

# **Cognitive availability of suicide following suicide bereavement**

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## Thesis Declaration Form

I 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:**

**Name:** Poppy Jones

**Date:** 14<sup>th</sup> June 2021

## Overview

Bereavement by suicide has a devastating impact on many people including the deceased's immediate and extended family, friends and colleagues. The overall focus of this thesis is on the impact a bereavement by suicide has on a loved one's thoughts about suicide, including their feelings towards potential methods. There is particular emphasis on the concept of cognitive availability in relation to suicide. The thesis is structured in three parts:

**Part one** presents a conceptual introduction focusing on suicide prevention by way of limiting physical access to means as well as limiting cognitive availability. From this, a gap in knowledge is identified in the way in which exposure to the suicide of a close contact impacts upon the cognitive availability of suicide and particular methods of suicide.

**Part two** presents an original empirical exploration of 20 individuals' thoughts related to suicide and methods of suicide having experienced a suicide bereavement. The results reveal that for many individuals the experience of being bereaved by suicide made suicide a legitimate option for themselves. Participants described a desire for reunion with the loved one, with suicide being a potential way of achieving this. However, there was an aversion to the method of suicide used by the loved one. The research was conducted as part of a joint project with another UCL clinical psychology doctoral candidate.

**Part three** provides a critical reflection on the process of conducting this thesis, including adapting to a new way of online working during the Covid-19 pandemic.

## Impact Statement

The findings from this thesis have utility across academic research and clinical practice domains.

Part one of this thesis illustrates the way in which both the media and past personal experience influence the cognitive availability of suicide. Although we know that suicide-bereaved individuals are at greater risk of attempting and dying by suicide, there has been much less research exploring what the impact, at the individual level, is of that bereavement, particularly on thoughts related to suicide and methods of suicide. The identification of this gap, combined with the findings from the empirical paper, may pave the way for more research being conducted focusing on understanding the relationship between suicide bereavement and the cognitive availability of suicide. This is necessary in order to formulate plans for how to appropriately support suicide-bereaved individuals and develop services that are informed by research.

Within clinical practice, in the first instance, this thesis demonstrates the need for practitioners to routinely inquire about the incidence of suicide bereavement related to both relatives and non-relatives. As it stands, assessments routinely ask, almost exclusively, about a family history of suicide but findings from this research and previous work suggest the impact of a suicide is more wide-reaching than just blood relatives. If relevant, the practitioner needs to sensitively and skilfully explore what an individual's responses and attitudes to suicide are following the bereavement. The findings from the empirical study suggest that these are very much idiosyncratic, and it is, therefore, the task of the clinician to attempt to understand the impact of the bereavement in order to appropriately and effectively respond to any risk issues that become apparent. Asking about a person's thoughts related to the deceased's method of suicide may facilitate the clinician putting in

place preventative measures, such as restricting physical access to particular means of suicide.

Dissemination of the empirical paper in a peer-reviewed journal will, hopefully, encourage dialogue between academics, clinicians and, importantly, the suicide-bereaved community. The early findings from part one of the thesis have been shared with professionals and service user representatives at an inner London child and adolescent mental health service. This created much discussion around a topic which frequently leaves clinicians feeling anxious.

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## **Part 1: Conceptual Introduction**

**A review of the literature describing suicide prevention  
approaches to limit cognitive availability and  
physical access to means**

## **Abstract**

Bereavement by suicide is a risk factor for suicidal ideation, suicide attempt and dying by suicide. Efforts have been made to address the factors that increase suicide risk.

Limiting physical access to means is the most effective intervention in the wider population.

However, much less focus has been placed on limiting the cognitive availability of suicide –

an individual's awareness of suicide as an option and knowledge of possible means of

suicide – in both the general population and the suicide-bereaved population. This

conceptual introduction will review the literature related to both limiting physical access

and limiting cognitive availability. A gap in knowledge related to how exposure to the

suicide of a close contact impacts on the cognitive availability of suicide is identified. The

introduction then considers how previous research has approached investigating

individuals' experiences, which informed the methodological approach of the related

empirical study.

## Introduction

Individuals bereaved by suicide are known to be at higher risk for suicide attempts and dying by suicide (Crosby & Sacks, 2002; Pitman et al., 2014; 2016). A key goal for professionals working with this group of individuals is to prevent such outcomes. While means restriction is an effective suicide prevention strategy, a distinction is made between restricting access to physical means and restricting cognitive access (or availability). There has been significant effort, and research, focused on restricting physical access, however, there has been less focus on limiting cognitive availability. Cognitive availability refers to an individual's awareness of suicide as an option and knowledge of possible means of suicide (Florentine & Crane, 2010). It is commonly influenced by two sources of information: media portrayals and knowledge acquired through personal past experience including exposure to others' suicidal behaviour (Biddle et al., 2012). There has been substantial research produced exploring the influence of the media on suicide, however, there has been far less research exploring, on an individual level, the impact that a bereavement by the suicide of a close contact has on subsequent thoughts about suicide and suicidal behaviour. This project, therefore, aims to investigate what impact a bereavement by suicide, including the method used, has on the nature of the bereaved person's thoughts about suicide. Qualitative interviews with individuals who have been bereaved by suicide will allow exploration of the impact. In turn, by furthering understanding of individuals' experiences, this research has the potential to facilitate provision of effective support to a vulnerable group.

This introduction will begin with an overview of suicide and suicide bereavement, detailing the impact that suicide bereavement can have on individuals and the proposed mechanisms that move an individual from suicidal ideation to suicidal behaviour. It will then

explore the literature related to suicide prevention by way of limiting physical access and cognitive availability.

## **Suicide**

### **Definition and epidemiology**

Across the world, approximately 800,000 people die by suicide each year, accounting for 1.4% of all deaths (World Health Organisation; WHO, 2016). Although suicide occurs throughout the lifespan, its incidence is particularly pronounced within those aged 15-29, where it is the second leading cause of death (WHO, 2016). Worldwide death by suicide occurs 1.8 times more often among males than among females (WHO, 2016), with estimates suggesting that for each suicide, 20 individuals attempt suicide (WHO, 2016), and an even higher proportion of people experience suicidal ideations (Borges et al., 2010; Nock et al., 2008). Notably, while men are more likely to die by suicide, women are significantly more likely to attempt suicide, which is often referred to as the gender paradox in suicide (Canetto & Sakinofsky, 1998; O'Loughlin & Sherwood, 2005).

In the UK in 2018, there were 6,507 registered deaths by suicide (Office for National Statistics, 2019). Understandably, an individual's choice of suicide method strongly influences whether their suicide attempt will be fatal. Hanging, strangulation and suffocation is currently the most common method employed by both men and women in the UK, with poisoning being the second most commonly recorded method of suicide (Office for National Statistics, 2019). Historically, self-poisoning has been the preferred method for females, however, since 2013, this has changed to hanging, suffocation and strangulation, with the gap between this method and poisoning widening further in 2018 (Office for National Statistics, 2019).

Following a death by suicide, there is a subsequent impact on those who have been bereaved. This ripple effect is discussed in more detail below.

## **Suicide bereavement**

### **Definition and prevalence**

Suicide bereavement describes the period of grief, mourning and adjustment following a death by suicide that is experienced by family members, friends, colleagues and any other contacts of the deceased who are affected by the loss (Pitman et al., 2014). Estimates for the number of people who will be immediately and intimately affected following a person's death by suicide ranges from six (Clark & Goldney, 2000) to 60 (Berman, 2011) to 135 (Cerel et al., 2019). This results in a population of between 4.8 million and 108 million people bereaved by suicide annually worldwide, and whose well-being, including their mental health, is impacted.

### **Impact of suicide bereavement**

Following a bereavement by suicide, those left behind often experience agonising questioning (van Dongen, 1990), increased rates of mental health problems including depression (Pitman et al., 2014) and post-traumatic stress disorder symptoms (Zisook et al., 1998), increased risk of psychiatric hospital admission (Pitman et al., 2014), as well as stigma, both from others (Jordan, 2001; Sheehan et al., 2018) and towards self (Morrish-Vidners & Dunn, 1988). They also experience social isolation (Jordan, 2001) and complicated grief responses (Jordan, 2008; Shear et al., 2011). Of particular significance is the fact that people bereaved by suicide are at higher risk themselves for suicidal ideation, formulating a

plan for suicide, attempting suicide, as well as being more likely to die by suicide (Crosby & Sacks, 2002; Pitman et al., 2014; 2016).

Given the significant number of people dying by suicide, as well as the known impact that a suicide bereavement has on those left behind, provision of support for people bereaved by suicide has become an important government priority, as reflected in the 2012 suicide prevention strategy for England (Department of Health, 2012). In order to support this, an important aspect has been to understand why people bereaved by suicide are at increased risk of engaging in suicidal behaviour themselves. A number of explanations have been hypothesised. Firstly, suicides are known to cluster in families with histories of psychiatric disorders and suicides, suggesting that genetic factors, as well as shared environmental factors may partly account for familial aggregation of suicide (Agerbo, 2003). Secondly, for non-relative aggregation, theories used to explain the increased risk of suicide include assortative mating (in partners; Agerbo, 2005), assortative relating (in friends; Joiner, 2003) and shared environments. Thirdly, across both relatives and non-relatives, the strain of being on suicide watch, exposure to social adversity and social modelling apply (Pitman et al., 2014). Fourthly, non-suicide specific factors following any form of bereavement are also relevant, including, but not restricted to, psychological distress and loneliness, financial difficulties and the potential for substance misuse (Stroebe et al., 2007). Lastly, social transmission of suicidal behaviour is also thought to contribute to risk of self-harm and suicide (Haw et al., 2013; Quigley et al., 2017; Sisask & Värnik, 2012). Linked to this is the idea of suicide suggestion – the effect that a role model’s suicidal behaviour has on an observer’s suicidality – which may educate individuals about novel ways of dealing with emotional distress, specifically by becoming suicidal (Abrutyn & Mueller, 2014).

## **Models of understanding suicidal behaviour**

A number of theoretical models exist to help researchers and clinicians understand suicidal behaviour, specifically what factors impact why people experience suicidal ideations and why only a small group then goes on to attempt, or die by, suicide. Two particularly influential models of suicidal behaviour and suicide are the Interpersonal Theory of Suicide and the Integrated Motivational-Volitional Model of Suicidal Behaviour.

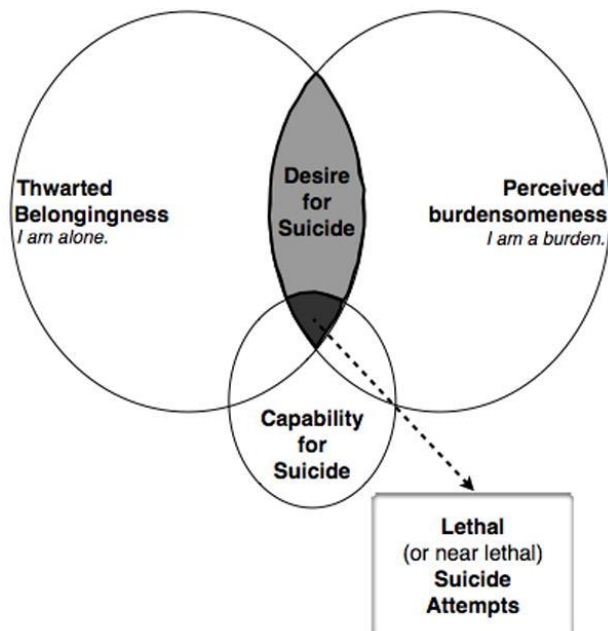
### **The Interpersonal Theory of Suicide**

The Interpersonal Theory of Suicide was originally developed by Joiner (2005) and presented in more detail by Van Orden and colleagues (2010). The theory provides an explanation for why the majority of people who have suicidal ideations do not go on to attempt suicide. It differentiates pathways between those individuals who have a desire for suicide but do not engage in suicidal behaviours from those that do engage in suicidal behaviour. With this in mind, Joiner's theory is the first theory of suicide within what has become known as the 'ideation-to-action' framework (Klonsky & May, 2014).

The Interpersonal Theory of Suicide attempts to integrate numerous psychological and social risk factors for suicide into a comprehensive theoretical framework. It proposes three components that together create the psychological context that leads someone to attempt suicide. A desire for suicide occurs when both thwarted belongingness and perceived burdensomeness are simultaneously present, but neither are sufficient to promote a suicidal act without the additional capability for suicide.



**Figure 1** Joiner, Van Orden and colleagues (2005; Van Orden, et al., 2010) *Interpersonal Theory of Suicide*



Thwarted belongingness describes a state when an individual's need for social connectedness and integration is unmet and is apparent when people feel lonely or socially isolated (Conwell, 1997; Trout, 1980) and in situations of family conflict (Brent et al., 1994; Duberstein et al., 2004; Waern et al., 2003). The other key interpersonal construct, perceived burdensomeness, refers to an individual's perception that they are a burden on those around them and that they are so flawed as to be a liability to others. This leads to beliefs related to others being better off if they were dead. Observable indicators of this construct include the distress associated with unemployment (Lester & Yang, 2003), incarceration (Fazel et al., 2008) and serious physical illness (Whitlock, 1986), as well as low self-esteem (Chatard et al., 2009).

Crucially, Joiner suggests that a desire to die is insufficient for lethal suicidal behaviour because in order to die by suicide an individual must lose some of the fear associated with suicidal death by overcoming an inbuilt self-preservation tendency. This is

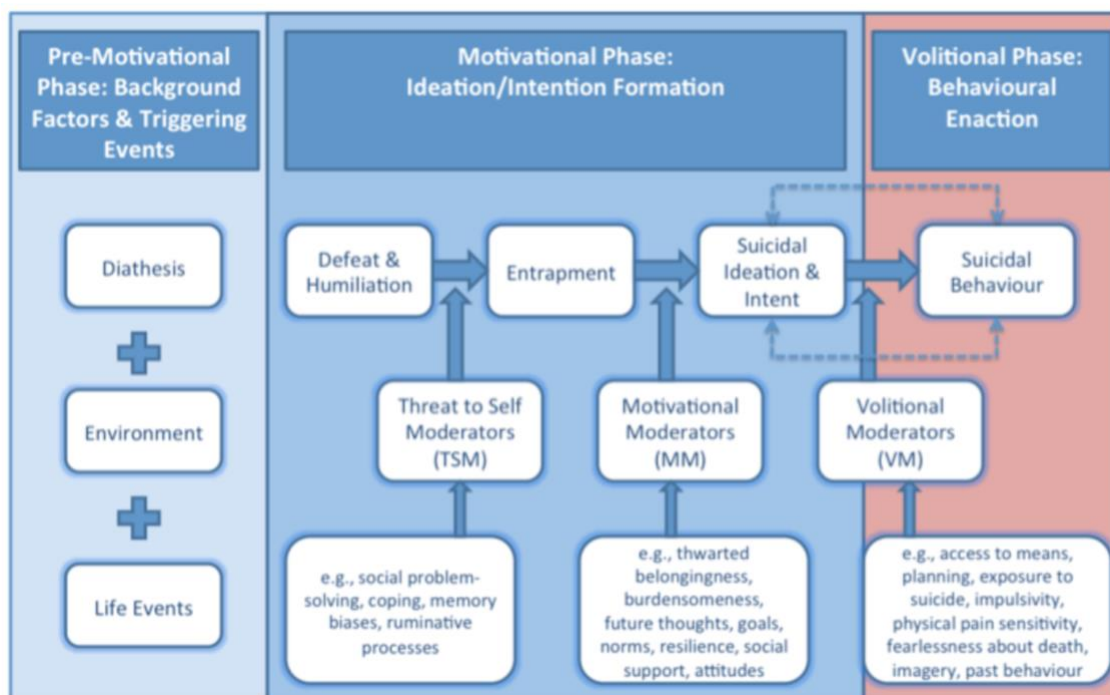
accounted for by the construct of acquired capability for suicide. Joiner suggests that there are two necessary components in order to acquire capability: increased tolerance to physical pain and reduced fear of death. These are achieved by habituating to repeated exposures to physically painful and/or fear-inducing experiences, such as combat exposure, self-harm, the experience of others' deaths and repeated suicide attempts. Importantly, exposure to others who have engaged in suicidal behaviour may also trigger habituation to the fear of suicidal behaviour, therefore explaining clusters of suicide as a consequence of elevated acquired capability. Accordingly, it is the combination of thwarted belongingness, perceived burdensomeness and acquired capability that culminates in an individual being able to make a lethal suicide attempt.

### **The Integrated Motivational-Volitional Model of Suicidal Behaviour**

O'Conner and Kirtley's (2011; 2018) Integrated Motivational-Volitional Model of Suicidal Behaviour incorporates exposure to suicide as one of the volitional moderators that is proposed to enable the transition from suicidal ideations to suicidal behaviours. This model (see Figure 2) proposes three phases to the development of suicidal behaviour, beginning with the pre-motivational phase which emphasises distal risk factors such as biological vulnerability and environment. The next phase – the motivational phase – emphasises more proximal risk factors such as defeat and entrapment, and these, together with motivational moderators such as thwarted belongingness and burdensomeness, similar to those identified by Joiner, can lead an individual to develop suicidal ideations. Similar to Joiner and Van Orden's model (2005; 2010), O'Conner and Kirtley's model is also consistent with the ideation-to-action framework (Klonsky & May, 2014), and suggests a number of volitional moderators which facilitate the transition from ideation to suicidal behaviour (the

final phase). These include access to means, planning, exposure to suicide, impulsivity, physical pain sensitivity, fearlessness about death, imagery and past history of self-harm or suicide attempts.

**Figure 2** O'Connor and Kirtley's (2011; 2018) Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour



While there are numerous models for understanding suicide, two of which have been discussed here, the Interpersonal Theory of Suicide is most relevant to this thesis due to the central importance of acquired capability.

### Suicide prevention

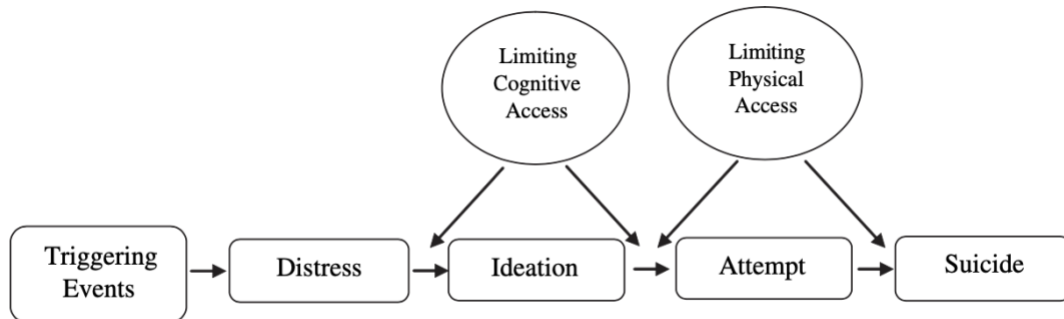
Given the significant number of people dying by suicide, as well as the known impact that a suicide bereavement has on those left behind, suicide prevention, specifically

postvention (an intervention conducted after a suicide), represents a major public health concern and an important government priority (HM Government, 2019).

While many treatments for suicidality occur at an individual level in the context of individualised care planning, some key approaches that carry much evidential support for their effectiveness occur at the population level. Education for primary care physicians around the assessment and management of depression has been associated with increased identification of individuals who are experiencing suicidal ideations, as well as a reduction in suicide rates (Mann et al., 2005). Programmes within schools focused on increasing students' knowledge about suicidal behaviour and related antecedents have also shown promise in increasing such knowledge and decreasing suicidal ideations, although there is no evidence yet of a decrease in suicide rates (Cusimano & Sameem, 2011). Means restriction is another approach which can be implemented at community and national levels and aims to reduce access to high-lethality means of suicide. It is currently one of the key elements of the National Suicidal Prevention Strategy for England (Department of Health, 2002), and research evidence shows this to be the most effective and wide-reaching suicide prevention approach (Klonsky et al., 2016).

A key distinction in means restriction is made between efforts to limit physical access to suicide methods and those that attempt to reduce the 'cognitive availability' of suicide (i.e., an individual's awareness of suicide as an option and knowledge of possible means of suicide; Florentine & Crane, 2010). Figure 3 below illustrates the proposed timing of both of those interventions. Each of these will be discussed in turn, beginning with limiting physical access.

**Figure 3** Florentine and Crane's (2010) points of intervention between stages in the suicidal process



**Fig. 1.** Points of intervention between stages in the suicidal process.

### **Limiting physical access**

#### *Defining limiting physical access*

Limiting physical access to suicide methods refers to how easily an individual can physically acquire the means to end their life. England's National Suicide Prevention Strategy (Department of Health, 2002) identifies a number of methods which are amenable to intervention including reducing ligature points for hanging and strangulation within psychiatric inpatient and criminal justice settings, access to medications commonly used for self-poisoning, accessibility of high-risk locations such as bridges, and high-rise car parks and buildings, and rail networks.

#### *Physical availability*

Preferred suicide methods vary between countries, in part, due to physical availability of means but also due to the acceptability of a given method within a culture. For example, firearm suicides are common in the United States, jumping from a tall building

in Hong Kong and ingestion of pesticides in Asian countries. Generally, in countries where it is common to have a firearm stored in a private residence, suicide rates using a gun are more prevalent (Ajdacic-Gross et al., 2006; Miller et al., 2007). In line with this, when laws restricting access to handguns are implemented (e.g., waiting periods, permit requirements, background checks and use of gun cabinets) a reduction in the rates of suicides using guns has also been noted (Anestis & Anestis, 2015).

Self-poisoning using pesticides accounts for approximately one third of the world's suicides (Gunnell et al., 2007), however, rates vary considerably by country. Pesticide self-poisoning was the most common means of suicide in Sri Lanka between 1976-2011 (Knipe et al., 2014). However, as with regulated gun sales, limiting the availability of particularly lethal pesticides, resulted in an overall reduction of suicide rates by 70% since 1995 (Knipe, et al., 2017). Similar restrictions have been implemented in the UK to reduce instances of self-poisoning using drugs such as paracetamol and salicylates. Following the introduction of legislation in 1998 (Committee on Safety of Medicines, Medicines Control Agency, 1997) which imposed a restriction on the maximum number of paracetamol and salicylate tablets that could be sold in one transaction, as well as a move towards packaging medications in blister-packs, a number of noteworthy outcomes were observed including a decrease in the number of deaths associated with both paracetamol and salicylate poisoning as well as a reduced need for liver transplants following paracetamol poisoning (Hawton et al., 2001).

Suicides by jumping from a height vary in frequencies and mostly relate to local accessibility of structures or buildings to jump from (Ross & Lester, 1991). For example, the percentage of people living in high-rise buildings in Singapore increased from 9% to 51% between 1960-1976, during which time suicide rates by jumping from tall buildings quadrupled (Gifford, 2007). Correspondingly, the occurrence of individuals jumping from

bridges has also led to the wide-spread instillation of barriers on many famous bridges. A meta-analysis found that construction of different types of barriers at jump sites internationally resulted in an average decrease per year of 3.2 suicides to 0.7 (National Institute for Health and Care Excellence, 2018). A powerful naturalistic example of limiting physical access is at the Grafton Bridge in Auckland, New Zealand. Barriers were first fitted in the 1930's but were the subject of many complaints owing, in part, to their 'unsightliness'. They were eventually removed in 1996, after which there was a five-fold increase in suicides at this site in the following four years. When they were re-installed, suicides at this site ceased during a three-year follow-up study period (Beautrais et al., 2009).

#### *Substitution when access of physical means is restricted*

When limiting access of physical means, there is the concern that individuals may substitute one method for another, potentially more lethal, method. Some research suggests that there may only be a small risk of substitution for jumping, as individuals who attempt suicide by jumping from specific sites reported choosing the location due to symbolism associated with it (Rosen, 1975). In line with this, a meta-analysis of seven studies found that following the construction of barriers at high-frequency suicide sites there was a small, but not significant, increase in suicides at nearby jump sites (National Institute for Health and Care Excellence, 2018). Low levels of substitution were also noted in relation to medication overdoses when prescribing was reduced for high-lethality medicines (Schapira et al., 2001) and when pack sizes were limited for paracetamol (Hawton et al., 2004).

There is the suggestion that mental practice or rehearsal is an important process in acquiring capability for suicide (Van Orden et al., 2010), which links back to Joiner and colleagues' (2005) theory outlined above. The potential absence of concurrent mental practice or rehearsal of an alternative method would suggest that method substitution in an acutely suicidal period is less likely to occur. Additionally, habituating to one means of suicide does not necessarily mean that habituation occurs for other means.

### *Acute suicidal periods*

The central assumption underlying attempts to limit access to means of suicide is that for many individuals in crisis, the acute suicidal period may only last for a relatively short amount of time. Indeed, a study of individuals who had survived a near-lethal suicide attempt found that nearly a quarter of them had deliberated for less than five minutes between deciding to attempt suicide and acting upon that decision (Simon et al., 2001). A similar study found that nearly half of individuals presenting to hospital following a suicide attempt had thought about it for less than 10 minutes (Deisenhammer et al., 2008). Individuals who had spent longer deliberating showed higher suicidal intent. This relatively short period of time spent deliberating can often define such an attempt as an 'impulsive' attempt and, therefore, by making it harder for an individual to access a method during this critical time period, there may be the opportunity to reduce the possibility of inflicting (serious) harm. Extending this, if an individual has a preference for a particular method and the period of high suicidality is short, then substitution of the method may not occur (Daigle, 2005). However, if it were to occur, it may be with a less lethal method resulting in a higher probability of survival (Hawton, 2007).



## *Acceptability*

The acceptability of a particular suicide methods plays a key role in whether the method will be used by a suicidal individual (Farmer & Rohde, 1980). Even when a method may be easily accessible, if that method is not culturally familiar as a method of suicide, it may not be used commonly. For example, suicide by charcoal-burning was relatively uncommon in Hong Kong prior to 1998. However, following wide publicisation of the death of a women using this method, including the method being pictorially shown in local news, with the impression given that charcoal burning was an easy, effective and comfortable way to die, incidences of suicide by charcoal-burning rose considerably to the third most common suicide method in Hong Kong (Lee et al., 2002). Therefore, once a method is seen as 'acceptable', it is often noted that suicides using that method increase. This is particularly true in vulnerable or younger individuals (Independent Press Standards Organisation, 2020).

## **Limiting cognitive availability**

### *Defining cognitive availability*

Cognitive availability refers to an individual's awareness of suicide as an option and knowledge of possible means of suicide, including characteristics and beliefs about the method such as technical aspects, accessibility, painfulness and outcome (Florentine & Crane, 2010). There are two common sources of information about methods of suicide; these are media portrayals and knowledge acquired through personal past experience, including exposure to one's own and others' suicidal behaviour (Biddle et al., 2012). Cognitive availability may therefore influence an individual's choice of suicide method, which has consequences for the outcome as the lethality varies greatly between methods. There are vastly disproportionate amounts of research into each of the two common

sources of information about method of suicide, however, available literature pertaining to each will be discussed sequentially following an overview of suicide clusters.

### *Suicide contagion and clusters*

A suicide cluster is a series of suicides that occur in close temporal or geographical proximity (Larkin & Beautrais, 2012). Clustering of suicidal behaviour is more common in young people compared to adults (Gould, Wallenstein & Kleinman, 1990; Gould, Wallenstein, Kleinman, O'Carroll, et al., 1990; Gould et al., 1994), and can occur within different institutions including schools (Brent et al., 1989), universities (MacKenzie, 2013), prisons (McKenzie & Keane, 2007) and psychiatric hospitals (Haw, 1994). Numerous suicide clusters have been identified across the globe (Hawton et al., 2020).

There are two main types of clusters: mass clusters and point clusters (Joiner, 1999). Mass clusters, which are thought to be media-related such as wide-spread news of a celebrity's suicide, are where suicides cluster in time, irrespective of geography, while point clusters are where an unusually high number of suicides occur close in time and/or space, such as within small geographical areas or within institutions.

It is thought that suicide clusters occur as a result of suicide contagion or imitation. In the 1970s, David Phillips coined the term 'the Werther Effect' (more colloquially known as 'copycat' suicides) which refers to a spike in suicides in which the deceased is thought to have emulated the suicide of a widely publicised death such as that portrayed in the media (Niederkrötenhaller et al., 2012). This term stems from the high number of suicides after the publication of Goethe's 'The Sorrows of Young Werther' in 1774, in which the lead character dies by suicide after a failed love affair. The Werther Effect has been supported by

considerable data, much of which has focused on celebrity suicides and the portrayals of suicide in other forms of media, to the exclusion of personal past experience.

### **Cognitive availability and media portrayals of suicide**

#### *Media*

The media is a powerful force in disseminating information about suicide and has the ability to increase awareness and educate the public about risk factors for suicide as well as the consequences of suicide (Niederkrötenhaler et al., 2010). However, the dispersal of information needs to be managed in such a way so as not to become a risk factor in itself. Media has a particularly negative impact when content includes detailed technical descriptions of suicide methods, is repeated and sensationalises or glamorises suicide, which is particularly relevant to reporting suicides of celebrities or well-known individuals (Hawton & Williams, 2005). The empirical evidence for the media increasing cognitive availability will now be discussed.

#### *News reports*

High-profile news reports mentioning the use of helium as a method of suicide were followed by an increase in Google search activity and traffic on Wikipedia's page describing suicide using helium (Gunnell et al., 2015). In line with this, suicides on the Toronto subway doubled following news reports of suicide deaths between 1970-1971 (Littmann, 1983). However, when the media has abstained from reporting on subway suicide deaths, decreases in rates of suicide have been observed in Toronto (Littmann, 1983), Vienna (Sonneck et al., 1994) and Detroit (Motto, 1970). Further, news stories with negative descriptions of suicide were 99% less likely to incite suicide contagion (Stack, 2005).

Cognitive availability of a particular method may also impact upon method choice when someone is thinking about attempting suicide. Biddle and colleagues (2012) conducted qualitative interviews with individuals who had made 'near fatal' suicide attempts. They found that many of the respondents shared having seen media reports of suicides which had influenced their awareness of a particular method. This is concerning as greater cognitive availability of highly lethal methods could lead to increasing suicide attempts and, potentially, deaths using such methods. Also of interest, studies have suggested that the choice of suicide method is more easily influenced in younger adults (Lin et al., 2010), a generation who are more computer-literate and have higher rates of internet use, including possible access to pro-suicide sites. This same group may also be more vulnerable to imitation effects (Pirkis & Blood, 2001; Schmidtke & Hafner, 1988).

### *Screen media*

A growing number of research studies are examining the links between suicidal behaviour and portrayals of fictional suicides such as in films and television shows. Early indications point to similarly concerning associations between portrayals of suicide and increased suicidal ideation and behaviour as is seen in print media and internet-based news (Posselt et al., 2020).

In particular, the release of the Netflix series '13 Reasons Why' was met with widespread concerns from both parents and professionals about the show's portrayal of an adolescent's suicide, which forms the central theme of the plot of seasons one and two. A number of papers have since been published showing that internet searches for phrases including 'how to commit suicide' and 'how to kill yourself' increased in the 19 days following the show's release (Ayers et al., 2017), while admissions to a children's hospital

for self-harm and suicidal behaviours, as well as suicide rates, also increased in the months following the Netflix premiere (Bridge et al., 2020; Cooper et al., 2018). While a greater knowledge of suicide risk factors (Chesin et al., 2020) and an increase in positive (i.e., help-seeking) internet searches (such as 'suicide hotline number') was also noted following the release of the series, these findings remain concerning. Although not explicitly included in the discussion sections of these papers, it would not be inconceivable to consider cognitive availability as a mechanism for understanding the increases in internet searches, suicidal behaviour and suicides following exposure to such information and depictions.

#### *Celebrity suicides and the media*

Robin Williams, a Hollywood actor, took his own life in August 2014 and so ensued highly publicised reports with graphic details about his death. Immediately following his death, both harmful and helpful Google search terms increased, however, this was particularly pronounced in harmful searches including 'commit suicide', which showed the strongest relative increase (Arendt & Scherr, 2017). Time-series models indicated that in the five months following Robin Williams' death, there was approximately a 10% increase in suicide deaths, accounting for an additional 1,841 cases in the US (Fink et al., 2018). Although this increase in suicides was observed in both males and females and across all age groups, it was particularly pronounced in males and individuals aged 30-44. Additionally, a 32.3% increase in the number of suicides using the same method was observed in the same time period, compared to an increase of 3.1% of all other methods combined. Similar findings have been reported for other celebrity suicides (Stack, 2002) and elsewhere in the world (Fu & Chan, 2013; Fu & Yip, 2007).

Publication of celebrity suicides also has an impact on suicide methods adopted by individuals. An increase in suicides by charcoal burning in South Korea from below one percent to around five percent was noted in the 12 months following the suicide of a celebrity actor using that method (Chen et al., 2014), potentially facilitated by extensive media coverage (Fu & Chan, 2013). A similar trend was also observed in Taiwan following the death of a singer using the same method (Chen et al., 2012).

As a result of the known impact that media can have on suicidal behaviour, the World Health Organisation (2008) and the International Association for Suicide Prevention published guidance on what media outlets should include and avoid reporting in the media. Additionally, the Samaritans published media guidelines for reporting suicide (Samaritans, 2020), however, media outlets and internet reports do not always adhere to these guidelines. The media could potentially exert suicide prevention effects through highlighting unpleasant details of suicide, particularly the element of pain (Sarchiapone et al., 2011). This is because misconceptions are commonly held by individuals about the lethality and pain associated with suicide methods, with a tendency for lay persons to underestimate the pain and overestimate the lethality of different methods relative to professionals (Rhyne et al., 1995). Indeed, Biddle et al. (2010) found the main influence on someone who had attempted suicide by hanging was the belief that the method was rapid, painless and 'clean'. More attentive reporting of certain unpleasant details of suicide may be helpful in reducing the popularity of some methods (Florentine & Crane, 2010), ensuring that suicide is not glamorised.

Importantly, the media does have the opportunity to be an agent for positive change. The counterpoint of the Werther Effect is the Papageno Effect, the ability that the media has on presenting alternatives to suicide in a time of crisis. The term comes from the

character, Papageno, who was considering suicide in an 18<sup>th</sup> century opera until other characters showed him different ways to resolve his problems. In this way, the media is able to increase awareness including around risk factors for suicide, decrease stigma - which is a known barrier to help-seeking (Reynders et al., 2014) - and educate audiences about the availability of support. Celebrity disclosures of lived experience of mental health difficulties have been found to increase knowledge of particular disorders, inspire others having similar experiences to seek help, and promote advocacy (Beck et al., 2013). Indeed, when news articles have been published about the suicide of a celebrity or other well-known individual, it has been noted that both positive internet searches and calls to suicide helplines increase by as much as 300% (Ramchand et al., 2019).

### **Cognitive availability and past personal experience**

While the concept of cognitive availability is a relatively new area of interest for research, there has been much evidence to support the role that the media plays in making suicide cognitively available in people's minds. However, there is far less research focusing on the association between personal past experience, including exposure to one's own and others' suicidal behaviour and knowledge of technical aspects of suicide, and how cognitively available suicide is.

It is widely known that people who are bereaved by suicide are at higher risk themselves for suicidal ideations, attempting suicide and dying by suicide (Crosby & Sacks, 2002; Pitman et al., 2016). Specifically, adults that are bereaved by suicide are significantly more likely to attempt suicide than those bereaved by sudden natural causes, regardless of whether the deceased was a blood-relative or not. This may suggest that it is something about the way in which their loved one died, not only the fact that they died, which impacts

upon someone's suicidal behaviour (Pitman et al., 2016). Medical-related professionals including physicians are also at higher suicide risk (Dutheil et al., 2019). While this is a population that has relatively easy and ready access to means (Hawton et al., 2000), including controlled drugs, they are also a population that possess a significant amount of knowledge related to ways in which to end their life, both through their medical training (e.g., which drugs and doses are likely to cause death) but also through occupational exposure to people who have self-harmed, attempted suicide or, indeed, died by suicide. Related to this, Biddle and colleagues (2012) found that, on some occasions, healthcare professionals had inadvertently given patients information that they had later used to plan an attempt. It is possible that this occupational exposure may make suicide more cognitively available in medical professional's minds. Indeed, psychiatrists who have experienced the suicide of a patient they were working with report having had intrusive thoughts about suicide following the patient's death (Chemtob et al., 1988).

Large surveys collecting both qualitative and quantitative data have allowed exploration of the impact of suicide bereavement on both an individual and a group level. They have helped with understanding the impact that a suicide bereavement may have on an individual's mental health, attitudes about suicide and risk of suicide. These types of surveys have revealed that a considerable proportion of people who are bereaved by suicide themselves go on to experience suicidal thoughts either for the first time or repeatedly (Cerel et al., 2016). Indeed, the University of Manchester's National Suicide Bereavement Survey (2020), the largest of its kind, found that 38% of participants had considered taking their own life after the suicide bereavement, while 8% reported making a suicide attempt following the person's death. For this 8%, 64% of them made the attempt within a year of the suicide bereavement, while 36% made the attempt after more than a



year. This may suggest that the suicide attempt was not an impulsive response to the loss given the length of time since their loved one's death. Further to this, Pitman and colleagues (2017) conducted a large mixed-methods study which included qualitative questions, one of which probed an individual's own attitudes to suicide following the suicide bereavement. Thematic analysis of responses suggested that for some, the experience of being bereaved by suicide had made suicide a more tangible option including normalising it as a potential and feasible escape when faced with adversity. While these studies suggest that the experience of suicide bereavement impacts on potential later suicidal ideation and attempt, as well as, for some, making it a legitimate option, it is not known how the experience impacts upon thoughts related to the method.

It would seem apparent that, for some people, the possibility of attempting suicide becomes more cognitively available to them following the bereavement. Importantly, those bereaved by suicide may be exposed to intimate details about the method, by way of attendance at the inquest, dealings with the coroner's office or police, or, in some instances having witnessed the scene where someone died. Having knowledge of technical aspects of suicide is a component of the cognitive availability of suicide. Findings from two studies (Biddle, 2003; Spillane et al., 2019) exploring the experience of family members who attended the deceased relative's inquest found that relatives reported finding it 'very shocking' and 'extremely stressful' to listen to the graphic evidence about the circumstances of the death. One spouse of a deceased shared that "The pathologist's report was horrendous because it told me exactly how long it took him to die..." while another said "There was nothing positive about it – only that they told me his brains were splattered so he died instantly. Actually, it was comforting to hear that – that he died straight away I mean. I didn't know that before". Biddle suggested that, for some, medical information was

comforting to hear, helping family members learn that the deceased died quickly without suffering. Although not concluded by the authors, being privy to such technical, and potentially positively-valanced information may have the unintended effect of influencing attitudes related to suicide by that means. This links to a previous study by Biddle et al. (2012) which found that individuals who had had near-fatal suicide attempts recalled stories of friends or acquaintances that had attempted or died by suicide and that for some they had 'learnt' information about a method from others. Additionally, Biddle et al. (2010) found that key factors influencing choice of method include certainty, ease, rapidity and 'cleanness' of a method, which may be gleaned during the bereavement process.

### **Summary**

In sum, each year 800,000 people die by suicide and an even greater number are impacted by that loss. The experience of suicide bereavement puts people at greater risk of a number of adverse outcomes including mental health problems and stigma. Importantly, it also increases the risk that they too will have suicidal thoughts and, potentially attempt suicide. This is, therefore, a group for which appropriate support is imperative.

A considerable amount of research has been undertaken in order to understand and, ultimately, prevent suicide. This research has utilised many different methodologies including large population samples and time series analyses, which have been able to identify trends in preferred suicide methods between countries and within demographic groups defined by age and sex. This type of research can also help with consideration of the impact that different measures, such as means restrictions, have on population suicide rates. These types of studies are helpful in informing government, health authorities and third sector organisations about the effectiveness of different interventions, what groups

they are more effective for and, to some extent, whether there are undesired effects such as method substitution. They also help to establish what factors may impact an individual's risk, for example, intense media activity around a celebrity suicide or exposure to television programmes that graphically depict a suicide or suicidal behaviour. This helps demonstrate that having (easy) access to information, as well as having a specific suicide method cognitively available, impacts upon the behaviour of some, potentially, vulnerable individuals.

It seems possible that the concept of cognitive availability operates at various levels including at a population level (for example, by way of intense, and perhaps inappropriate, media reporting of the suicide of a well-known individual or portrayals of suicide in film/television), at a community level (with hearing about the suicide of others in schools, universities, prison and psychiatric hospitals) and also at an individual level with the suicide of friends or relatives.

The impact of suicide bereavement on individuals and groups of people has been explored through the use of large mixed-methods surveys. These studies have helped increase understanding around the impact that a bereavement by suicide may have on an individual's mental health, attitudes about suicide and risk of suicide (Pitman et al., 2013; 2017; University of Manchester, 2020). However, despite this being a group that is likely to have had exposure to technical details of the method of suicide, thus potentially making it more cognitively available, there is a prominent gap in the literature related to understanding what impact the experience of suicide bereavement has on people's thoughts about suicide and specifically about potential methods. Existing qualitative papers have effectively provided insight into attitudes and thoughts about suicide following a suicide bereavement but have not yet linked this to the impact that the experience has on

thoughts about the method. A qualitative methodology is an appropriate choice for the current project as a qualitative approach, such as a semi-structured interview, has the advantage of gaining a greater sense of what the nature of a small group of peoples' thoughts and feelings are, compared to a larger, quantitative study. Naturally, with a smaller sample, there is less possibility to generalise findings more broadly to the suicide-bereaved population. However, given that this is a phenomenological study, the first of its kind known to the authors, generalisability is not a goal.

### **Thesis aim**

The aim of the thesis is to investigate what influence a bereavement by suicide, including the method used, has on the nature of the bereaved person's thoughts about suicide.

### **Potential implications**

There are a number of implications for the knowledge that will be acquired through this research. Firstly, and perhaps most importantly, a better understanding of peoples' experience, including their thoughts and attitudes following a suicide bereavement, will help us better support them. Support comes in many forms including better postvention options, more thoughtful, insightful and informed questions asked by clinicians during risk assessments, as well as clinicians feeling more able to confront uncomfortable topics. For example, enquiring whether there is a history of suicide in unrelated close contacts (Pitman et al., 2016) and whether or not they are thinking about the method that the deceased person used. Secondly, it may help inform services and clinicians to put in place support that protects an individual from that method, or thinking about that method, in a way that they

find acceptable. In addition, such knowledge is of use when considering if there is a role for cognitive interventions to play in addressing any unhelpful cognitions that were identified during the risk assessment process.

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## **Part 2: Empirical Paper**

**Understanding the relationship between suicide  
bereavement and the cognitive availability of suicide:  
A qualitative interview study**

## **Abstract**

**Background:** People bereaved by suicide are at increased risk of attempting suicide and dying by suicide. Personal past experience, include exposure to one's own or others' suicidal behaviour has been proposed to make suicide more 'cognitively available'. However, there is a current lack of understanding of the association between suicide bereavement and cognitive availability. Therefore, the aim of the current study was to examine how suicide bereavement impacts upon thoughts related to suicide, including the method used.

**Method:** Twenty individuals who had been bereaved by the suicide of a close contact were interviewed. Data was analysed using thematic analysis.

**Results:** The analysis identified four themes: changes in participants' views about suicide as an option (both becoming an option and being deterred from suicide as an option); the impact that the method of suicide has on participants' own consideration of potential methods of suicide (importantly, including aversion to the same method); the experience of suicidal ideation as a means of understanding the deceased's suicidal mind; and thoughts related to reunion with the deceased.

**Conclusions:** The findings suggest that exposure to the suicide of a friend or relative can make suicide more cognitively available, including suicide becoming a valid option, particularly when faced with hardship. However, individuals seem deterred from considering the same method used by the deceased. It would be worthwhile for practitioners to explore the experience of suicide bereavement with individuals seeking support in order to effectively safeguard.

## Introduction

Globally, approximately 800,000 people die by suicide each year (World Health Organisation, 2016). Each of these deaths has a ripple effect on those around them, with estimates of between six (Clark & Goldney, 2000) and 135 (Cerel et al., 2019) people affected by the loss. It is now widely understood that a bereavement by suicide increases risk of mental health difficulties including depression, psychiatric hospitalisation and increased risk of experiencing suicidal ideations, attempting suicide and dying by suicide (Pitman et al., 2014; 2016). All of these risk factors are of understandable concern and consequently provision of support following suicide bereavement is a government priority (Department of Health, 2012). However, these support efforts are hindered by a paucity of explanatory frameworks for suicidality after suicide bereavement. Attempts to understand the association between suicide bereavement and increased risk of suicidal ideations, as well as suicide attempts and deaths, have theorised a number of mechanisms including genetics and shared environment for blood relatives (Agerbo, 2003) and assortative mating and relating and shared environments for non-blood relatives (Agerbo, 2005; Joiner, 2003), as well as suicide suggestion and imitation (Abrutyn & Mueller, 2014). However, these do not adequately address the association between suicide bereavement and subsequent suicidality, therefore impeding the development of effective postvention (an intervention conducted after a suicide) options.

Many individuals experience suicidal ideations, but fewer go on to engage in suicidal behaviour or die by suicide (Schreiber et al., 2010). The Interpersonal Theory of Suicide proposed by Joiner, Van Orden and colleagues (2005; 2010) suggests it is the acquired capability for suicide that differentiates those who engage in suicidal behaviour from those that do not. They suggest that acquired capability is achieved through two pathways: (a)

increased tolerance to physical pain and (b) reduced fear of death. The experience of others' deaths as well as one's own self-harm and suicide attempts are a means of acquiring the capability for suicide. In a similar manner, O'Conner and colleagues' model (The Integrated Motivational-Volitional Model of Suicidal Behaviour; 2011; 2018) posits exposure to suicide, fearlessness about death and past behaviours as volitional moderators, which move an individual from ideation-to-intent.

Much of the work preventing individuals from moving from ideation to attempt of suicide has focused on limiting physical access to means (Department of Health, 2002). Reducing ligature points for hanging and strangulation in inpatient facilities, reducing accessibility to high-rise locations such as bridges, buildings and carparks, as well as restricting access to medications, poisons and firearms have been implemented with reasonable success in many countries (Anestis & Anestis, 2015; Hawton et al., 2001; Knipe et al., 2017; National Institute for Health and Care Excellence; 2018). However, much less research has focused on the cognitive availability of suicide, which refers to one's awareness of suicide as an option and knowledge of possible means of suicide, including characteristics and beliefs about the method such as technical aspects, accessibility, painfulness and outcome (Florentine & Crane, 2010). Two common sources of information provide details about methods, namely media depictions and familiarity garnered through personal past experience of one's own or others' suicidal behaviour (Biddle et al., 2012). Cognitive availability may influence the adoption of a particular method of suicide, which has a bearing on the likelihood of death.

A significant amount of evidence exists globally that demonstrates that extensive, and often inappropriate, media reporting and depictions of suicide, including glamourisation and technical details of a method, may incite risk in the use of a particular method (Bridge



et al., 2020; Fink et al., 2018; Fu & Chan, 2013; Littmann, 1983). This is particularly pronounced in already vulnerable individuals including those with a history of depression or suicidal behaviour or younger adults or adolescents (Cheng et al., 2007; Lin et al., 2010; Pirkis & Blood, 2001; Schmidtke & Hafner, 1988).

Much less research has focused on the impact that the experience of suicide bereavement has on the cognitive availability of suicide. Recent large scale research has found that 38% of suicide-bereaved individuals had considered taking their own life following the bereavement, with 8% making an attempt (University of Manchester, 2020). Exploring this idea more deeply, previous large scale qualitative research has found that experiencing a bereavement by suicide impacts upon a person's attitudes towards suicide as an option, whether feared or not, and for some individuals, normalises the possibility of suicide as a response when faced with adversity (Pitman et al., 2017). This research suggests that personal past experience does, indeed, impact upon the first component of cognitive availability – an individual's awareness of suicide as an option. However, to the author's knowledge, no research has focused on the impact that being privy to intimate and detailed knowledge of a method of suicide, which can, for example, be acquired by finding a loved one's body after a suicide or being involved in the investigatory process following a suspected suicide, including attending an inquest, can have on thoughts about a method of suicide. Therefore, this study aimed to investigate, after suicide bereavement, what the influence of the deceased's suicide and suicide method was on the nature of the bereaved person's thoughts about suicide.

## **Method**

### **Ethical approval**

The study received full ethics approval through the University College London (UCL) research ethics committee (see Appendix A).

### **Recruitment and screening process**

The current study formed a joint project with another clinical psychology doctoral candidate at UCL (see Appendix B for further detail on respective contributions).

Adults (aged 18+) who had experienced bereavement by the suicide of a close contact were invited to take part. This could include family members, friends or colleagues, and was defined as 'a relative or friend who mattered to you, and from whom you were able to obtain support, either emotional or practical'. Although the focus of the two research projects was different (the other project explored the phenomenon of intrusive mental imagery experienced after suicide bereavement; Quayle, in preparation) participants were drawn from the same pool of prospective participants. Interviews and transcriptions were completed independently.

The studies recruited a self-selecting community sample in two ways. Firstly, the study was advertised on the research team's Twitter accounts (for tweet and pictorial advert see appendix C). Secondly, the authors collaborated with a leading suicide bereavement charity, Support After Suicide Partnership, who circulated an email (see appendix D) to their members, which included a link to the tweet as well as a link to the study's webpage.

All prospective participants who responded to the advert or tweet were guided to an online study homepage (see appendix E), which gave a brief overview of the project and

what taking part involved, as well as a link to view and download a copy of the participant information sheet (see appendix F). After the homepage, prospective participants were taken to a screening questionnaire (see appendix E) that collected basic demographic information and information related to their bereavement, namely the time elapsed since their close contact's death and their relationship to the deceased. Three optional free-text questions at the end of the screening questionnaire asked people, if they felt able, to describe any experiences of intrusive images or thoughts related to their close contact's suicide and anything else related to the circumstances of the death that they felt was relevant for the researchers to know. Although these questions were not mandatory to submit the form, participants wrote between one and three sentences in relation to each of the first two questions. Once the form was submitted, participants were guided to view or download a suicide bereavement support guide (Public Health England, National Suicide Prevention Alliance, 2015). The brief free-text questions, as well as basic demographic information related to kinship and time since death, allowed the researchers to purposefully sample participants who were as representative as possible, as well as selecting participants who described having either thoughts or images related to the suicide.

Potentially suitable participants were then contacted via email inviting them to a brief (10 minute) screening phone call where they had the opportunity to ask any questions related to the research and consent process and the researcher was briefly able to assess risk, determine English language fluency and access to device and internet, and schedule a mutually convenient day and time for the interview.

## Interviews

All interviews took place during mid-week office hours to ensure that if any risk issues were to arise, the researchers were able to consult with other team members and take appropriate risk management action. Although originally approved by the ethics committee for face-to-face interviews on the UCL campus, due to the Covid-19 pandemic, all interviews were conducted using StarLeaf, an online video platform. Participants were sent an invitation link that they could use to access the platform. The researcher ensured that a signed consent form (see Appendix G) had been received prior to beginning the interview. It was mandatory for participants to supply the address of where they were when the interview took place, as well as general practitioner details, to ensure that should any risk issues arise, the researcher would know who to alert and where to direct emergency services. Participants were explained their right to withdraw at any time, as well as what would happen to their data following the interview. Participants were provided with the opportunity to review a copy of the transcript for accuracy. Seven participants requested a copy and two responded with comments or amendments.

All interviews were audio recorded using a dictaphone. Interviews lasted between 54 minutes and 1.5 hours. A topic guide was designed specifically for this study and can be found in Appendix H. Care was taken when constructing the topic guide to ensure that the wording of questions was sensitive and acceptable to the suicide-bereaved population (Padmanathan et al., 2019) and that the interview process was as comfortable and minimally distressing as possible. A preliminary draft of the topic guide was reviewed by an Expert by Experience and amended in line with their feedback. For example, they suggested clearly letting the participant know at the beginning of the interview that they did not have to answer any of the questions if they preferred not to and that they could take a break at

any point. The guide was used flexibly to ensure that all pre-determined areas were covered (if the participant was agreeable), while allowing for unpredicted aspects of peoples' experiences to be discussed and explored. Interviews began with some general rapport building followed by some clarifying questions related to the age of the close contact at the time they died, the time since the death and the participant's current age. The researcher then began with a broad, orienting question that asked participants to describe their relationship with the deceased. This question was designed to put the participants at ease before moving on to questions more related to their close contact's suicide. It also provided some context for understanding their experiences in relation to the self-perceived quality of the relationship. From the beginning, the interviews took the form of a conversation between the participant and the interviewer. Subsequently, a series of open-ended questions facilitated the participant to continue to talk about the lead up to their close contact's death, their thoughts related to the suicide, their experience following the bereavement, as well as the impact that the bereavement had on their own thoughts about suicide, their own ways of coping and any thoughts related to reunion with the deceased. Where necessary and appropriate, some gentle prompts (e.g. "Could you explain a bit more about that?") permitted the researcher to ensure that topics were sufficiently explored.

At the end of the interview, the researcher conducted a risk assessment using information that had arisen during the interview. Participants were emailed the 'Help is at Hand' suicide bereavement support guide (Public Health England, National Suicide Prevention Alliance, 2015) immediately following the interview. All interviews were manually transcribed verbatim by the first author in the days following the interview. Follow-up emails were sent to all participants one week after the interview for a welfare

check. A copy of the transcript was included in the email for those participants that had requested so.

### **Thematic analysis**

The data was analysed using the established convention of thematic analysis. The six steps laid out by Braun and Clarke (2006) were closely followed. First, the interviews were manually transcribed verbatim in the days following the interview to ensure immersion. The researcher spent time reading and re-reading the transcripts, noting down initial ideas, in addition to those recorded immediately following the interview. Second, careful line-by-line examination of each transcript allowed for detailed notation of salient features. This was performed using NVivo (QSR International, 2018). Coding labels remained close to the original words and meaning of the interviewee. Third, codes were reviewed and collated into preliminary themes based on perceived connections. These were organised within a table in Microsoft Word for ease of reviewing. Fourth, thorough reading of the extracts assigned to each preliminary theme ascertained whether extracts were consistent with each other, allowing for revision where necessary. This was conducted by both the first author (PJ) and a second researcher (AP). The extracts within each theme were then checked against the transcripts to ensure that they represented the original data and that all relevant data had been coded. Fifth, using the table of themes and extracts, names were devised for the themes. Lastly, the analysis was written up, selecting quotes that epitomised the themes that they illustrated. Appendix I includes an example of the analytic process.

## **Validity checks**

Conforming to guidance for conducting qualitative research (Elliott et al., 1999; Mays & Pope, 2000; Stiles, 1999), the following validity checks were employed. Firstly, ten percent of transcripts were independently coded by a second researcher (KQ) to ascertain consistency in identification of codes. Secondly, the thematic framework was shared and reviewed with the whole research team on multiple occasions. Thirdly, a clear explanation of the method of data collection and analysis (including an example of the iterations taken to arrive at final themes) has been provided within this publication. Fourthly, an array of quotations were selected, which, not only illustrated the themes identified, but which also gave voice to as many of the participants as possible, not just those who were more eloquently able to put their experience into words. This included attending to negative cases (those that seemed to contradict the explanation), which was especially prevalent within the first theme. Fifthly, the findings were compared to previous research as examined in the discussion. Lastly, the researcher's reflexivity and own position are shared below and discussed in more detail in the critical appraisal.

## **Position as a researcher**

The validity of qualitative research can be improved through the sharing of the researcher's position (Elliott et al., 1999). When I approached this research, I was coming from a phenomenological position (Willig, 2012), hoping to understand what the experience of suicide bereavement was like for the participants and consequently how their thoughts, feelings and perceptions around suicide were influenced. This position was in the context of not having personally experienced a bereavement by suicide. Indeed, my clinical experience had been within services where people describe feeling suicidal themselves, and one of the

ultimate or overarching goals was to manage risk and prevent suicide. Although I had knowingly worked therapeutically with people who had been bereaved by suicide, in many more situations I had not explicitly inquired, leaving it to the client to disclose, which I now understand to be a disservice to them. In coming into this research, it was from a position of curiosity and intrigue, wanting to step into their shoes, rather than from a position of providing advice, trying to 'fix' a problem or indeed of defensiveness, given that many of the participants had felt let down by the very system within which I work. I attempted to 'bracket' my own assumptions and skills developed through training to enable me to remain open and inquisitive to participants' experiences (Rolls & Relf, 2006). I endeavoured to do this by monitoring my emotional posture going into interviews (Fredman, 2007), keeping a research journal, noting down my initial reactions and thoughts immediately after each interview, as well as during the analysis process, and sharing and reflecting upon these with the wider research team. I was also aware of my own demographics and the assumptions that participants may have made about me based on how I presented during the interviews, which may have influenced what they chose to share.

## **Results**

### **Sample characteristics**

A total of 20 participants took part in the study, all of whom were interviewed online. The participants had been bereaved collectively by a total of 22 close contacts who had died by suicide. Notably, two participants had each been bereaved by the suicide of two close contacts and, although they focused on one of the bereavements in particular in the interview, they did reflect on the impact of both losses at multiple points throughout. Table 1 below summarises the characteristics of study participants. Although efforts were made to



recruit a diverse sample, the sample was predominantly white British (80%) and female (80%). The time elapsed since the bereavement ranged from 16 months to 24 years and spanned a range of kinship groups. The deaths referred to by participants involved a range of different methods of suicide, of which the most common was death by hanging and strangulation.

## **Themes**

The thematic analysis identified four superordinate themes capturing the nature of individuals' thoughts about their own potential suicide following bereavement by suicide. These were: (1) changes in their views about suicide as an option; (2) the impact that the method of suicide has on their own consideration of potential methods of suicide; (3) the experience of suicidal ideation as a means of understanding the deceased's suicidal mind; and (4) thoughts related to reunion with the deceased. Within two of these superordinate themes, there were a number of subordinate themes that described significant clusters of similar, or related, experiences, which will be expanded upon below.

When presenting the results of the thematic analysis, extracts from the interview transcripts have been used to illustrate the themes and subthemes identified. As the interviews were transcribed verbatim, some of the excerpts may be grammatically incorrect, however, they have not been altered. Individuals' names or any other identifying characteristics have been removed. This has been indicated by the use of brackets, where relevant. Both the total number (indicated by *n*) and the percentage (%) of participants who provided data captured in relation to each theme have been presented. Some quotations have been coded under more than one theme. Table 2 below summarises the themes and subthemes identified by each participant.

**Table 1** Characteristics of study participants

	<i>n</i>	(%)
<b>Gender</b>		
Female	16	(80.0%)
Male	4	(20.0%)
<b>Participant Age (Years)</b>		
Range	23-64	
Mean ( <i>SD</i> )	44.75 (12.48)	
<b>Ethnicity</b>		
White British	16	(80.0%)
White British/White Irish	1	(5.0%)
Other white	1	(5.0%)
Mixed race <sup>a</sup>	2	(10.0%)
<b>Country of Residence</b>		
England	15	(75.0%)
Scotland	2	(10.0%)
Wales	3	(15.0%)
<b>Age of Deceased (Years)</b>		
Range	13-70	
Mean ( <i>SD</i> )	34.59 (15.54)	
<b>Characteristics of the Deceased<sup>b</sup></b> ( <i>n</i> = 22)		
Blood Relative	15	(68.2%)
Male	16	(72.7%)
Mother	2	(9.0%)
Father	1	(4.5%)
Brother	4	(18.0%)
Sister	1	(4.5%)
Daughter	3	(13.5%)
Son	3	(13.5%)
Husband	2	(9.0%)
Partner	2	(9.0%)
Ex-Partner	1	(4.5%)
Cousin	1	(4.5%)
Friend	2	(9.0%)
<b>Cause of Death<sup>b</sup></b> ( <i>n</i> = 22)		
Hanging and strangulation	15	(68.2%)
Drowning	3	(13.6%)
Jumping or lying in front of a moving object	2	(9.0%)
Fall	1	(4.5%)
Self-poisoning	1	(4.5%)
<b>Time Since Bereavement (Years)</b>		
Mean ( <i>SD</i> )	5.71	(7.30)
Range	1.36-24	

<sup>a</sup> Mixed race ethnicities - White and Black African and White and Asian; <sup>b</sup> Sum of percentages for characteristics of the deceased and cause of death do not equal 100% due to rounding to one decimal place.

## **1. Changes in their views about suicide as an option**

The majority of participants ( $n = 18$ , 90%) described how the suicide of their close contact had impacted upon their own thoughts about suicide. For some, it had made suicide more available as a possible option, normalising it as something that people might consider and finding it comforting to know that 'it's there' as an option in times of pain or distress.

However, having experienced the devastation of a suicide, some participants reported this being a deterrent from dying by suicide, as well as a belief that any problems or bad days experienced were not insolvable and are, instead, temporary. As can be seen in Table 2 below, the groups of participants who held these beliefs were not mutually exclusive. Many people simultaneously held conflicting personal views about whether suicide was an option.

### **1.1. Suicide becomes an option**

Over half of participants ( $n = 12$ , 60%) spoke in some way about how the experience of being bereaved by suicide had impacted upon their thoughts about suicide being a possible option for them as well.

#### *1.1.1. Suicide being a legitimate option*

Half of participants ( $n = 10$ , 50%) spoke about how, following the suicide bereavement, suicide became a legitimate and viable option, particularly when faced with adversity. Participants referred to it as "a get out card", "a viable option" and "a backup".

**Table 2** *Table of themes by participant*

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15	P16	P17	P18	P19	P20
<b>1. Changes in own views about suicide as an option</b>	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆
1.1. Suicide becomes an option		▲	▲	▲	▲		▲		▲	▲	▲				▲	▲	▲			▲
1.1.1. Suicide becomes a legitimate option		△	△	△					△	△	△				△	△	△			△
1.1.2. Normalised dying by suicide			△							△					△					△
1.1.3. The comfort of having suicide as an option			△	△	△				△	△	△						△			△
1.1.4. Reduced fear of death							△			△	△				△	△				
1.2. Deterred from suicide being an option	▲			▲	▲	▲		▲	▲		▲	▲	▲	▲			▲			▲
1.2.1. Not wanting to inflict on others the same suffering	△			△	△	△		△	△		△	△	△	△			△			△
1.2.2. Suicide being a permanent solution to a temporary problem	△												△	△						
<b>2. The impact of the method of suicide on consideration of own potential methods of suicide</b>			◆	◆			◆		◆	◆					◆		◆		◆	◆
2.1. Aversion to the same method			▲	▲			▲		▲	▲					▲		▲		▲	▲
2.2. A desire to protect others from the trauma of discovery				▲					▲	▲										▲
2.3. Concerns around being found alive and wanting to guarantee own death									▲	▲					▲		▲			▲
<b>3. The experience of suicidal ideation as a means of understanding the deceased's suicidal mind</b>			◆				◆		◆	◆					◆		◆	◆	◆	◆
<b>4. Thoughts related to reunion with the deceased</b>			◆							◆					◆	◆	◆	◆		

*"If it's so unbearable, if this happens or that happens, I can always do that. It's almost your get out card, in a way. Afterwards, it's like, which you would never have considered before, but it's like, now, well there's always that." (Female in her 60s bereaved by the suicide of her ex-partner)*

*"...for me the suicidality was something after [the deceased] died, I think it just, it becomes so much more of an option... I didn't ever think about suicide like I do now as an option because, I dunno, I had never been in that place, whereas after [the deceased] died, I think it becomes a reality, it becomes something that people do" (Female in her 20s bereaved by the suicide of her sister)*

*"I think the other thing it did was, it made it an option. It was almost like, well, you know what, if she's done it, then what's to stop me doing it?...that seemed like a viable option to me." (Female in her 40s bereaved by the suicide of her adolescent daughter)*

Some spoke about how it was the identification with the deceased and the desire for connection which permitted suicide to become a legitimate option for them.

*"...you miss them and you want, like I've wanted to put his clothes on. I've worn his jumper, or, you want to be with him again and in wanting to be with him again, you can want to do anything that he might have done, which might include all of those things he did at the end." (Female in her 40s bereaved by suicide of her brother)*

### *1.1.2. Normalised dying by suicide*

Four participants (20%) felt that the suicide of their close contact had normalised suicide as something that people could reasonably do when struggling.

*“I think because [the deceased] had done it, it almost normalised it for me.”*

(Female in her 40s bereaved by the suicide of her adolescent daughter)

Experiencing the bereavement by suicide also heightened participants’ awareness of the perceived prevalence of suicide in society.

*“It’s completely normalised it. It’s f\*\*\*\*\* everywhere.”* (Male in his 20s

bereaved by the suicide of his brother)

### *1.1.3. The comfort of having suicide as an option*

A number of participants ( $n = 8$ , 40%) found comfort in the idea that suicide was a possibility, particularly when faced with pain or hardship. Within this sub-theme, it was clear that there was much uncertainty or indecision related to whether they would die by suicide, but that it seemed as though it were a comfort to have that possibility available to them.

*“Because it is really conflicting because sometimes I find it quite comforting, that you know, there’s an option there to stop the pain, as it were.”* (Male in his 40s

bereaved by the suicide of his friend in young adulthood)

*“...and there’s always that it feels like a comfort to know that there’s that fall back to where I’ve already decided like if things get too bad, I now know there’s an answer to do it”* (Female in her 40s bereaved by the suicide of her brother and her cousin)

#### *1.1.4. Reduced fear of death*

The bereavement and the subsequent opening up of suicide as an option occurred in parallel to a reduction in the fear of death for five participants (25%). This reduced fear of death coupled with suicidal ideation was a frightening combination for some.

*“But there was...one of the things that has persisted is it’s made me a little bit less scared of death. And whilst I’m fine now, I do look at it and wonder if that would impact again if I felt down.”* (Female in her 40s bereaved by the suicide of her adolescent daughter)

## **1.2. Deterred from suicide being an option**

Over half of participants ( $n = 12$ , 60%) reported that the experience of suicide bereavement had resulted in some thoughts associated with wanting to avoid dying by suicide. There was overlap between participants who disclosed thoughts related to suicide having become an option with being deterred or wanting to avoid dying by suicide. The holding of conflicting views was, at times, an uncomfortable feeling for them - thinking and feeling that suicide was an option, while also wanting to avoid it due to being aware, first-hand, of the pain that was experienced by relatives and friends in the aftermath.

### *1.2.1. Not wanting to inflict on others the suffering they had experienced*

All participants spoke extensively about the impact that the suicide had had on themselves, friends and family of the deceased, as well as others involved immediately following the discovery of the body. Twelve participants (60%) reported that the suffering that they, and others, had experienced had deterred them from wanting to die by suicide. This appeared to be the single strongest deterrent.

*“I don’t think from having seen the mess, I wouldn’t want to put my wife through the mess that I’ve had to pick up with my children. I think it leaves [a] horrible legacy for the people left behind, that’s difficult to come to terms with, having witnessed this, I wouldn’t want to put them through it.”* (Male in his 60s bereaved by the suicide of his daughter)

Some participants spoke about contemplating suicide, but that this was not associated with true intent because, having had first-hand experience of suicide bereavement, they felt they were prevented from acting upon any thoughts.

*“I think part of why it never moved into what I would call active thoughts of it, was because I understood what it meant to do that to other people. So I think, that probably was a block in my head to be able to actually ever have any actual thoughts of doing it because I very much understood from seeing like, well from knowing how I felt and also seeing all of my family, so I think from that point of view, that probably played in a lot as to how I actually felt about it.”* (Female in her 20s bereaved by the suicide of her mother)



The devastation associated with the discovery of the deceased contributed significantly to the thoughts and feelings of some of the participants. Having either experienced or imagined the process of discovery and associated feelings, many felt that it was not possible to die by suicide without negatively impacting others and therefore were dissuaded.

*“Because it is really conflicting because sometimes I find it quite comforting, that you know, there’s an option there to stop the pain, as it were. And then, I mean it is difficult, but I think that kind of processing the options, looking at the different paths, I think in some ways, it’s helpful, because what it does, because eventually I always come out going ‘there’s no way I can do this without affecting someone else, still not an option’ and I think in a way, it’s quite helpful.”* (Male in his 40s bereaved by the suicide of his friend in young adulthood)

#### *1.2.2. Suicide being a permanent solution to a temporary problem*

All participants reflected on potential reasons why their loved one may have died by suicide. There was a wide range of possible explanations, some to do with struggling with mental health difficulties, significant stresses associated with work and life, as well as financial difficulties. Although able to recognise potential influences in why their loved one may have died by suicide, three participants (15%) felt that suicide was a very permanent solution, in that moment, to problems that were not insolvable and indeed may have been transient.

*“It’s all very much of that moment in time, I don’t think the problems would have been, in the long-term, insolvable.” (Male in his 60s bereaved by the suicide of his daughter)*

## **2. The impact that the method of suicide has on their own consideration of potential methods of suicide**

Nealy half of participants (n = 9, 45%) discussed their own thoughts about a method of suicide in a way that suggested a clear association with the method that their loved one had used.

### **2.1. Aversion to the same method**

Of those that linked the method used by their loved one and their own thoughts related to a method, all described an aversion to the use of the same method.

*“I didn’t, when I was suicidal, I wasn’t gonna [use the same method]. That was the only thing that I wouldn’t do.” (Male in his 20s bereaved by the suicide of his brother)*

The reasons for the aversion varied between participants. Three participants (15%) spoke about the need to minimise the distress experienced by themselves and by others by considering the use of a different method.

*“...in order to carry out suicide...you need to be able to be in the state of calmness and shut down your emotions...that I would never be able to kill myself with the*

*way [the deceased] did because of the level of distress it would cause me...as soon as you get any distress or panic, in my experience, you can't do it...so, that's why it would not be possible to use, to do that, I've never considered copying anything that [the deceased] did."* (Female in her 20s bereaved by the suicide of her sister)

Aside from the element of distress, another expressed how they felt that they were not brave enough to die in the same way, preferring a way that was perceived as being more peaceful or less violent.

*"I'm just not brave enough to do something like that...I'm not brave enough to do what he did."* (Female in her 50s bereaved by the suicide of her son)

One participant spoke clearly about mental images he had of his brother's suicide, as well as images of himself attempting suicide. However, he was clear that when he pictured the way in which his brother had died, he could never envisage himself using the same method because, this, in some way 'belonged' to his brother. He also felt that the imagery rehearsal was a necessary component to enable him to die by suicide using a particular method.

*"...I had so much f\*\*\*\*\* negative images of [it]...all the imagery I've had of [the method used by the deceased] has always been my brother. I've always seen him do it, and I can't put myself in that situation. I can't see myself in that situation*

*because it's him...I had to be able to see myself doing it."* (Male in his 20s bereaved by the suicide of his brother)

## **2.2. A desire to protect others from the trauma of discovery**

Although for some the reality or imagined images of discovery deterred them from suicide definitively, others ( $n = 4$ , 20%) distinguished between being discouraged from that particular method of suicide rather than suicide more broadly.

*"...I think, probably the most I've thought about is the pain that he did to others as well. That's become quite an obsession for me...how do you, how would I do it having the minimum impact on others. And I've thought quite elaborately, elaborate plans to try and avoid what happened in that situation, should I do it."*  
(Male in his 40s bereaved by the suicide of his friend in young adulthood)

The trauma of the discovery was linked to both the impact on the people and professionals that had found or recovered the body, as well as thoughts linked to the appearance of their loved one's body in death.

*"...I was so traumatised by what had happened to [the deceased] and the way she looked afterwards...so I thought the best way for me is to make it easy for others when they come across me. To make it so that, I just looked like I'd fallen asleep...it was about just making [it] as least traumatic to other people. That I wasn't inconveniencing them."* (Female in her 40s bereaved by the suicide of her adolescent daughter)

### **2.3. Concerns around being found alive and wanting to guarantee own death**

Five participants (25%) expressed concerns related to the fear of being found alive if they were to attempt suicide. The “risk of living” or “not succeeding” was referred to multiple times.

*“...I think the only kind of definitive thing it’s given is I would want to make sure I was dead. I would hate for somebody to find me and have to feel like they had to try and revive me, or like, there was some sort of paramedical care to give.”*

(Female in her 20s bereaved by the suicide of her father)

### **3. The experience of suicidal ideation as a means of understanding the deceased’s suicidal mind**

Many participants (n = 14, 70%) shared that following their bereavement by suicide they had experienced passive (thoughts of suicide but no plan to carry it out) or active (with a plan) suicidal ideation. For the majority, this was a new experience, reporting that they had never previously thought about suicide or ending their life.

Many participants spoke about agonising questioning related to why the deceased might have died by suicide. Participants spoke about their frustration that the only person that was able to answer this question was not around to do so. However, although a frightening position to be in, some of the participants who had experienced suicidal thoughts found that this was effective in enabling them to understand what might have been going on for their close contact and was ultimately helpful.

*“I think it took me to a very, very scary place that I don’t ever, ever want to be in again but in some ways, I felt like, because I kept asking ‘why?’, the universe showed me why. If that makes sense? Because they say, don’t they? Be careful what you wish for, because I kept asking this question constantly, it consumed me, I feel like I was given the answer. And that’s when I kind of went ‘woah, I get it, I get it now. I understand why’, you know?”* (Female in her 40s bereaved by the suicide of her friend)

Many participants spoke about the intense sadness they had felt that their loved one had ‘chosen’ to leave everyone behind. However, the experience of suicidal ideation had illustrated how, when in that frame of mind – active suicidal ideation – thinking was not always clear and was narrowed to their own current pain.

*“But I used to think it might have just been a very difficult decision for him, because he would have thought of everyone else. But that was not, I know that that wouldn’t have been part of his mindset because I’ve been there myself, you just don’t, you just don’t think of anyone else whatsoever, it’s all about you.”*  
(Male in his 20s bereaved by the suicide of his brother)

Some participants had, themselves, attempted to die by suicide following the bereavement and shared how the experience of being acutely suicidal and engaging in suicidal behaviour had provided insight into the psychological angst as well as the difficulty there was in reaching out to those around them.

*"...when I tried to take my own life, it became blatantly obvious to me then, how [the deceased] must have felt. Because I felt completely hopeless, completely like nothing was going to change and I can only describe it, as mental agony...I couldn't see another way out, so it was the only way and I thought 'this is how [the deceased] must have felt'...And that wasn't very helpful because I thought, 'why didn't she turn to me cos I would have helped her with that', but then again, that was quite helpful, because I thought, 'well I didn't turn to anyone, either', didn't want to burden them. So, in some ways it was a useful experience...because it gave me a really deep understanding of why people take their own life." (Female in her 40s bereaved by the suicide of her adolescent daughter)*

#### **4. Thoughts related to reunion with the deceased**

Six participants (30%) verbalised a desire to be reunited with the deceased. This was separate from any religious beliefs around life after death. The possibility of reunion was an attractive notion and for many, suicide was the means to reunion.

*"It was a pull, you know that balance I'm talking about, that was one of the things on the balance that would say 'this is a great idea', to put it bluntly, you know, it was like, suicide's a good option because it means that, you know, I'll see [the deceased] again. It was an attractive option for that....and it was one way of stopping the pain...I wasn't just going to stop the pain. No, I was going to stop the pain with bells on with seeing [the deceased] again." (Female in her 40s bereaved by the suicide of her adolescent daughter)*

Participants who had experienced suicidal ideation spoke about a profound feeling of loneliness during the acute period. For some, this linked closely to their desire to reunite with their loved one and a sense of the deceased calling to them.

*"...they [loneliness and yearning for reunion] play beautifully into each other's hands, basically. Yeah, they play off each other...it's a downward spiral because it's, you want to be dead and you want to be with the other person and they're like 'do it, do it, do it, do it'. Yeah, it's not fun."* (Male in his 20s bereaved by suicide of his brother)

## Discussion

### Main findings

The findings from these qualitative interviews conducted with individuals bereaved by the suicide of a close contact provide important new information concerning how suicide loss can impact upon a person's thoughts related to suicide and the method of suicide. Such evidence is particularly relevant given the higher rate of suicidal behaviour observed in those bereaved by suicide, as well as the lack of knowledge around the association between personal past experience and the cognitive availability of suicide.

During the course of the interviews, all participants described in-depth the devastation that the suicide had caused for themselves and those around them. Although some reported being wholly deterred from suicide as a result, a greater proportion described a more conflicted picture, whereby the loss had made them want to avoid inflicting the same devastation on others, while also opening suicide up as an option, particularly if faced with inescapable hardship. This was comforting for some. For a



minority, the possibility of suicide seemed to be explained by a diminution of the fear of death, something that was concerning to individuals when occurring alongside suicidal ideation. Participants spoke about how these views formed following the bereavement and, as such, correspond to the theoretical construct of cognitive availability (Florentine & Crane, 2010). In addition to this, some participants reported experiencing suicidal ideation for the first time following the death and, although a very distressing experience, it allowed many individuals to understand and empathise with the position their loved one was in leading up to their suicide, which was ultimately seen as helpful.

One of the key novel findings from this research was the notion that individuals experience an aversion to dying by suicide using the same method as their close contact. There was, however, not agreement on the reason for being deterred from using the same method. Factors included a desire to minimise one's own distress, as well as the perceived violence of the method. In addition, one participant spoke about the need to mentally rehearse the act of suicide, which has been suggested as an important process in acquiring capability for suicide (Van Orden et al., 2010), a central tenet of the Interpersonal Theory of Suicide (Joiner, 2005; Van Orden et al., 2010). However, that particular participant spoke about how rehearsal of mental imagery of the method used by the deceased only ever featured the deceased, rather than himself, and that meant they were not able to engage with that same method.

Finally, a number of participants spoke about thoughts of reuniting with their loved one. While yearning for the deceased is a common grief reaction (Bowlby & Parkes, 1970), what seemed to distinguish the participants in this study was their desire for reunion, and for some, the means of this reunion being suicide.

## **Results in the context of other studies**

The finding that some individuals experienced suicidal ideation, and attempted suicide, for the first time following the bereavement is consistent with previous research which found that suicide attempts of role models trigger new suicidal thoughts and, in some cases, attempts in adolescents. These studies suggest that non-lethal suicidal behaviour may be learned through modelling by significant others as a way to manage emotional distress (Abrutyn & Mueller, 2014; Jamison, 1999). This is further supported by a number of large studies which found that suicidal behaviour among individuals' social groups was an important predictor of suicidal behaviour in the individual themselves (de Leo & Heller, 2008).

The findings from this study suggest that the experience of suicide bereavement also normalises suicide, making it a more tangible option, consistent with the results of a large-scale survey study (Pitman et al., 2017). It is also in line with quantitative studies, which have found that exposure to suicidal behaviour is related to more accepting views towards suicide in adolescents and young adults (Abbott & Zakriski, 2014; Stein et al., 1992), but extends the findings to an adult population. Additionally, those that hold accepting views towards suicide are fourteen times more likely to formulate a plan to end their lives compared to those who do not hold such beliefs (Joe et al., 2007). This may partially explain the association between suicide bereavement and increased risk of suicide attempts and death. In contrast, previous studies have suggested that the experience of peer suicide (Brent et al., 1996; Jordan et al., 2012) or one's own suicidal behaviour (Shand et al., 2015), including the devastating impact that it has on friends and family, may act as a deterrent from engaging in future suicidal behaviour. Some of the current study's findings complement this, such that individuals did reflect on their desire to avoid inflicting on

others the experience of suffering that they had experienced. However, these findings are complex as many individuals simultaneously held conflicting views about the availability of suicide as an option to them. The holding of views that are dissonant and, as such, competing, can lead to feelings of unease and tension (Festinger, 1962) and, as a result, individuals are motivated to reduce the discomfort and dissonance, in order to achieve consonance. This preference for consonance may serve as an opportunity for clinical intervention.

In relation to methods of suicide, previous studies have found increases in the use of a particular method immediately following the publicised suicide of a well-known individual (i.e., not a close contact; Chen, et al., 2014), particularly in those individuals who identified with the deceased (Fink et al., 2018). The findings from the current study appear inconsistent with this, such that individuals spoke fervently about an aversion to using the same method were they to engage, or when they had engaged, in suicidal behaviour. Indeed, one participant said, “that was the only thing that I wouldn’t do”. The trauma of the discovery of the deceased featured in some of these cognitions. This does raise the question of whether individuals modified their cognitions (for example, “I could die by suicide if I used a different method that I perceive to be less traumatic for those left behind”) with an aim to reducing the discomfort and restoring balance (Festinger, 1962).

### **Strengths and limitations**

To the author’s knowledge, this is the first qualitative study exploring the impact that a suicide bereavement has on the cognitive availability of suicide, including availability of thoughts related to the method of suicide used by the deceased. Given that this is a

relatively new area of research, the sample size of 20 for a qualitative study was deemed sufficient.

Originally, it was intended that participants would be interviewed in person, in which case participants would have likely been restricted to those living in the Greater London area. However, as a result of conducting the interviews online, participants were recruited from a much wider geographical area across the UK. This is a strength given that there is great variability in the suicide rates of English regions and Wales, with London and the South East having the lowest age-standardised suicide rates for both males and females (Office of National Statistics, 2019). However, as a result of the method of recruitment, the study was restricted to those who had access to technological devices and internet connections, which may have limited the inclusion of certain socioeconomic groups and ages. Suicide rates begin to rise in those aged 80+ (Office of National Statistics, 2019) and it is possible that the bereavement experience of similarly aged loved ones and close contacts may be dissimilar compared to the younger people recruited here, thus impacting differently on the cognitive availability of suicide, including thoughts related to method selection. This too may be impacted by the accessibility and acceptability of certain methods. This is especially relevant given the differences in the methods used by older and younger people and between older men and women (Shah & Buckley, 2011). Given the almost exclusive online recruitment strategy, this cohort's experience may have been missed.

It should be noted that the majority of participants were White British (80%) and female (80%), which although consistent with the sample population of the largest suicide bereavement study conducted internationally (University of Manchester, 2020), does under-represent the experiences of men bereaved by suicide and those from other ethnicities. This is important given the higher rate of male suicide (1.8 times more than

females; World Health Organisation, 2016) and differences in rates of suicide by ethnicity. Indeed, although Caucasian populations report experiencing the highest rate of suicidal ideation, rates of suicide are higher among young men of Black African and Black Caribbean origin, and among middle aged Black African, Black Caribbean and South Asian women, compared to their White British counterparts (Bhui & McKenzie, 2008). The interplay between ethnicity, culture, and potentially religion, may influence thoughts related to suicide, methods of suicide and reunion, in a different way compared to White British individuals and, therefore, may not have been represented in the current results.

There is the possibility that the sample is skewed towards a help-seeking population given that one means of recruitment was via dissemination of study information to individuals affiliated with bereavement charities. Their experience may be different from individuals who do not access such support services. However, some potentially non-help-seeking individuals were recruited via social media advertisement and word of mouth.

The study employed the use of a semi-structured topic guide, which allowed the interviewer to follow up on aspects of an individual's experience that may not have been anticipated or to achieve more of an understanding of a respondent's particular thoughts, beliefs or experiences. The topic guide was developed in consultation with an Expert by Experience, ensuring that it was both acceptable and sensitive to the population in question.

An interesting finding related to a participant's need to mentally rehearse the suicide method only became apparent towards the end of the interview process. This would have been an interesting concept to ask all participants about when discussing their thoughts related to the deceased's method and their thoughts around their own potential method.

The author responsible for transcribing and analysing the data took part in a bracketing interview (Rolls & Relf, 2006), which facilitated reflection on their own position coming into the research and while conducting the interviews. During the analytic process, the author plus three other researchers in the team discussed and revised multiple iterations of the thematic framework which enhanced reflexivity and ensured rigour. It is important to note that the use of validity checks is a slight deviation from the guidelines for thematic analysis (Braun & Clarke, 2020). However, ultimately, this was a trade-off between fidelity to the thematic analysis guidelines and a desire to enhance the coherence and validity of the findings.

### **Clinical and policy implications**

The findings from this study suggest that, following a bereavement by suicide, a considerable proportion of people report changes in their thoughts about suicide and whether they perceive it to be a legitimate or viable option. This was the case not just for blood relatives.

This change in views around suicide may have the potential to impact the level of risk of an already at-risk group (Crosby & Sacks, 2002; Pitman et al., 2014; 2017). The meanings attached to suicide by bereaved individuals were idiosyncratic, highlighting the need for clinicians to inquire about whether people accessing services have experienced a suicide bereavement (of both relatives and non-relatives) and explore the meanings derived from the losses and the impact, if any, on their own thoughts about suicide. It would also be valuable to explore their thoughts around the method used by the deceased and whether that had any impact on their own consideration of methods. Clinicians would need to ensure that this was done in a sensitive and skilful manner, to ensure that ideas or new

information were not inadvertently given to people and that conversations did not serve the function of mentally rehearsing suicidal behaviour, thus potentially lowering inhibitions.

Clinicians should also direct suicide-bereaved individuals to support resources, regardless of the time elapsed since the bereavement (Public Health England, National Suicide Prevention Alliance, 2015).

### **Future research**

The novel finding that being bereaved by suicide leads to an aversion to the use of that particular suicide method warrants investigation on a larger scale and in other settings, for example, clinical communities of patients on wards and young people in schools and universities, to determine whether the findings are consistent across settings. Quantitatively determining whether the method used by suicide-bereaved individuals who made near-fatal attempts or died by suicide were similar or the same as that used by their close contact may facilitate improved risk management of suicidal individuals and help tailor intervention.

Qualitative studies retrospectively exploring the suicidal mind of individuals who had made near-fatal attempts would aid understanding around this period of suicidality, including whether individuals had engaged in mental rehearsal in anticipation of the attempt, and, importantly, would also elucidate what sort of support was needed in that moment in order to have been prevented the individual from making an attempt.

### **Conclusion**

The current qualitative study of 20 suicide-bereaved individuals begins to pave the way for understanding the experience and meaning-making that occurs following the loss of a close contact to suicide. It seems apparent that, for many, bereavement by suicide makes

the idea of suicide as an option more cognitively available. However, the findings from this study do not support the latter part of the definition of cognitive availability, that detailed knowledge of the method makes it more available, and therefore more likely to be used, if considering one's own suicide. Given the findings that individuals bereaved by suicide are at higher risk of suicidal behaviour, as well as dying by suicide, it is vital that ways are found to appropriately support this group. This should begin with clinicians sensitively inquiring about incidences of bereavement by suicide and subsequent exploration of the impact of that loss on the individual, including their thoughts about suicide and potential methods.



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## **Part 3: Critical Appraisal**

## **Introduction**

This critical appraisal is a reflection on my experience of completing this thesis including conducting the literature review in Part 1 and the empirical study in Part 2. When preparing to write this section, I listened back to a bracketing interview I had done and found that this was able to transport me back to the mindset I was in when preparing for, and conducting, the interviews. It helped me notice how quickly we can forget what was going through our mind at a specific time, and potentially how the stories and narratives we construct vary and change over time and depending on who we are sharing them with.

This section is split into six parts covering: project selection, the conceptual introduction, recruitment, the experience of conducting the interviews and data analysis, as well as potential changes I would make were I to repeat the project. Given that this project had received (initial) ethical approval just prior to the declaration of the Covid-19 pandemic, the implications of conducting research in the context of this backdrop will be interwoven into each section given its interplay in all aspects.

### **Reflections on project selection**

Having been involved in numerous research projects that experienced significant recruitment difficulties, at the beginning of first year I initially thought that I would opt for a secondary data quantitative analysis project. My application to, and subsequent acceptance for, this primary qualitative data collection could not have been further from what I had thought I had originally wanted.

The project itself appealed to me for a number of reasons. Suicide (whether threats, gestures, attempts or death) has been found to be the single biggest anxiety-producing situation for psychotherapists (Menninger, 1990), perhaps, in part due to some of the

associated feelings of helplessness (Richards, 2000). This resonates with me and my experience of working with clients who present as 'risky'. I have, obviously, wanted to do everything possible in my power to prevent them from engaging in suicidal behaviour and, ultimately, prevent them from dying by suicide. I think during my clinical practice, when faced with someone presenting with suicidal thoughts, I have tended to resort to a structured format by way of conducting an appropriate risk assessment, rather than sit with those feelings, and I am aware of how this may be perceived as shutting down a client's feelings and experiences. This, too, is the case with bereavement, where we can often feel as though we need to 'have the answer' or 'fix', rather than simply sitting with, and bearing witness to, the immeasurable pain that is associated with loss. Coming into this project, I was very aware of my desire for this project to shape the kind of clinician I am when working with people who are feeling suicidal, as well as engaging with those that have been bereaved by suicide and, by extension, any significant loss.

The project was a joint piece of research with another UCL trainee whose study focused more on intrusive mental imagery experienced after a suicide bereavement. At the time of selecting a research project, I had not thought much about whether I wanted to be a sole researcher on the project (not counting the role of supervisors) or whether I wanted to collaborate with a colleague. However, having completed every step of this process with a fellow trainee, I cannot emphasise how grateful and appreciative I am of having her company. I think this is particularly true given that all the steps following the writing of the ethics application were conducted remotely and, as a result, I recognise that it can be a lonely endeavour. It was unbelievably helpful to bounce ideas, thoughts, reflections and questions off someone else who knew every intricacy of the project.

### **Reflections on conceptual introduction**

In the conceptual introduction, I endeavoured to review the literature that existed in relation to suicide prevention with a prominent focus on limiting physical access and limiting cognitive access. This was with the goal of assessing where the proposed empirical paper would sit within the landscape of literature related to suicide prevention, specifically of those bereaved by suicide. The conceptual introduction illustrated a gap in the literature related to understanding the cognitive availability of suicide in relation to personal past experience of, in this case, suicide bereavement. The key challenge I encountered was being able to adequately locate the current empirical study within the realm of existing research about the experience of suicide bereavement, as well as holding in mind the broad concept of cognitive availability for understanding the potential link between bereavement and thoughts about suicide and methods of suicide. I found this particularly hard given how much research already existed in relation to the links between celebrity suicides, news reports and media portrayals of suicide and suicidal behaviour. At times, this made me jump ahead to thinking about one of the end goals – suicide prevention – rather than exploring how we go about exploring the phenomenon, which would then enable thought into how we manage any associated risks.

### **Reflections on the recruitment process**

Initially, the study received ethical approval for face-to-face interviews taking place on the University College London (UCL) campus. However, following the UK Government's message to 'Stay at Home', we submitted an amendment to move the interviews online, with the use of a video platform called StarLeaf. Upon reflection, this was enabling to the recruitment process as it made the study more accessible to a greater number of people, by

way of participation being open to the whole of the UK, rather than restricted to those that lived close enough to London to attend an in-person interview (for which we were also constrained by the financial implication of a travel expense cap). Incidentally, the majority of participants who I interviewed would not have been able to be invited for interview had it been face-to-face given their location. Also, the time commitment required of participants was reduced to a maximum of 1.5 hours for the interview, rather than the interview time plus any necessary travel time.

When thinking about how to advertise the study, we thought carefully about recruiting both a help-seeking population through the dissemination of study information via a large bereavement charity but also on twitter, which we hoped would also capture a population who might not have been in touch with support services. We acknowledged that, in some ways, this limited the audience to those that had access to the internet and by extension were users of Twitter and other social media sites or support services. However, a number of participants reported hearing about the study through friends or family members, which suggests that the reach of the advert was wider than just those individuals who had access to social media and/or support services. Those that volunteered were a self-selecting group, which may not generalise to every experience of a non-self-selecting group, but this is not always possible to avoid.

In my experience, the process of recruitment has always been the hardest part of any research project. However, I found this population was a group that were only too willing to give up their time to take part. I think this is testament to both the desire to talk in-depth, and in an uncensored manner, about their painful experience as well as the cry for acceptable, sensitive and tailored support services or interventions. In the UK, we are part of a society that finds talking about death uncomfortable (Co-op, 2018). Indeed, many

participants referred to the stigma they perceived in relation to their loved one's death by suicide. They also alluded to the perceived lack of training of services and/or clinicians when working with clients who had been bereaved by suicide. I think these difficulties couple to make this a group that is very keen to further research knowledge in order to minimise, as much as is possible, the pain experienced by bereaved families in the future.

One of the biggest challenges associated with the recruitment process related to considering how we would recruit a group that included individuals for which the bereavement had impacted on thoughts about their own suicide. We were conscious that screening questions designed to elicit information about thoughts following suicide bereavement needed to be sensitive and appropriate. To support this, we included *'After bereavement by suicide, some people spend time thinking about what led their loved one to consider suicide. Is this something you have experienced? If so, please provide details below'*, with a follow up question of *'If there are any other details about the circumstances of the death of your loved one that you would like to mention, do please use the space below'*. Neither of these questions explicitly referred to people's own thoughts about suicide, or own suicidality or mental health, and while many individuals did report thinking about (or knowing) what factors had led up to their loved one's suicide, fewer spontaneously reflected on themselves including their own mental health journey following the bereavement. This made selecting and inviting participants difficult, particularly when the sister-study was able to so explicitly ask about the experience of intrusive mental imagery. This meant that at the beginning of the screening telephone call or the interview, I was unaware of whether this was someone for whom suicide had become cognitively available following the bereavement or whether it was someone for whom the loss had very much deterred them from suicide. I was also aware of my propensity for wanting a sample for

which I could explore the concept of cognitive availability. Fortunately, we were able to get a mixed group, which added to the richness of the data and did not neglect the experience of people for which the cognitively availability of suicide did not figure. This was necessary in order to begin to understand what it was about this group that differentiated them from the group who did report the bereavement making the possibility of suicide more of an option.

### **Reflections on the experience of conducting interviews**

#### **Online interviews**

The interviews were conducted over an online video platform, which I was initially a little hesitant about given I had anticipated the interviews being very emotive and, potentially, painful for the participants. Generally, I thought the online communication worked well and participants did not seem concerned or disappointed about doing it online, as opposed to face-to-face when I mentioned that this had been our original intention. The occasions where online interviewing was slightly more problematic was when internet connection was poor and the participant or myself would cut out or our videos would freeze onscreen. I worried that my having to ask them to repeat something, particularly if it was something emotive, would be invalidating. However, on the whole, participants did not share any annoyance about this, more so shrugging it off, which was likely a product of being five-plus months into a remote and online way of life.

#### **Researcher versus clinical role**

As mentioned, one of the reasons I chose this project was because I thought that it had the potential to hone some of my skills when working clinically with bereaved

individuals and, more specifically, with those bereaved by suicide, as well as when working with individuals who were feeling suicidal. Although both roles (researcher and therapist) require, in the first instance, some similar skills, for example, active listening, curiosity, elicitation of information and the taking of a neutral and non-judgemental position, there are key distinctions between them. Specifically, a therapist's role moves more into thinking about change, while a researcher's does not. During the interviews, I had to hold in mind the distinction between these roles and indeed the difference between the people I was encountering. Typically, when I work clinically, clients have come to me, the therapist, for help, whereas in this research, I (the researcher) was approaching the participant for help (Josselson, 2013).

I feel my clinical training and experience brought much to the process including being able to sit with, and bear witness, to intense pain and sadness. I found it freeing to be in a role of pure active listening, trying, as much as was possible, to understand an individual's experience as if I were in their shoes and seeing it through their eyes. I relished the opportunity to not be responsible for, or consider, the next steps (with the exception of immediate risk assessment). For example, how I might help a participant challenge a negative thought or identify unhelpful thinking styles. I also felt able to push a little when asking follow-up or clarifying questions, something that, perhaps, I would not have felt able to do without my experience as a therapist (Josselson, 2013).

However, at other times, I noticed some challenges when straddling the two roles. When a participant was particularly distressed or when they were pondering about getting extra support, I noticed myself taking on, or wanting to take on, more of a therapist role by way of validation or advice-giving. For example, I recall one participant agonising over their loved one having not left a suicide note and noticed myself sharing research that only



between 10-30% of the suicide population leave a suicide note (Ho et al., 1998), and acknowledging that, all too often, film portrayals of suicide paint a picture of suicide in a specific way, including with the individual often leaving a note. I questioned whether this was motivated by the researcher or clinician in me but noted that the participant seemed to find it helpful. I also found that I had to monitor my neutrality when clients alluded to negative experiences that they, or their loved ones, had had when accessing, or trying to access mental health services. Some participants were understandably very critical of the NHS or specific services, and I was aware that it was the very same organisation that I worked for. Therefore, I had to ensure that I did not come across as defensive, instead, remaining neutral and curious. At the same time, I was also aware that research exists that suggests poorer support following suicide bereavement, including the experience of stigma, and the tendency for others to feel discomfort and potentially avoid conversations around suicide, can make it harder for those bereaved (Dyregrov, 2004; Pitman et al., 2018). As such, there was a need to validate this very real experience that participants were having or had had.

Numerous participants spoke about how they had shared more with me than they had with their own therapist. For example, one participant said *“with a therapist, I don’t think I’ve been as open with a therapist as I have with you, to be honest”*. This felt like an important acknowledgment and it made me wonder what, in my role as a therapist, am I complicit in that potentially closes down the space to speak about, dissect and reflect on what someone is thinking and feeling. It made me reflect on what it was from this experience of conducting the research that I wanted to bring back to my clinical practice. I heard when people said they wanted a space to talk and I share the view that this is imperative. However, at the same time, it made me wonder how I could facilitate this in my

clinical practice without being complicit in potentially allowing elaboration and rehearsal, and potentially lowering a vulnerable individual's inhibition for suicidal behaviour, thus increasing their likelihood of engaging in such behaviour. I don't yet have an answer or solution to this, but it is definitely something that I will continue to consider.

### **Reflections on the process of analysis**

I transcribed all 20 interviews by hand, which helped me to become familiar with each participant's story and the dataset as a whole. However, I noticed that there were some participants and narratives that, at the time of the interview, and afterwards, I was more connected to. Upon reflection, this may have been impacted by how emotional the participants were, finding myself at times drawn into the emotion, as well as how able, for whatever reason, a participant was to look inward, engage in self-reflection and subsequently put into words their thoughts, feelings and experiences. During the process of analysis, I was very conscious that I was not unduly amplifying certain voices or particular narratives, although I acknowledge that certain participants' quotes were more frequently used than others' owing to the succinctness of different points.

### **Reflections on changes I would make**

As outlined in the discussion section of the empirical paper (Part 2), this study had a number of limitations. The demographics of my participants were mostly White British and female. These proportions were similar to those reported by the current largest study of suicide bereavement in the world (University of Manchester, 2020). Although we made a considered effort to reach men and those from black and ethnic minorities, we had a disproportionately small number express interest in taking part. I believe this is one of the

biggest drawbacks of the study. The fact that the participants were not as culturally and ethnically diverse as is evident in the UK population, as well as the fact that the male voice (a group that is significantly more likely to die by suicide; World Health Organisation, 2016) was not heard from as much, is a big shame. Additionally, we did not ask about peoples' religious views, which may have had relation to both their thoughts related to suicide (Theme 1), as well as their thoughts about reunion (Theme 4). This has understandable consequences for the generalisability to such populations. Were I to conduct the study again, I would make an even more considered effort to reach out to services such as CALM (Campaign Against Living Miserably), which although is no longer focused solely on male suicide, has roots based in the pursuit of preventing male suicide, as well as potentially via charities such as James' Place, whose mission is to stop men dying by suicide. Similarly, I would have made a more concerted effort to reach the older adult population (suicide rates begin to rise in those aged 80+; Office of National Statistics, 2019), as their experience may differ from younger participants. This would likely be facilitated by a non-online advertisement. I would also ask people what their religious affiliation was. To the extent that it is ethically possible, I think there is value to be gained from recruiting a population that had themselves attempted suicide following a bereavement by suicide in order to elucidate what factors they felt contributed to their attempt and the method that they used.

### **Conclusion**

This was my first experience conducting such a large qualitative project, and there were multiple obstacles to work through. I enjoyed reading around the subject matter but was challenged by the process of incorporating such a large amount of research into a

succinct and flowing narrative. I benefited from the requirement to balance the 'researcher' hat with my usual role as a clinician and was able to use the experience of speaking with participants to reflect on potential areas for development in my clinical practice. Overall, I found the project truly fascinating, captivated by the subject matter and particularly by peoples' willingness to share, in an uncensored manner, their experience of bereavement.

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# **Appendices**





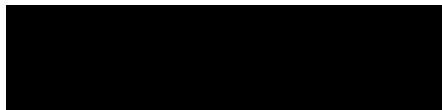
i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: <https://www.ucl.ac.uk/srs/file/579>
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely



**Professor Michael Heinrich**  
**Joint Chair, UCL Research Ethics Committee**

## **Amendment approval**

**From:** VPRO.Ethics

**Subject:** **APPROVED: Ethics Amendment -16587/001**

**Date:** 24 April 2020 at 12:12:44 BST

**To:** "Jones, Poppy"

**Cc:** "Quayle, Katie", "Kamboj, Sunjeev"

Ethics ID Number: 16587/001

Dear Poppy

That's great, thank you for getting back to me so quickly. I can now state that the REC Chair has approved your attached amendment request. Please take this email as confirmation of that approval.

**IMPORTANT:** For projects collecting personal data only

You should inform the Data Protection Team of your proposed amendments to include a request to extend ethics approval for an additional period.

Best wishes and take care,  
Lola

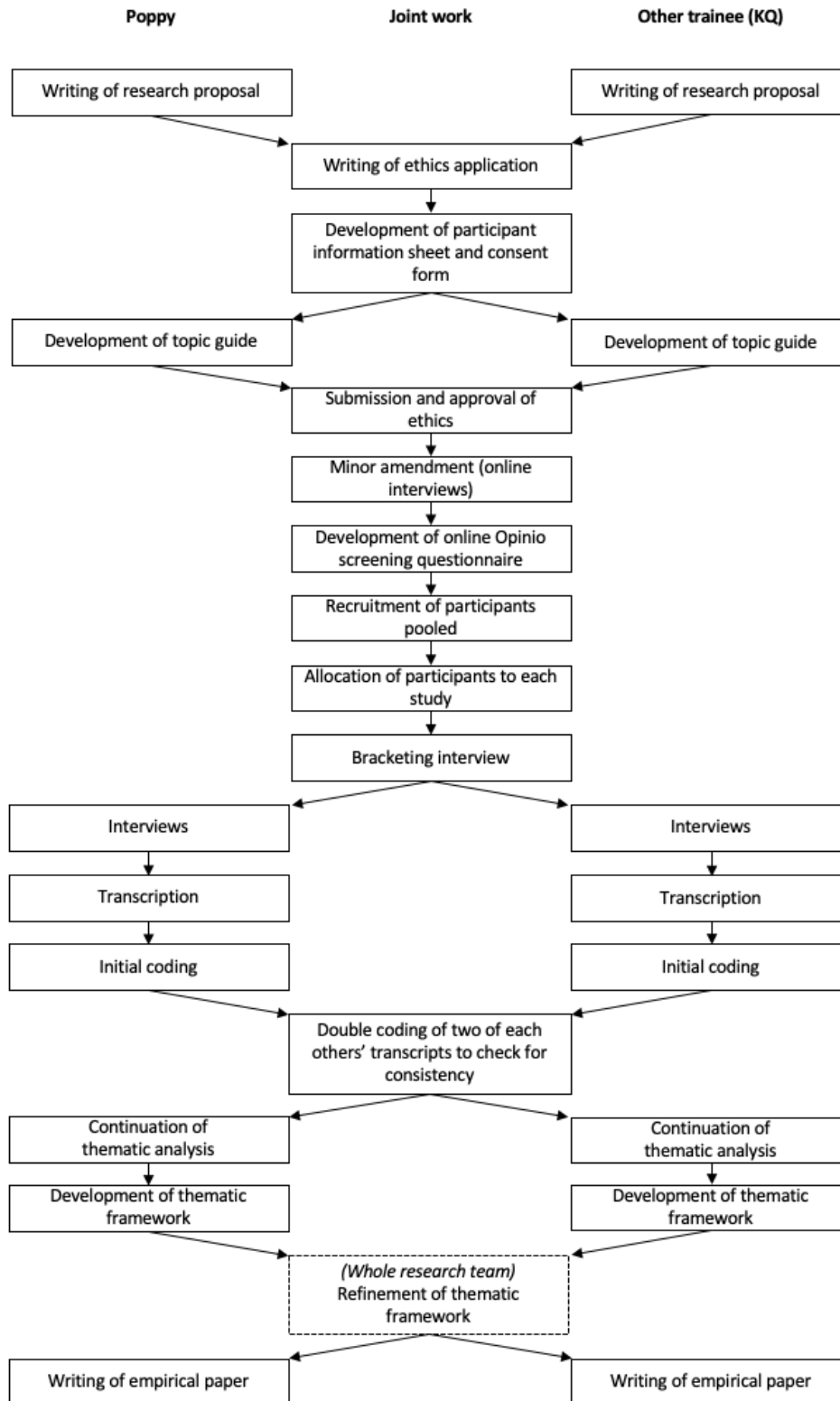
Lola Alaska  
Research Evaluation Administrator

Office of the Vice-Provost (Research)  
University College London, Gower Street, London WC1E 6BT  
Web: <http://www.ucl.ac.uk/research>

UCL Internal:  
2 Taviton Street, London WC1H 0BT

## Appendix B: Flow chart of respective contributions to this joint thesis project


Note: Part 1 (conceptual introduction) and Part 3 (critical appraisal) of each thesis was written completely independently



## Appendix C: Tweet and advert for Twitter recruitment


### Tweet:

Have you lost a friend or relative to #suicide? Our team @UCL @UCLPALS @UCLPsychiatry are researching experiences of thoughts and mental images after #suicidebereavement. If interested in taking part in an online interview, please click on this link <https://opinio.ucl.ac.uk/s?s=66703>



### Research about thoughts and images following suicide bereavement

Researchers from UCL would like to invite people who have lost a friend or relative to suicide to participate in a research study. This is to understand more about the thoughts and images people experience after a suicide bereavement.



Participation would involve a confidential, online interview about your experiences. This would last no longer than 90 minutes and would be conducted using a platform of your choice (e.g. Skype, MS Teams, etc).

If you would like to know more or are interested in taking part then please go to <https://opinio.ucl.ac.uk/s?s=66703> or contact:  
Poppy Jones or Katie Quayle  
This study has been approved by the UCL Research Ethics Committee 16587/001

## **Appendix D: Recruitment email distributed by a leading suicide bereavement charity**

Dear SASP member,

I am one of the Patrons of the Support After Suicide Partnership, and work at University College London (UCL), where I am conducting research to understand the impact of suicide bereavement. The study I am currently working on with UCL colleagues aims to understand the experience of intrusive thoughts and mental images after suicide loss. Sarah and Hamish have kindly offered to publicise this study through the SASP membership. I would be very grateful if you would consider sending this email to the members of your own organisation, or indeed specific individuals who you feel might be willing to participate in this research study. Attached to this email is the information sheet and below is the link where participants can express their interest in taking part, and also download a copy of the information sheet:

<https://opinio.ucl.ac.uk/s?s=66703>

We have also tweeted about the study, and would be very grateful if your organisation could retweet this:

<https://twitter.com/DrAPitman/status/1273262149742313472>

Our study has been approved by the UCL Research Ethics Committee for video interviewing instead of face-to-face interviews, in view of the COVID-19 restrictions. Interviews will take place using an online platform of the participants' choice (for example, Skype, Microsoft Teams, etc.), as long as the participant is a UK resident.

If you have any questions about the study do please contact my UCL colleagues:

Poppy Jones:

Katie Quayle:

Many thanks for your support.

Dr Alexandra Pitman

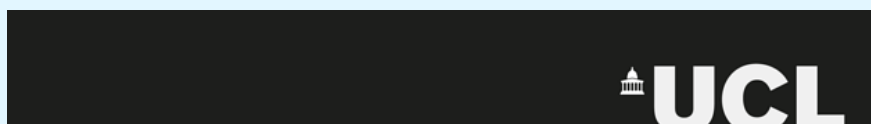
Associate Professor in Psychiatry, Honorary Consultant Psychiatrist

UCL Division of Psychiatry

<https://supportaftersuicide.org.uk/who-we-are/our-patrons/>

## Appendix E: Online screening questionnaire

### Understanding the Experience of Intrusive Thoughts and Images After Suicide Bereavement



Thank you for your interest in taking part in this research project.

Below is a summary of the study aims and methods. Please click below to download the detailed participant information sheet.

[Participant Information Sheet.pdf](#)

#### Overview of the Project

Each year approximately 6,000 people die by suicide in the UK, and in each case a network of relatives, friends, colleagues, and neighbours are left behind. We are beginning to understand the impact of suicide bereavement on health and social functioning, but there is much more to learn. People seem to be affected in very different ways, and require different types of support at different stages. The more we understand about the experience of suicide bereavement, the more we can tailor support for those who are left behind.

Some people experience intrusive thoughts or images in their mind related to the death. This research study aims to further our understanding of how individuals who have been bereaved by suicide experience mental images or thoughts about the death. We want to understand the impact that these images or thoughts have on the bereaved.

#### What it involves?

Our criteria for eligibility relates to the nature of a bereaved person's intrusive thoughts or images after suicide loss. If you are eligible to take part, and consent to do so, you will be invited to an online interview (using a platform of your choice such as Skype, Microsoft Teams). Due to the terms of our ethical approval we are unable to use Zoom. The interview will last around an hour, and a maximum of 90 minutes, and be audio-recorded. More details are available in the Participant Information Sheet. Any questions can be directed to either of the researchers:

**Poppy Jones**  
**Katie Quayle**

Further information on how UCL protects participant information can be found in our general privacy notice for participants in health and care research studies, click [here](#)

If you would like to volunteer to take part in the study, or are interested in learning more about the research, please fill in your contact details and other information on the following page. One of our researchers will then get in touch with you to discuss the study further.

Start

Powered by  
[Opinio Survey Software](#)

## Understanding the Experience of Intrusive Thoughts and Images After Suicide Bereavement

1. How did you find out about this research? (e.g. twitter, a support group etc.)

2. Name:

3. Where are you a resident?

(NB: We are unable to analyse data from beyond the UK due to the terms of our ethics approval)

Please select  
England  
Wales  
Scotland  
Northern Ireland  
Outside of the UK

4. Contact Number:

5. Email:

6. Preferred mode of initial contact:

- Telephone  
 Email

7. Best time to contact you [select multiple]:

- Weekdays  
 Weekends  
 Morning  
 Afternoon  
 Evening  
 Anytime

8. If you were to take part in this study, we are required by the terms of our ethics approval, to ask you for the address at which you will be present during the interview. Are you, in principle, agreeable to providing us with that address if you consent to take part?

- Yes  
 No

9. Age:

Please select  
18-25 years  
26-35 years  
36-45 years  
46-55 years  
56-65 years  
66-75 years  
76-85 years  
86-95 years  
96+ years

10. Gender:

Please Select  
Male  
Female  
Transgender Female  
Transgender Male  
Gender Non-Conforming  
Other  
Prefer Not To Say

11. **Ethnicity:**

Please select one of the options below  
White British  
White Irish  
Other White groups  
Asian or Asian British: Indian  
Asian or Asian British: Pakistani  
Asian or Asian British: Bangladeshi  
Asian or Asian British: all other  
Black or Black British: Caribbean  
Black or Black British: African  
Black or Black British: all other  
Mixed race: White and Black Caribbean  
Mixed race: White and Black African  
Mixed race: White and Asian  
Mixed race: all other  
Chinese  
Other ethnic groups  
Unable to respond

Other ethnic groups. Please state:

12. **What relationship was the person who died to you? i.e. He/She was my...**

Please tick one of the options below  
Brother  
Sister  
Father  
Mother  
Son  
Daughter  
Partner or spouse  
Ex-partner or ex-spouse  
Grandparent  
Close friend  
Close colleague or client  
Cousin  
Niece or nephew  
Uncle or aunt  
Uncle by marriage or aunt by marriage  
Brother-in-law or sister-in-law  
Mother-in-law or father-in-law  
Other – (eg half-, step-, or adoptive relative or a relative by marriage). Please state below.

Other. Please State.

13. **How long ago did your relative or friend die? (years and months)**

If you feel able to, please write a couple of sentences in response to the questions below. This is to give us an idea of the experiences you have had, including in relation to any intrusive thoughts or images.

14. **After bereavement by suicide, some people may experience images that pop into their mind that relate to the suicide. Is this something you have experienced? If so, please provide details below.**

15. **After bereavement by suicide, some people spend time thinking about what led their loved one to consider suicide. Is this something you have experienced? If so, please provide details below.**

16. **If there are any other details about the circumstances of the death of your loved one that you would like to mention, do please use the space below.**

Please click **Finish** below. The details you submitted will be saved and one of our researchers will be in contact with you.

Finish



## Understanding the Experience of Intrusive Thoughts and Images After Suicide Bereavement

Thank you for completing this questionnaire.

Please [click here](#) to view or download a document which details support services for people who have been bereaved by suicide, which you may find helpful.

Powered by  
[Opinio Survey Software](#)

## Appendix F: Participant information sheet



### **Participant Information Sheet for UCL Suicide Bereavement Study**

UCL Research Ethics Committee Approval ID Number: 16587/001

**Project Title:** Understanding the experience of intrusive thoughts and images after suicide bereavement: a qualitative interview study

**Researcher:** Poppy Jones [REDACTED] and Katie Quayle [REDACTED]

**Principal Researcher:** Dr Sunjeev Kamboj [REDACTED]

**Supervisors:** Dr Alexandra Pitman [REDACTED] and Dr Martina di Simplicio [REDACTED]

**Department:** UCL Division of Psychology and Language Sciences

You are being invited to take part in a doctorate research project. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take some time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

#### **What is the purpose of the research?**

Given the number of people that die by suicide each year, relatively little is known about the experience of those who are left behind. Everyone will be affected in their own way. Some people experience thoughts or images in their mind related to the death.

Often people feel they would benefit from support following the bereavement. There is limited tailored support which is in part because we still do not fully understand what different people experience.

This research aims to further our understanding of how individuals who have been bereaved by suicide experience images and thoughts, whether these relate to the deceased or the self, and how these impact upon them.

#### **Why have I been invited?**

You have been invited to participate in this study because you have been bereaved by the suicide of someone you know. In order to participate in the research, you must be at least 18 years old and have experienced a bereavement by suicide of a close contact. This could include a family member, a friend or a colleague. You must be able to speak English fluently and must not have been diagnosed with a cognitive impairment or learning disability. You must also live in the UK.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. You can withdraw at any time without giving a reason and without it affecting any benefits that you are entitled to. If you decide to withdraw, you will be asked what you wish to happen to the data you have provided up that point.

**What will happen to me if I take part?**

If you take part, you will be invited to take part in an online interview with one of our researchers, which will last up to 90 minutes. Interviews will be audio recorded (not video recorded) and will use a platform of your choice (such as Skype, Microsoft Teams etc.) You have the option to consent to review a copy of your interview transcript for accuracy.

You can choose to remove your data up until the point of transcription which will take place two weeks after your interview. This can be requested via email (within two weeks of the interview).

If you would be happy to take part in future research, then you can indicate this on the consent form. Your contact details will be held on a secure database and, if you consent to this, you may be contacted by us via email with information about taking part in future studies on this topic.

**Why will it be recorded and what will happen to my recording?**

The audio recording will only be used to allow the researcher to analyse the transcription of the interview. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings. During the transcription stage, recordings will be stored on encrypted and password protected drives. Following completion of the research, all recordings will be deleted.

**What are the possible disadvantages and risks of taking part?**

It can be difficult to talk about the death of someone who is close to you, and therefore some people may find it distressing to take part in the research. The interview can be paused at any time if you feel you are getting distressed.

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

Taking part helps researchers and healthcare professionals develop their understanding of individuals' experiences which helps to develop the right support for people.

**What if something goes wrong?**

If there is anything you are unhappy about while taking part in the research then we encourage you to raise this with the Principal Researcher whose contact details are listed on the first page of this information sheet. If you feel unable to do this, or do not feel it has been handled to your satisfactions, then you can contact the Chair for the UCL Research Ethics Committee – [ethics@ucl.ac.uk](mailto:ethics@ucl.ac.uk)

**Will my taking part in this project be kept confidential?**

All data will be collected and stored in accordance with the GDPR 2018. This means that all of the information that we collect will be kept strictly confidential and securely. When the research is written up, you will not be able to be identified.

**Limits to confidentiality**

Please note that what is discussed during the interview will be kept confidential. There may be some occasions where we have to break confidentiality, including if we feel that you, or someone else, is at risk of harm. We would try and ensure that we discussed this with you before taking the appropriate steps including contacting other professionals, such as your General Practitioner (GP) but acknowledge that this is not always possible. We require you to provide the name and contact details of your GP for this purpose on the consent form.

**What will happen to the results of the research project?**

Once the project is finished, it will be presented as part of a doctoral thesis and written up for publication in a peer-reviewed journal. If published, you will be able to access a copy of the publication via the Iris webpage of the Principal Investigator. The transcripts will be securely archived at UCL in perpetuity. Transcripts will have all identifiers removed and will only be identifiable by age, gender, ethnicity and time since bereavement. Transcripts will only be accessible my members of the research team.

**Local Data Protection Privacy Notice**

**Notice:**

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at [data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk)

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice for participants in health and care research studies, click [here](#)

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used will be as follows:

Name	Age
Address	Sex
Contact Number	Ethnicity
Email	

The lawful basis that will be used to process your personal data are: 'Public task' for personal data and 'Research purposes' for special category data.

Your name and email will only be stored until such point as a final transcript of your interview has been made (subject to you reviewing the transcript). After this point, the transcript will be saved in a pseudoanonymised format. If you chose to have your contact details stored for communication about future research, then this will be kept securely and separately from data collected in this study.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at [data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk).

**Who is organising and funding the research?**

This research is being funded by UCL as part of their Clinical Psychology Doctoral Programme.

**How can I contact the researchers?**

You can contact any of the researchers listed on the first page of the information sheet via email or telephone.

**This information sheet is for you to save for your own records. If you consent to take part, we will also email you a copy.**

**Thank you for reading this information sheet and for considering taking part in this research study.**

## Appendix G: Participant consent form



### CONSENT FORM FOR INTERVIEW PARTICIPANT

Please complete this form after you have read the Information Sheet about the research.

**Project Title:** Understanding the experience of intrusive thoughts and images after suicide bereavement: a qualitative interview study

**Researcher:** Poppy Jones [redacted] and Katie Quayle [redacted]

**Principal Researcher:** Dr Sunjeev Kamboj [redacted]

**Supervisors:** Dr Alexandra Pitman [redacted] and Dr Martina di Simplicio [redacted]

**Department:** UCL Division of Psychology and Language Sciences

**Name and Contact Details of the UCL Data Protection Officer:** Alexandra Potts [redacted]

**This study has been approved by the UCL Research Ethics Committee: Project ID number: 16587/001**

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 emailed a signed 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.	
2.	I confirm that I live in the UK. I confirm that the following address is where I will be while the interview takes place: First line: _____ Second line: _____ Town: _____ County: _____ Postcode: _____	
3.	I voluntarily consent to partake in the study. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing, and 'research purposes' will be the lawful basis for processing special category data.	
4.	I confirm that I have access to an online video platform. I consent to my interview being audio recorded and understand that the recordings will be destroyed within 18 months of the data being collected.	
5.	I understand that my data gathered in this study will be stored securely on encrypted and password-protected drives. When the research is written up, I understand that it will not be possible to identify me. I also understand that I can withdraw my data up to two weeks after the interview has taken place.	

6.	I understand that assurances on confidentiality will be adhered to unless there is evidence that potential harm may occur. In such cases, I understand that the researcher(s) may need to contact relevant health professionals.	
7.	I wish to be contacted following transcription of my interview in order to review the accuracy of the transcription.	
8.	I agree that my anonymised research data (transcripts of the interview) may be used by the research team for future research.	
9.	I understand that by providing the details below of my registered General Practitioner (GP), I am giving consent for contact to be made should any risk issues arise.	

GP Name: \_\_\_\_\_

GP Address: \_\_\_\_\_

GP Contact Number: \_\_\_\_\_

**If you would like your contact details (name and email address) to be retained so that you can be contacted in the future by our research team 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

## Appendix H: Interview topic guide

### Topic Guide

At the start of each interview the interviewer will be clear that the interviewee does not have to answer any of the questions if they prefer not to, and that in this event the interviewer will move onto the next question and will fully understand their preference not to respond. The interviewer will also be clear that they can pause the interview at any point. Before every few questions the interviewer will remind the interviewee that they don't have to answer any question if they prefer not to. Throughout these interviews we will review this topic guide, and if we feel that any of the questions are inappropriate, we will remove them. If we feel that any other should be added, we will make a UCL REC application for a minor amendment.

In this document we outline the questions we propose to ask in guiding each set of interviews. The interviewer will begin with fairly broad questions, with some initial orienting questions to build on what was disclosed in the online screening questionnaire. The purpose of these will also be to build rapport, before moving on to a deeper exploration of imagery and/or cognitions.

#### **Study 2: Understanding the experience of intrusive thoughts after suicide bereavement Interviewer: Poppy Jones, Trainee Clinical Psychologist**

Semi-structured interview topics/key questions:

*Opening statement, e.g. "you told us in the questionnaire that you lost your [insert kinship] due to suicide [X] years ago, and that he/she was [X] years old at the time"...*

- *How would you describe your relationship with [name]?*
- *How did you find out about the death? Were there aspects of it that you did not find out about until much later?*
- *Are you aware of any factors or circumstances that may have contributed to their death? (prompts: including any mental health difficulties, financial difficulties, significant life events)*
- *Did you have any warning signs that he/she was considering suicide? E.g. expressing suicidal thoughts, previous attempts, comments on social media, becoming very withdrawn*
- *Have you had thoughts about how they might have felt before they died? What are your thoughts about what was going on in their mind at the time/leading up to his/her death?*
- *(If the nature of the death has been established from information gathered in the screening questionnaire) You mentioned your [kinship/name] died in a peaceful way/violent way, do you have any thoughts on what might have influenced the method that s/he might have chosen?*
  - o *Or*
- *(If no prior information disclosed) Would you mind if I asked about the way in which [name/kinship] died? And I ask you this because I would be interested to know why you thought they might have chosen that particular method.*
- *In what way, if any, has their death impacted/affected your thoughts about suicide? Has this affected your own thoughts about how you cope with difficulties in your own life?*
- *Have you had thoughts about wanting to be with that person? Do you have thoughts about reunion/reuniting with [name]?*

If they mentioned they had experienced their own suicidal thoughts:

- *You mentioned that you experienced your own suicidal thoughts following the death of [name], how has the way in which [name] died impacted upon you? (Prompt for thoughts, feelings and behaviours) How frequently do you experience these thoughts? How compelling are they? (prompt/clarification: do you feel they influence your thoughts or actions in any way? How do you cope with this?*

**Appendix I: Illustration of stage of analysis**

Transcript Extract	Initial Nodes <sup>a</sup>	Coding <sup>a</sup>	Theme / Subtheme
<p><b>Interviewer:</b> Yeah. I guess in what way, if any, has his death impacted upon your own thoughts about suicide?</p> <p><b>Participant:</b> I think probably, I guess in two different, maybe, conflicting ways. I, I guess I've, for context, feel like I've probably struggled with my mental health in my life before and after my Dad's death. And I, I guess I partially feel more like, I partially feel like it makes it almost like a valid option, I think for me when I have suicidal thoughts, my main thing that stops me is, it probably wouldn't work, or, you know, I made a pathetic attempt before and it was, you know, it, you know, the statistics on suicide are not good for the person trying to kill themselves and you'd be much worse off having tried to commit suicide and ended up not doing it and having to deal with the aftermath of that and all the problems you were having. I guess the fact that he went through with it particularly makes me feel like it's a valid, it obviously works for some people but it, also I guess makes me realise the impact and the, you know, the, I guess the effect it has on so many people, friends, family,</p>	<p>Feeling conflicted</p> <p>Struggles with mental health</p> <p>Makes it a valid option</p> <p>Concerns around it not working</p> <p>Previous suicide attempt</p> <p>Feel she would be worse off if didn't die</p> <p>His suicide made it more valid</p> <p>The impact on people around</p>	<p>Valid option</p> <p>Wanting to guarantee own death</p> <p>Valid option</p> <p>Impact on others</p>	<p>Suicide being a legitimate option</p> <p>Concerns around being found alive and wanting to guarantee own death</p> <p>Suicide being a legitimate option</p>





<p>you know, I feel like I can, can see that he wasn't, you know, he wasn't doing it, you know, he's obviously only doing it for himself, I guess.</p> <p>Interviewer: It sounds like, maybe, your own, having some insight into what it's like to feel in that dark place [yeah], gave you some insight to say 'he's not in the frame of mind to be thinking about the aftermath [yeah] maybe'</p> <p>Participant: Yeah exactly, I think the other probable main thing that it's had impact on me and my thoughts about suicide generally is that, it's probably not a good thing but I definitely feel much more nervous or apprehensive about talking to my family, in particular, about how I feel when I'm feeling low or if I have suicidal feelings because I feel like they're so, almost, on edge about it, having gone through it that they, you know, yeah, I guess they would be so worried about 'oh my god, her Dad's already killed himself, what if she does it too?', that whilst, you know, you know, not got an active plan for killing myself, but if I have suicidal thoughts that, whilst I would much rather talk about it to people because I feel like people</p>	<p>Understanding of his position</p> <p>Suicide probably isn't a good idea</p> <p>Apprehension about sharing when feel low</p> <p>People are on edge</p> <p>Possible jumping to conclusions</p> <p>Wants to talk to people around her/ get support</p>	<p>Being deterred from suicide</p> <p>Barrier to help-seeking</p>	
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<p>should talk about it, I would mainly only talk to my husband about it because my [family], whilst I'm really close to them, I guess are almost, you know, because they've gone through it already once quite recently, I wouldn't want to make them worry that it would happen again.</p>	<p>Don't want to worry people</p>		
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<sup>a</sup> The first full review of the transcripts was very in-depth. Some of the nodes identified were outside the realm of the research questions, and as such were not taken forward to the theme/subtheme phase. These have been retained for a potential future publication using the same dataset but with a different research question.

## Appendix J: Permissions for use of figures

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Best wishes,

Lianne

--

Lianne Parkhouse  
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<https://doi.org/10.1098/rstb.2017.0268>

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## Permission for Figure 2: O'Connor and Kirtley's (2011; 2018) Integrated Motivational-Volitional (IMV) Model of Suicide Behaviour

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