learning for me, men don't carry the burden. Not in the same way, I mean I don't.**	Hierarchy of grief

I think were there things I could have done differently? Yes, definitely yes. There's things I could have done differently, were there mistakes I made? Yeah there was probably one thing, one day his behaviour was outrageous and I got very very angry with him and I wished I'd been able to handle it in a more balanced way. Yeah. But **I don't blame myself for it. Because I think at the end of the day he made choices.** He was an intelligent young man and he made choices and then I think "hang on a minute, when I was that age would I have done those things?" No I wouldn't.	Self-blame
But [wife] finds it more difficult so what I've learned to do is back off. **Initially I went "no [wife], for goodness sake he did this, he did that." and she was more defending him.**	Differences in coping
And that was in the first year **so I decided "ok just don't go there any more."**	Adapting behaviour in response to others
But what we do do is we have rituals, so we've got a candle. So, first of all, **we've still got all his clothes. And we've got things, we've got photographs of him and we've still got things around and his room, we've still got his clothes in the wardrobe.** We've refurbed it though, so we've had it redecorated and we'll put a new bed in it and we've re-done the bathroom that he used to use.	Similarities in coping
But we have rituals. So on his birthday we all celebrate his birthday. We always go away and on the anniversary of his death we go away, so we go somewhere nice, somewhere we think he would like and celebrate that.	Commemorative acts

Commemorative acts

This descriptive code was used at individual level to note any instances of commemoration by participants beyond the main funeral or memorial service. Initially, the intention was to capture different types of commemoration that participants engaged in. Once I had finished initial coding, I realised that these acts were so varied that they were difficult to categorise further, with the exception of one sub-code called "anniversaries", where I noted any of these commemorative acts that related to either death dates or birthdays, finding that these were very common across participant groups. I also realised that the temporal element was important; participants rarely talked about commemorations that happened soon after the loss, but as time went on they seemed to become more important and salient.

Differences in coping

This code was used in the group-level analysis to note when participants used coping techniques that were different to coping techniques used by other group members. This was coded in two ways; first when the difference was referenced explicitly by a participant, as it was in this case. Second, once I had familiarised myself with a group's transcripts, I coded for differences in coping techniques that I identified between participants. During the analysis process I realised that the way people dealt with the loss could be related to how well the group coped overall, and the harmony within groups. When I reviewed data under this code after the initial round of coding, I focused on the impact that differences in coping had on relationships and whether they caused tension, or whether they contributed to group harmony as members were filling different needs

for each other through their coping styles having noticed that these were common consequences across groups.

Similarities in coping

This code is the converse of "differences in coping", coded and used in the same way during the analysis process.

Hierarchy of grief

I initially used this interpretive individual and group-level code to capture any instance of a participant talking about somebody's grief being greater or lesser than another's. After coding a number of transcripts, I realised that there may be patterns to this ranking that related to kinship. Once initial coding of all transcripts was complete, I returned to the data under this code and labelled each quote with a kinship label (in this instance "mother's grief greater than father's") and through this established that there was a consistent hierarchy across groups, which became in an important theme in the results of the study.

Self-blame

From previous literature I was conscious that blame may be a prevalent issue for participants, so began the coding process at the group level using three distinct codes "blaming others", "being blamed by others" and "self-blame" as codes. After coding several transcripts, I noticed that very few participants talked about blame placed on themselves, so combined these codes and instead used "blame" to capture any references to blame. In describing the theme of blame, I ensured that I noted the relative absence of self-blame from the transcripts.

Adapting behaviour in response to others

Similar to "differences in coping", this group-level code contributed to my understanding of harmony, and was used to capture any instances where a participant described making changes to the way they behaved when interacting with others in reference to the loss, or others changing their behaviour around them. As I went through the initial coding process, I realised that there were consistent patterns of group members either avoiding conversation about the loss or withdrawing from typical emotional support as a way to protect others in the close personal network (contributing to the theme of burden of emotion), and increasing their "checking-in behaviour" with others in response to a concern about mental health (contributing to the theme of developing a new identity). Both of these were subsequently coded for.

Appendix 11: Case studies for groups with a single participant

[redacted]

Appendix 13: Reflections on my role as a qualitative interviewer researching a sensitive subject

At times I found that my role as an interviewer was challenging. As I volunteer for a charity delivering emotional support for people who are struggling, sometimes my initial instinct was to explore an aspect of their bereavement that wasn't relevant to the interview schedule, as this is what I had been trained to do. I had to get used to striking a balance between ensuring interviews would be a positive experience for a participant and making sure that I had drawn out useful data by the end of the interview. Ultimately, I believe that this volunteering experience was an advantage, as I was already comfortable with talking to relative strangers about challenging topics and creating supportive spaces in which people feel able to express themselves.

Most participants commented at the end of their interview that it had been therapeutic in some way, either because it had helped unpack feelings or bring new perspectives to light, or simply because it was a chance to talk in-depth about a person or an experience that they didn't often get the chance to speak about at length and feel listened to in the way that they had been during the interview. Whilst it was reassuring to hear that an interview had been a positive experience, I was always conscious not to give participants any false expectations of the interviews being like a therapy session and made it clear that I was speaking to them as a researcher. I found that participants were often quite vocal about wanting to help others with the same experience, and that participating in this research was one of the ways they could do that.

Similarly, I sometimes found the balance between allowing somebody to tell their story and managing the interview to follow the schedule difficult. Even with time spent prior to the interview talking about their loss in general, people often had a lot to say in interviews and would sometimes forget the question I'd asked in the process of telling a story or describing an experience. With such a sensitive topic where it felt particularly important not to dismiss any aspects of a participant's loss, I sometimes found it hard to interrupt and refocus participants and potentially lost out on relevant data because time had been taken up by talking about other things. Overall, however, it always felt more important to build rapport with the participant and give them the chance to express things that were important to them than to stay on track all the time and I was often surprised at how open participants were willing to be. There were also times when I could tell through speech and body language that participants were uncomfortable with the questions I were asking, although nobody ever explicitly stated that they didn't want to talk about something. In these instances, I felt it would be unfair to press them about an area they felt uncomfortable talking about, and again potentially lost out on relevant data.

I also had to ask questions that I sometimes felt might not land well. For the sake of being able to capture data and maintain confidentiality, I would sometimes ask questions that would be obvious to anybody with experience of suicide bereavement, or I would ask questions about things that another participant would have talked about (e.g., funeral arrangements) and I wondered if it made them doubt my experience as a researcher or ability to listen. It also meant that I would sometimes end up going over the same information twice from multiple interviewees.