Exploring the nature of the phenomenon of intrusive mental imagery after suicide bereavement.

Katherine Quayle

D.Clin.Psy thesis (Volume 1), 2021

University College London

UCL Doctorate in Clinical Psychology

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: Katherine Quayle

Date: 10th June 2021

Overview

Intrusive mental imagery is a common phenomenon which occurs with increased prevalence following exposure to a traumatic event. Intrusive mental imagery has been reported by people bereaved by suicide but has not been formally investigated as a phenomenon within the context of suicide loss. **Part 1** of this thesis provides a conceptual introduction to intrusive mental imagery in suicide bereavement. The impact of suicide bereavement is discussed and current literature that looks at intrusive mental imagery in the context of posttraumatic stress disorder and traumatic bereavement is explored. Finally, the phenomenon of intrusive mental imagery in suicide bereavement is discussed. **Part 2** of this thesis presents a novel empirical study of the phenomenon of intrusive mental imagery in people bereaved by suicide, designed to explore both the nature and experience of mental imagery in people bereaved by the suicide of a close contact. Thematic analysis of detailed interviews with those bereaved by suicide loss provide an understanding of the nature of the phenomenon of intrusive mental imagery after a suicide bereavement. Findings have theoretical and clinical implications for understanding the experience of and supporting people bereaved by suicide, in addition to increasing to our understanding of intrusive mental imagery more broadly. Part 2 was conducted as a joint project (Jones, 2021) exploring the subjective experiences of people bereaved by suicide. Individual contributions are outlined. **Part 3** provides a critical review of this thesis, reflecting on the processes and challenges encountered, as well as reflections on the implications of the research.

Impact Statement

There is limited evidence for efficacy of interventions currently available for people bereaved by suicide. The Department of Health has acknowledged the need to develop evidence-based interventions in order to better support this group of people. Bereavement by suicide is a traumatic experience, however while intrusive mental imagery has been reported within this population in studies which look at traumatic and violent loss more broadly, there is little understanding of the phenomenon of intrusive mental imagery experienced by those bereaved by suicide. This thesis explored the nature of intrusive mental imagery experienced after suicide bereavement. Results of this thesis could be of use both clinically and academically. The empirical study conducted as part of a thesis provides, to our knowledge, the first phenomenological study of intrusive imagery experienced by people bereaved by a suicide loss; exploring the nature, experience and impact of intrusive mental imagery following suicide bereavement of a close contact. The results have potential for informing future research in the area of suicide bereavement in order to develop our understanding of this experience and the support sought by those bereaved, as well as informing research in the development of evidence-based interventions for intrusive mental imagery for people bereaved by suicide loss. Such research and the development of evidence-based interventions would inform clinical work with those bereaved by suicide. This research may also support individuals in having a shared understanding of their experience of intrusive mental imagery after suicide loss, which may be of value on an individual level. Academically, this research contributes to our understanding of the suicide bereavement process and the experience of intrusive mental imagery more broadly. Methodologically, this work

adds an in-depth subjective exploration using qualitative methods to the body of literature on suicide bereavement and intrusive mental imagery following traumatic loss and has demonstrated the value of such methods in this area. Overall, it is hoped that the results of this thesis will have useful implications both clinically and academically, as well as informing further research, which may contribute to future mental health policy.

Table of Contents

Thesis Declaration Form _____ 2

Overview _____ 3

Impact Statement _____ 4

Table of Contents _____ 6

Table of Tables _____ 9

Acknowledgements _____ 10

Part 1: Conceptual Introduction _____ 11

Abstract_____ 12

Introduction_____13

Suicide Bereavement _____ 15

Defining Suicide Bereavement _____15

Risks Associated with Suicide Bereavement _____ 16

Suicide Bereavement and Coping _____16

Intrusive Imagery _____19

Defining Intrusive Mental Imagery _____19

Intrusive Imagery in People Bereaved by Suicide _____ 20

Suicide Bereavement and Post-traumatic Stress Disorder _____ 21

Mental Imagery in Trauma-Related Disorders _____ 23

Imagery in Grief _____ 25

Imagery in Violent Loss and Suicide Bereavement _____ 27

Therapeutic Intervention _____31

Consideration for Methods _____33

Summary and Aims of the Thesis _____35

Summary _____ 35

Aims of the Thesis _____ 36

References _____ 38

Part 2: Empirical Paper _____ 47

Abstract _____ 48

Introduction _____ 49

Suicide Bereavement _____ 49

Intrusive Imagery _____ 49

Method _____ 51

Participants _____ 51

Materials _____ 54

Procedure _____ 55

Results _____ 57

Discussion _____ 81

References _____ 90

Part 3: Critical Appraisal _____ 94

Introduction _____ 95

Reflections on Selection of the Research Project _____ 95

Reflections on Methodology _____ 96

Reflections on Processes of Data Collection _____ 98

Reflections on Processes of Data Analysis _____ 102

Reflections on the Implications of the Research _____ 103

Conclusion _____ 105

References _____ 107

Appendices _____ 108

Appendix A – Ethical Approval _____ 108

Appendix B – Outline of Trainee Contributions _____ 110

Appendix C – Screening Questionnaire _____ 111

Appendix D – Participant Information Sheet _____ 113

Appendix E – Participant Consent Form _____ 116

Appendix F – Interview Schedule _____ 118

Appendix G – Outline of the Process of Thematic Analysis _____ 119

Appendix H – Distribution of Themes Amongst Participants _____ 122

Table of Tables

Table 1: Demographic characteristics of the sample_____ 53

Table 2: Thematic framework_____ 58

Table 3: Participant characteristics_____ 59

Acknowledgements

I would like to thank everyone who participated in the research study presented in this thesis for their time, courage and thoughtfulness during the interviews, which has provided such a rich source of information. I am so grateful for your willingness to share your stories and experiences with me.

I would like to thank my external supervisor Dr Alexandra Pitman for her time and expertise in supervising the design and running of this research study, and for her invaluable feedback on my thesis. I would also like to thank my internal supervisor Professor Sunjeev Kamboj for his supervision of this thesis, his encouragement and valuable guidance throughout.

I would like to thank my colleague and fellow trainee, Poppy Jones, for the numerous zoom meetings, emails, telephone calls and voice notes. I am so grateful for the support to get through an almost entirely remote thesis project.

Finally, I would like to thank my family and friends for their support during this doctorate. For your love and encouragement throughout this journey, I am so grateful.

Part 1: Conceptual Introduction

Understanding the nature of the phenomenon of intrusive mental imagery after suicide bereavement.

Abstract

Despite nearly 800,000 global suicide deaths annually (World Health Organisation [WHO], 2019) resulting in an estimated 48 million people exposed to suicide bereavement each year (Pitman et al., 2014), still little is known about the experience of those bereaved by suicide. This chapter explores the concept of intrusive mental imagery experienced by people bereaved by suicide, providing a detailed review of existing research relevant to the empirical chapter, which will examine the phenomenology of imagery experienced in people bereaved by suicide. Current research that looks at the impact of suicide bereavement has focused largely on the increased risk of adverse health and social outcomes in those bereaved by suicide, such as post-traumatic stress disorder (PTSD), depression, suicide attempt, and physical health problems, as well social support, stigma, and methods of coping. However, research tends to neglect the subjective experiences or individual symptoms experienced. Despite much research acknowledging the prevalence and impact of intrusive mental imagery in traumatic and violent loss more broadly, little is known about the distinct experience of intrusive mental imagery in those bereaved by suicide. To our knowledge, there is no research which explores the phenomenon of intrusive mental imagery experienced by people bereaved by suicide. In order to further explore the nature and experience of intrusive mental imagery experienced by people bereaved by suicide, this chapter provides a review of current literature, consideration of methods for exploring the phenomenon are discussed, and finally the research aims are outlined providing an introduction to the empirical chapter.

Introduction

The World Health Organisation (WHO) estimates that nearly 800,000 people die due to suicide each year across the world and identifies the highest crude suicide mortality rates as recorded in the European region (WHO, 2019). Consequently, each year millions of people worldwide are bereaved by suicide. Studies report increased negative health and social outcomes, as well as increased risk in people bereaved by suicide (Erlangsen et al., 2017; Pitman et al., 2014), however it remains unclear as to why people bereaved by suicide face such adverse impacts (Erlangsen et al., 2017; Pitman et al., 2014, 2020).

Despite significant adverse impacts and increased risks faced by those bereaved by suicide, much of the support available following suicide loss falls on the shoulders of charity organisations with very little tailored, evidence-based support available from mental health teams within the National Health Service (NHS). Policy makers are paying increasing attention to the risks associated with suicide bereavement, acknowledging the need to develop a new national suicide prevention strategy to continue to address the devastating impact that suicide has on the bereaved. Providing effective support to those bereaved by suicide is a key priority identified within the strategy; acknowledging the need for developing effective evidence-based interventions to support people bereaved by suicide in the grieving process, preventing additional long-term emotional distress and supporting recovery (Department of Health, 2012). The limited evidence for efficacy of interventions currently available to people bereaved by suicide has further been acknowledged (Adriessen et al., 2019; Linde et al., 2017; McDaid et al., 2008; Szumilas & Kutcher, 2011;).

The suicide bereavement experience is often described as traumatic (Pitman et al., 2016) and many studies have identified an increased risk of developing PTSD, and symptoms akin to those found in PTSD, namely intrusions, in those bereaved by suicide and other violent loss alike (Dyregrov et al., 2003; Erlangsen et al., 2017; Kaltman & Bonanno, 2003; Mitchell & Terhosrt, 2017; Zisook et al., 1998). Similarly, studies have identified the experience of memories and recurrent intrusive imagery in those bereaved relating to the suicide or violent loss of their loved one for years following the death (Baddeley et al., 2015; Jackson et al., 2015). The experience of such intrusive imagery can be incredibly distressing and is associated with bereavement-related PTSD, depression and complicated grief which can persist at elevated rates for years after the loss (Baddeley et al., 2015; Murphy et al., 1999). Although such links have been identified, intrusive mental imagery experienced by people bereaved by suicide remains poorly understood and is therefore often largely overlooked when supporting people bereaved by suicide (Dyregrov, 2002).

In order to develop evidence-based interventions aimed at providing enhanced support for people bereaved by suicide, we first need to consider existing research in the area, exploring the concept of intrusive mental imagery experienced by people bereaved by suicide, and further develop our understanding of the subjective experience and individual symptoms of suicide bereavement associated with the identified risks in suicide loss.

This introduction will explore the concept of intrusive mental imagery experienced by people bereaved by suicide, with consideration for the occurrence, prevalence, nature and treatment of intrusive mental imagery. It will begin by defining key concepts including suicide bereavement, discussing associated risks and coping in suicide bereavement, before defining mental imagery and describing

imagery experienced in suicide bereavement. A review of the literature will evaluate research in the area of intrusive mental imagery in bereavement and trauma, and more specifically imagery in violent loss and suicide, before briefly reviewing work in the area of imagery-rescripting interventions, which is a novel intervention in the treatment of specific clinical groups, but not as yet applied to people bereaved by suicide. Finally, gaps within this area of research will be discussed, methods for the research will be outlined and the aims and associated research questions will be defined.

Suicide Bereavement

Defining Suicide Bereavement

Suicide bereavement describes a period of grief experienced by family, friends and close contacts of the deceased who are affected by the loss after a suicide death (Pitman et al., 2014). Research in the area of suicide bereavement together with WHO suicide statistics suggests that between 48 million and 500 million people are exposed to suicide bereavement every year (Pitman et al., 2014). Although grief is a normal response to loss, there is much evidence that suicide has a more damaging impact upon families, friends, colleagues, and communities who are affected by the loss. These adverse outcomes (e.g., difficulties in adjustment, chronic grief, mental health problems, and quality of life) are likely related to the sudden nature of suicide loss, usually unexpected and paired with a lack of anticipatory grief (Pitman et al., 2020), however this remains unclear and still little is known about the phenomenology of the experience of suicide bereavement.

Risks Associated with Suicide Bereavement

Much research in the area of suicide bereavement to date has focused on the increased risk of adverse outcomes associated with suicide loss (Eng et al., 2019; Erlangsen et al., 2017; Lobb et al., 2010; Pitman et al., 2014, 2015). It is well established that people bereaved by suicide face an increased risk of negative outcomes following the bereavement. Studies report increased negative health and social outcomes and increased risks associated with bereavement by suicide of a close contact, including increased risk of complicated grief (Lobb et al., 2010) and increased physical health problems after the loss (Erlangsen et al., 2017), in addition to an increased risk of depression, substance misuse, admission to psychiatric care, and risk of suicide (Eng et al., 2019; Erlangsen et al., 2017; Pitman et al., 2014, 2015). Furthermore, psychological symptoms and disorders experienced following suicide loss can persist at elevated rates for many years after the bereavement (Murphy et al., 1999); an indication of the potential impact of the risks associated with suicide bereavement.

Suicide Bereavement and Coping

Negative Psychological Impacts

Grief is a normal response in the bereavement experience following the loss of a close contact, however there is much evidence that suicide results in grief reactions different from those of other non-violent deaths (Jordan, 2001; Reed, 1998; Silverman et al., 1994) and has a more significant impact upon those bereaved, as described. This may be explained by the more complicated bereavement processes identified in those bereaved by suicide compared with other bereavement. Gaffney

and Hannigan (2010) describe a less conscious coping experience in those bereaved by suicide, characterised by detachment and strong feelings similar to intrusion and avoidance cycles documented in trauma literature (Horowitz, 1976). There has been increasing focus and understanding of the traumatic impact of sudden and violent deaths, such as suicide (Dyregrov et al., 2003; Li et al., 2003). Those bereaved by suicide often report the importance of recognising their loss as a significant trauma (Pitman et al., 2016) and the need for interventions to treat specific symptoms caused by traumatic reminders, such as flashbacks and nightmares relating to the suicide, in order to reduce the traumatic reactions faced in suicide loss (Dyregrov, 2002). However, this is seldom addressed in therapeutic support offered to those bereaved by suicide. Furthermore, the sense of a lack of understanding of these dimensions of loss has been reported to contribute to poor rapport and absence of trust in the therapeutic relationship (Dyregrov, 2009). We must therefore begin to acknowledge the significance of the trauma reaction and experience in suicide bereavement.

It is noted that with traumatic bereavements, movement between emotional experience and restoration tasks is not as controlled as it often is in other bereavements (Gaffney & Hannigan, 2010), contributing to the complexity of the bereavement process and difficulties faced by those bereaved by suicide. This further highlights the importance of postvention support; support developed for people bereaved by suicide that facilitate recovery after their suicide bereavement and prevent adverse outcomes for this group including suicidal behaviour (Andriessen, 2009), however there is a lack of sufficient evidence-based practice within this area (Andriessen, 2004; Clark, 2001; Grad et al., 2004). Gaffney and Hannigan (2010) note the importance of better understanding the phenomenological aspects of the

aftermath of the bereavement in improving our knowledge of this experience and thus informing and enhancing therapeutic intervention.

Positive Affect

As demonstrated, much research has identified the obstructive role of negative affect in the experience of coping following suicide of a close contact, however there is also evidence which highlights the presence and role of positive affect in coping with chronic distress. Folkman and Moskowitz (2000) suggest that, in the face of chronic stress conditions, positive affect may play a significant role in coping, such that positive affect may interrupt rumination and depression thus interrupting negative affect and increasing one's ability to cope with the distress. Hence, positive emotions may provide important psychological relief in the face of distress. In a study which looked at caregiver bereavement, Folkman (2001) reports that despite interviews focusing on negative affect in distressing experiences, participants also wanted to talk about the positive events and aspects of their experience. This suggests that positive affect and emotion, even in the face of traumatic loss and chronic stress conditions, may have adaptational significance in the coping process. Following a bereavement, adaptive strategies are used to contribute towards a decrease in negative psychological and physical consequences or to decrease the level of grief experienced by the individual (Stroebe & Schut, 2001). It remains unclear as to whether positive affect plays a similar role in the experience of those bereaved by suicide, particularly given the traumatic nature of the bereavement and the complex grieving processes identified in those bereaved by suicide (Gaffney & Hannigan, 2010).

Intrusive Imagery

Given the traumatic nature of suicide loss, an experience characterised by traumatic reminders relating to the suicide, and the elevated risk of PTSD, it is thought that one of the psychological sequelae of suicide bereavement is likely to be the experience of intrusive mental imagery (Golden & Dalgleish, 2010).

Defining Intrusive Mental Imagery

Intrusive mental imagery is the subjective experience of a sensory perception in the absence of an external percept, often described as 'seeing in the mind's eye', which is experienced as a sudden, involuntary memory of an event which intrudes into one's awareness uninvited, hijacking one's attention (Clark & Mackay, 2015; Holmes & Mathews, 2010; Ng et al., 2016). Although intrusive memories can be experienced in other sensory modalities, such as audition and bodily sensations, visual intrusions are the most common experience of intrusive mental imagery following a trauma (Clark & Mackay, 2015). Intrusive memories of a trauma are considered the hallmark symptom of PTSD and are often accompanied by high levels of strong emotion (American Psychiatric Association [APA], 2000; Holmes & Mathews, 2010). Post-traumatic stress disorder is often experienced following a traumatic event (Ehlers & Clark, 2000) and the traumatic experience of witnessing or learning of a traumatic event involving a loved one is acknowledged within criteria for PTSD (American Psychiatric Association [APA], 2013). Intrusive mental imagery is often experienced as intense, vivid and full of sensory detail, thus is often absorbing and reported to be a distressing, negative and an unwanted experience (Brewin et al., 2009). In studies of depression, the presence of frequent intrusive

mental imagery has been found to predict the course of the disorder (Brewin et al., 1999). Such findings indicate the significance of the role of intrusive imagery in mental health, distress and functioning.

Intrusive Imagery in People Bereaved by Suicide

Those bereaved by suicide often describe experiencing intrusive mental imagery about their loved one's death; a common feature of bereavement-related post-traumatic stress (APA, 2013; Golden & Dalgleish, 2010). Research has identified that intrusive mental imagery relating to the death of a loved one following a violent loss is positively associated with depressive symptoms, symptoms of PTSD and complicated grief symptoms in those bereaved (Baddeley et al., 2015). Despite reporting of intrusive mental imagery in people bereaved by suicide, as well as high levels of distress reported by those experiencing intrusive mental imagery following a trauma, little is known about this specific phenomenological experience following suicide loss. Many symptom inventories assessing for PTSD, depression and complicated grief following bereavement do not ask about the content of death-related imagery (Baddeley et al., 2015) and intrusive mental imagery is largely absent in interventions supporting those bereaved by suicide. This is likely due to a lack of knowledge and understanding of the phenomenon, or indeed confirmation of whether or not this is a common experience. A better understanding of intrusive mental imagery experienced by those bereaved by suicide will not only inform assessment of the distress and impact upon those bereaved but will further inform therapeutic intervention and strategies for coping with any intrusive mental imagery in suicide loss. Given the traumatic nature of bereavement by suicide and the

symptoms experienced in this population, research on mental imagery in PTSD may have some relevance for this area.

Suicide Bereavement and Post-Traumatic Stress Disorder

Post-traumatic stress disorder is a common reaction following a traumatic event (Ehlers & Clark, 2000). Although bereavement is generally excluded from the diagnostic criteria for PTSD, more recent updates to these criteria (e.g., Diagnostic and Statistical Manual of mental disorders (5th ed.) [DSM-5]) have acknowledged the traumatic experience of witnessing or learning of a traumatic event involving a loved one. Within the definition of post-traumatic stress disorder, a traumatic event is defined as "exposure to actual or threatened death, serious injury, or sexual violence" ('criterion A' feature of trauma-related disorders; APA, 2013, p.271) by one or more of the following: directly experiencing the event, witnessing the event in person as it occurred to another, learning that the event occurred to a close family member or close friend, or experiencing repeated or extreme exposure to aversive details of the traumatic event (APA, 2013, p.271).

Given the sudden, often unexpected, traumatic nature of suicide loss it is not surprising that there is much evidence that people bereaved by violent loss, such as suicide, are at greater risk of developing PTSD when compared to other non-violent losses (Erlangsen et al., 2017; Kaltman & Bonanno, 2003; Mitchell & Terhosrt, 2017). Rates of PTSD in those bereaved by violent loss including suicide are significantly higher than in those bereaved by natural death, estimated at 50% in violent loss in comparison to 15% in those bereaved by non-violent loss (Dyregrov et al., 2003; Kaltman & Bonanno, 2003; Mitchell & Terhosrt, 2017). More explicitly, Erlangsen and colleagues (2017) report increased risk of PTSD in spouses bereaved

by a partner's suicide in comparison to those bereaved by other types of loss. This further supports links between suicide bereavement and increased rates of PTSD, when compared to other manners of death. Moreover, PTSD in those bereaved by violent loss is found to be more chronic and enduring than in populations bereaved by natural causes of death (Kaltman & Bonanno, 2003; Murphy et al., 1999, 2003), further evidencing the lasting impact of suicide bereavement on mental health when compared with other bereavements. Similarly, people bereaved by suicide often experience increased rates of complicated grief and poor mental health (Eng et al., 2019; Erlangsen et al., 2017; Lobb et al., 2010; Pitman et al., 2014, 2015). Both complicated grief and mental ill-health have been found to be associated with an increased number of symptoms of PTSD in people bereaved by suicide and violent loss (Mitchell & Terhorst, 2017; Nakajima et al., 2012). Hence significant links between bereavement by suicide and PTSD have been identified. Furthermore, using the Impact of Event Scale (IES; Horowitz et al., 1979) to measure PTSD symptoms (APA, 2013), intrusion scores have been found to be elevated in those bereaved by suicide, more so than scores on avoidance subscales, and have a strong correlation with poor mental health outcomes, again to a greater extent than avoidance subscales (Kaltman & Bonanno, 2003; Mitchell & Terhorst, 2017) indicating the prevalence and impact of intrusive PTSD symptoms within this population.

In summary, the evidence describing the association between suicide bereavement and PTSD symptoms highlights the traumatic nature of suicide bereavement and, more specifically, presents a case for intrusive imagery forming part of the experiences of by people bereaved by suicide.

Mental Imagery in Trauma-Related Disorders

Trauma memories are frequently reported following a traumatic experience and are a key feature of PTSD (Ehlers & Clark, 2000). Trauma memories are often intrusive in nature, experienced involuntarily and in high frequency. Often, trauma-related intrusive memories ('traumatic intrusions') experienced following a trauma involve vividly reexperiencing aspects of the traumatic event, often paired with sensory details and are highly distressing (Ehlers & Clark, 2000). Traumatic intrusions are thought to reflect points in the trauma memory that have not been adequately integrated into autobiographical memory (Brewin, 2001). During a traumatic event or experience, memory is encoded primarily in a sensory-perceptual manner, rather than verbally/conceptually. This biased encoding is thought to reflect extreme arousal which causes disruption to normative memory processes (Brewin, 2001). Sensory memory is more likely to trigger involuntary intrusions (Brewin et al., 1996; Brewin, 2001; Ehlers & Clark, 2000; Holmes et al., 2005). Involuntary reexperiencing of the traumatic event can be triggered by various stimuli and situations; external cues which were present during or around the time of the trauma such as visual or auditory cues, and internal cues, such as emotional states and sensory feedback (Ehlers & Clark, 2000). Intrusive memories are often described as snapshots of the traumatic event, known as hotspots, which often represent a range of emotions experienced over the course of the trauma (Holmes et al., 2005). Intrusive memories can be experienced in many sensory modalities, however visual intrusions, often described as intrusive mental images, are reported to be the most common following a trauma (Clark & Mackay, 2015; Ehlers & Steil, 1995). Intrusive mental images of a trauma can be experienced as if the trauma is happening again in the here and now; an experience referred to as a flashback (Ehlers & Clark, 2000). These

intrusive mental images and flashbacks are often indicators of the most disturbing or traumatic parts of the trauma for the individual (Holmes et al., 2005). Thus, the experience of intrusive mental imagery is often an unwanted and highly distressing experience, triggering a range of different emotions, which can have debilitating functional impacts upon activities of daily living (Holmes et al., 2005; Iyadurai et al., 2019; Steil & Ehlers, 2000).

Intrusive mental imagery is often the focus of trauma interventions. Identifying and targeting modifiable treatment mechanisms, such as intrusive memories, as the core clinical feature in the post-trauma experience, is found to be highly effective in the treatment of psychological trauma (Kazdin, 2007; Singh et al., 2020). Due to the highly emotive nature of intrusive imagery following a trauma, removing the distress associated with the intrusive imagery but not the imagery or memory itself is effective in managing this distressing experience (Clark & Mackay, 2015).

Not everyone that experiences a trauma will develop symptoms that meet criteria for PTSD, however many will experience imagery relating to the trauma. Intrusive imagery is key in further understanding the experience of intrusive memories of a traumatic event (Clark & Mackey, 2015). Given the traumatic nature of suicide loss, greater insight into the experience of imagery in suicide bereavement is essential in developing a rich understanding of this unique traumatic experience, in order to identify how interventions for imagery in trauma more generally may be applied to manage any intrusive mental imagery that occurs following suicide loss.

Imagery in Grief

It is not uncommon for those grieving for a loved one to experience imagery in relation to their loss (Boelen & Huntjens, 2008). This is often experienced as intrusive imagery and research has found that intrusions are common across all types of loss (Boelen & Huntjens, 2008). It is well established that intrusive imagery relating to the individual's loss is a common phenomenon in complicated grief following a bereavement, with symptoms of complicated grief persisting for at least six months causing functional impairment (Prigerson et al., 2009). Some authors argue that there is a degree of overlap between imagery in complicated grief and PTSD, drawing similarities in the content of intrusive imagery experienced, such that in both conditions intrusive imagery of the events surrounding the loss is experienced, which precipitates the onset of the condition (Fox et al., 1999; Shuchter & Zisook, 1993). However, there is also evidence to suggest that the experience of intrusive imagery in complicated grief differs from that of imagery experienced in PTSD.

Intrusive imagery in complicated grief appears to be related to yearning for the loved one and the presence of the loved one in imagery is often experienced as comforting (Boelen & Huntjens, 2008). This experience is in contrast to the distressing intrusive imagery of the trauma more typically experienced in PTSD (Ehler, 2006; Prigerson et al., 1999; Raphael & Martinek, 1997). Stroebe and Schut (1999) suggest that imagery in non-traumatic bereavement is more voluntary in nature in contrast to imagery in trauma, which is experienced as involuntary. This raises many questions when considering the grieving experience of those bereaved by suicide given the traumatic nature of the loss and increased rates of both complicated grief and PTSD identified within this population.

Although studies have investigated the relationship between grief intrusions and intrusions in PTSD, there is still little systematic investigation of the content of intrusive images experienced in grief. In addressing this gap in the research, Boelen and Huntjens (2008) looked at intrusive images experienced by people following the loss of a loved one. They found that positive intrusive images, reenactment images, images surrounding the death and unpleasant images of the future were all experienced frequently by those bereaved, and that the occurrence of these intrusions were similar across all subgroups of mourners and did not vary considerably by cause of death. For example, negative intrusions of the death were no more likely to be experienced in those bereaved by violent loss in comparison to those bereaved by non-violent loss. Such findings suggest that imagery in grief is more universal in nature for both violent and non-violent loss. However, Boelen and Huntjens (2008) further identified that different intrusions had unique links with depression, anxiety and complicated grief. Such that, intrusive images of the moments surrounding the death of the loved one had significant links with anxiety but were not found to be linked to depression and complicated grief, whereas reenactment imagery was found to be linked with depression. In contrast, positive intrusive memories were found to be associated with complicated grief and were not associated with anxiety and depression. Such findings suggest that different intrusions may give rise to different emotional problems for those bereaved, thus mental health outcomes in those bereaved may be linked to imagery experienced in grief. However, we should not overlook the positive experience of imagery in grief, which has been found to be more prevalent than images of reenactment, moments surrounding the death and unpleasant images (Boelen & Huntjens, 2008).

In summary, these findings provide further evidence to support the phenomenon of intrusive mental imagery experienced in the course of grief following traumatic bereavement such as suicide loss. Current research highlights the role of different intrusive imagery in a number of emotional problems experienced in grief, which has important implications when considering support interventions for people following a bereavement. Yet, still much is unknown about the phenomenon of imagery in grief including the content of imagery, how this is experienced (e.g., the degree to which it is experience as voluntary or involuntary) and the impact that this imagery has on those bereaved. Furthermore, research continues to untangle the experience of imagery in grief from that of PTSD, where the experience of intrusive imagery may be quite different. Thus, our understanding of this experience remains tentative and a more comprehensive study of imagery following traumatic bereavement is warranted.

Imagery in Violent Loss and Suicide Bereavement

Violent death often results in the development of persistent PTSD symptoms beyond that of a normal grief response (Kaltman & Bonanno, 2003). People bereaved by suicide report their bereavement experience as a significant trauma, characterised by traumatic reminders such as flashbacks and nightmares that relate to the suicide of their loved one (Dyregrov, 2002; Pitman et al., 2016). Intrusive mental imagery in bereavement-related trauma following violent death is often associated with aspects of the death itself as well as ruminating about the circumstances of the death (Baddeley et al, 2015; Jackson et al., 2015). In the context of a sudden traumatic death such as suicide, the narrative of the loved ones death is typically aversive and fragmented, likely due to the "faulty" nature of information processing, as with any

traumatic experience (Brewin & Holmes, 2003). The experience of recurrent intrusive imagery in those bereaved by suicide is thought to develop from the sense of unreality, which often follows a suicide; a painful process of sense-making, constructing hypothetical images that replay the suicide of their loved one and stories relating to their loved one's experiences, in order to bring some order and meaning to their own experience (Baddeley et al., 2015; Neimeyer & Levitt, 2000; Williams et al., 2020). The narrative model of traumatic death (Rynearson, 2012) suggests that reenactment imagery, which involves vivid recreations of the death and a loved one's dying moments, features prominently in the narratives of those bereaved by sudden violent loss (Murphy et al., 1999; Rynearson, 1984). Reenactment imagery of the death is reported almost universally among those bereaved by violent loss, even among those who were not present at the death, which is often the case with suicide. In such circumstances, death imagery is thought to be shaped by witness reports or information provided by third party sources, such as police and media reports (Baddeley et al., 2015; Rynearson, 2001; Williams et al., 2020).

Similar to the experience of imagery in trauma and PTSD, the experience of recurrent intrusive imagery in suicide bereavement and violent and traumatic loss is highly distressing, described in cases as "horrendous" (Jackson et al., 2015), leaving those bereaved feeling helpless in the experience (Baddeley et al., 2015; Jackson et al., 2015; Ochberg, 2006). Intrusive mental imagery can persist for months or years following a traumatic death such as suicide (Jackson et al., 2015; Ochberg, 2006), although the experience of intrusive mental imagery is thought to lessen over time (Baddeley et al., 2015; Carnelley et al., 2006). Death imagery in violent loss of a loved one, which is high in frequency and experienced as "fixating", has been found to be associated with bereavement-related mental health problems such as

depression, trauma-related intrusions, avoidance and hyperarousal symptoms (Williams et al., 2020) and reduced psychological resilience (Rynearson, 2018). Hence, imagery relating to the suicide of a loved one is likely to have a similar negative impact upon the mental health and functioning of those bereaved, perhaps explaining the increased risk of adverse outcomes faced by those bereaved by suicide.

Over the past two decades research in the area of suicide bereavement has been increasing, perhaps due to the impact and recognised risk of adverse outcomes associated with this distinct bereavement experience, as well as the large number of people affected by suicide. However, when reviewing the literature that explores intrusive mental imagery in suicide bereavement, it is noted that much of the research looks at imagery in violent loss or sudden death as a unified experience, including homicide, fatal accidents, sudden illness such as heart attack, and suicide as one (Baddeley et al., 2012; Boelen & Huntjens, 2008; Murphy et al., 1999; Ochberg, 2006; Rynearson, 2001, 2018; Rynearson & Correa, 2008; Williams et al., 2020). There is some discrepancy within the research as to whether the content of intrusive imagery is separate or connected to the type of death (see, Rynearson, 2012; Williams et al., 2020). In contrast, Baddeley and colleagues (2015) identified some variation in the content of intrusive mental imagery experienced by those bereaved by different types of violent loss, such that the type of loss may influence intrusive mental imagery experienced by those bereaved. For example, they found that imagery relating to revenge is more likely to be reported by those bereaved by homicide compared with those bereaved by suicide. This is perhaps due to the nature of the death and subsequent thoughts and feelings left in those bereaved,

which relate more specifically to this type of violent loss and may be less present in survivors of suicide loss.

Research has also identified that different intrusive thoughts or images may give rise to different emotional problems in those bereaved, given the unique links found between depression, anxiety and complicated grief with different types of intrusive imagery (Boelen & Huntjens, 2008). It appears that in comparison to homicide and other violent loss, few studies have specifically looked at bereavement by suicide, reflected in a lack of both qualitative and quantitative research in the area (Baddeley et al., 2015). Furthermore, death imagery identified in violent loss has been found to attenuate over time, unlike intrusive imagery in PTSD, depression and complicated grief symptoms, which suggests differences in the formation of bereavement-related imagery (Baddeley et al., 2015).

Given the traumatic nature of suicide bereavement and the associated mental health risks, it would be of value to further explore the nature and experience of imagery over time in suicide bereavement. Considering the identified gaps in the research, it is imperative that we have a better understanding of the content, nature and experience of intrusive mental imagery in suicide bereavement more explicitly, not assuming that this is a shared experience among all those bereaved by violent loss. Reflecting upon the literature reviewed thus far, the need to better understand the experience of intrusive imagery in suicide bereavement is further justified when considering the intersections in the experience of mental imagery in suicide bereavement with both trauma, PTSD, and imagery in grief. Considering the research, it is hypothesised that the phenomenon of intrusive mental imagery in suicide bereavement may share characteristics from each of these domains, thus creating a unique and distinctive experience which requires further exploration

before we can begin to consider the development of therapeutic interventions and support for this group of people.

Therapeutic Intervention

In developing our thinking in the area of intrusive mental imagery following psychological trauma, research suggests that identifying mechanisms of change can help overcome conceptual challenges when advancing treatment for people bereaved by suicide (Iyadurai et al., 2019; Kazdin, 2007; Pocheret at al., 2020). Hence, focusing on a core clinical feature or symptom, such as intrusive mental imagery relating to the traumatic bereavement for example, rather than focusing on full diagnostic components of a diagnosis, such as PTSD, would be beneficial (Harvey et al., 2004; Iyadurai et al., 2019; Kazdin, 2007; Pocheret at al., 2020; Singh et al., 2020).

As noted, evidence-based interventions for people bereaved by suicide are insufficient (Adriessen et al., 2019; Linde et al., 2017; McDaid et al., 2008; Szumilas & Kutcher, 2011) however, given the substantial public health impact of suicide and associated risks for those bereaved, such interventions are essential. Given the fundamental role of intrusive mental imagery in grief, trauma and more specifically suicide bereavement and violent loss, our attention is drawn to imagery rescripting interventions as a candidate intervention approach for those bereaved by suicide. Imagery rescripting interventions have been found to be effective in other clinical contexts where intrusive mental imagery plays a key role in the maintenance of poor mental health and distress (Brewin et al., 2009; Holmes et al., 2016; Kunze et al., 2017; Pajak & Kamboj, 2014; Steil et al., 2011). Mental imagery plays a central role in the maintenance of psychological disorders; through cognitive-based rescripting

interventions, appraisals of the recurrent intrusive imagery relating to traumatic or negative experiences become less threatening, resulting in less imagery distress (Nilsson et al., 2012; Wheatley & Hackmann, 2011; Wild et al., 2007). Imagery rescripting is largely used within the treatment of trauma where post-trauma imagery serves to maintain trauma-related distress (Hagenaars & Arntz, 2010), as well as in treatment for symptoms rooted in unfinished grief (Levitan, 2007), with great success. Rescripting reenactment imagery related to the violent death of a loved one is thought to deconstruct and reintegrate the intrusive imagery, giving the bereaved 'ownership' of the story of their loss, giving them control over the imagery and preventing distressing imagery from intruding freely (Rynearson, 2012a). Cognitive task interventions have also been successful in reducing involuntary intrusive mental imagery, whilst preserving voluntary memories following psychological trauma (James et al., 2015; Lau-Zhu et al., 2019; Singh et al., 2020) and has further led to the successful development of interventions targeting intrusive memories in long-standing trauma in complex PTSD (Kessler et al., 2018). This further highlights the role of cognitive process in interventions for intrusive imagery.

Given the success of such interventions in targeting distressing and debilitating intrusive imagery and their associated effect on wellbeing, we might expect that this research could be extended to intrusive mental imagery in suicide bereavement. Recent evidence suggests that mental imagery has a great impact on emotional outcomes and the risks associated with suicide bereavement, thus targeting imagery may weaken this impact (Ji et al., 2019); hence, support for such interventions in suicide bereavement. However, there is also evidence to suggest that mental imagery can act as a protective factor, such as in depression (Holmes et al., 2007; Renner et al., 2017), whilst neuroimaging studies provide evidence to suggest

that yearning for a deceased loved one is associated with the activation of neural reward pathways (O'Connor, et al., 2008). This would suggest that imagery-rescripting-based interventions would need to be designed with care and employed in a highly individualised way with bereaved individuals. Obtaining a detailed understanding of the phenomenology of suicide-related imagery among survivors would appear to be an important first step before developing rescripting interventions for this highly vulnerable group.

To date there is a lack of qualitative research which looks exclusively at the phenomenon and experience of intrusive imagery following suicide loss. Such findings demonstrate the need to better understand the nature and impact of intrusive mental imagery experienced by those bereaved by suicide in order to inform therapeutic strategies and support for this group of people. In order to consider therapeutic interventions, we must first develop our understanding of the phenomenon and subjective experience of intrusive mental imagery in those bereaved by suicide. As noted in current research, if we are to develop evidence-based interventions that target intrusive imagery, we first need to understand the processes involved in their onset, specific modulating mechanisms in their experience and the impact that such experiences have upon those bereaved by suicide (Singh et al., 2020).

Consideration of Methods

In order to further explore the nature of the phenomenon of intrusive mental imagery experienced by those bereaved by suicide a qualitative approach is taken to gather rich data which presents in detail the subjective experience. Using qualitative

methods will provide a detailed phenomenological description of the imagery content and the experience of imagery, whilst further exploring the impact of this experience on people bereaved by suicide. Many studies have successfully used semi-structured interviews to elicit and describe the content and phenomenological features of mental imagery (Hackmann et al., 2000; Pajak et al., 2013). Furthermore, the use of thematic analysis is employed to analyse themes within the data. Detailed thematic analysis takes an inductive approach to identifying beliefs and meaning making within the experience. This method has been used effectively to explore imagery content and determine themes within intrusive mental imagery in traumatic experiences (Pajak et al., 2013). Thematic analysis provides a rich and detailed account of data and is a helpful tool used within psychology to identify, analyse and report patterns or themes within a data set. Furthermore, during the course of thematic analysis, 'emerging themes' can be identified; themes and concepts which are embedded within the interviews, generating unanticipated themes and insight into the phenomenon in question (Braun & Clarke, 2006). This study looks to draw themes and patterns within the novel phenomenon of the experience of intrusive mental imagery in suicide bereavement, hence thematic analysis fulfils this role; describing patterns across qualitative data, without being theoretically bound, as with IPA and grounded theory analysis (Braun & Clarke, 2006).

Braun and Clarke (2006) identify many merits of thematic analysis, which are of value to the research at hand. With the intention to draw rich data across experiences, thematic analysis usefully summarises key features of large data sets offering a thick description of the data, highlighting both similarities and differences within the data and thus across experiences. Furthermore, thematic analysis allows for social and psychological interpretation of the data and can produce qualitative

analyses which is suited to inform policy development. However, thematic analysis also has some key limitations. A qualitative approach is intended to be an inductive process. It is however acknowledged that the use of a semi-structured interview topic guide, which ensures exploration of content and meaning of the experience of intrusive imagery with space to explore new ideas that arise for the individual, does impose some a priori constraints on the themes that might be elicited through thematic analysis. It is also argued that thematic analysis has limited interpretative power beyond description if it is not used within an existing framework which serves to anchor analytic claims as is with other analytical approaches (Braun & Clarke, 2006). However, given that little is known about the phenomenon of intrusive mental imagery in suicide bereavement, qualitative exploration constitutes an important starting point. This analytical approach fulfils the aim of the research to explore the phenomenon of intrusive imagery, to provide increased insights into the experience, offering a tentative understanding of its role in the bereavement process and subsequent risks associated with bereavement by suicide.

Summary and Aims of the Thesis

Summary

In summary, there is evidence to support the theoretical presence of intrusive mental imagery in suicide bereavement. However, the content and experience of intrusive mental imagery in suicide bereavement more specifically remains unclear, and still little is known about the impact of this experience upon those bereaved by suicide. Much research suggests that intrusive mental imagery is distressing and acts to maintain psychological disorders (Brewin et al., 1999, 2009) suggesting that

intrusive mental imagery should be targeted within psychological interventions to reduce distress, promoting recovery and wellbeing. However, considering the literature which highlights the role of positive affect in coping experiences, it remains unclear as to whether imagery may serve as an adaptive mechanism for coping during a traumatic bereavement or whether such imagery serves to play a role in the complex grieving process of those bereaved by suicide, which gives rise to many adverse outcomes within this population. Although the experience of intrusive mental imagery is subjective and likely a unique experience for each of those bereaved, a better understanding of the phenomenological experience and common themes within this experience will aid our thinking in developing enhanced targeted postvention support for those bereaved by suicide (Gaffney & Hannigan, 2010).

Aims of the Thesis

This conceptual introduction provides an overview of the current theoretical understanding and impact of suicide loss and associated risks faced by this group of people. It further identifies and explores potential links with intrusive mental imagery in the context of traumatic experiences, and more specifically violent loss and suicide bereavement.

To our knowledge, the phenomenon of intrusive mental imagery experienced by those bereaved by suicide has not been explored qualitatively. Increasing our understanding of the content and nature of intrusive imagery experienced by those bereaved by suicide and the impact of this experience is vital in the development of evidence-based intervention and support for a group who face significantly increased risks to their mental health and wellbeing. Evidence-based interventions aimed to support people bereaved by suicide are insufficient (Adriessen et al., 2019; Linde, et

al., 2017; McDaid et al. 2008; Szumilas & Kutcher, 2011). We hope that understanding the nature of the phenomenon of intrusive mental imagery after suicide bereavement will facilitate the development of novel interventions for people bereaved by suicide, which are currently lacking. This work may also contribute to the development of the national suicide prevention strategy (Department of Health, 2012) by informing effective evidence-based support for those bereaved by suicide in order to reduce additional long-term emotional distress. In turn, such developments seek to reduce not only the impact of suicide bereavement on individuals and families, but further reducing the wider impact that suicide bereavement has on our communicates and societies.

Based on the preceding review, we assume that intrusive mental imagery is an important phenomenon in those bereaved by suicide. The content and nature of the experience of intrusive mental imagery in those bereaved by suicide and the impact of this experience is explored in this research.

A better understanding of the phenomenon of intrusive mental imagery and related experience in suicide bereavement could have important theoretical and clinical implications. These include advancing our understanding of the nature and factors contributing to the maintenance of the complex grieving process following suicide loss and associated risks. This would enable the development and evaluation of targeted evidence-based clinical interventions following suicide loss in order to provide better support for and enhance outcomes for people bereaved by suicide.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D.C: American Psychiatric Association.

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders (Vol. 4th ed. Text revision). Washington D.C.: American Psychiatric Association.

Andriessen, K. (2004). Suicide survivor activities, an international perspective. *Suicidology, 9*(2), 26-31.

Andriessen, K (2009). Can postvention be prevention? *Crisis, 30(1),* 43-47. doi: 10.1027/0227-5910.30.1.43

Andriessen, K., Reavley, N., Krysinska, K., Hill, N.T.M, Reifels, L., Robinson, J., & Pirkis, J. (2019). Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. *BMC Psychiatry, 19*(49), 1-15. https://doi.org/10.1186/s12888-019-2020-z

Baddeley, J.L., Williams, J.L., Rynearson, T., Correa, F., Saindon, C. & Rheingold, A.A. (2015). Death thoughts and images in treatment-seekers after violent loss. *Death Studies, 39*(2), 84-91. https://doi.org/10.1080/07481187.2014.893274

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Brewin, C.R. (2001). A cognitive neuroscience account of posttraumatic stress disorder and its treatment. *Behaviour Research and Therapy, 39,* 373–393. https://doi.org/10.1016/S0005-7967(00)00087-5

Brewin, C.R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of Posttraumatic Stress Disorder. *Psychological Review, 103*, 670–686. https://doi.org/10.1037/0033-295X.103.4.670

Brewin, C.R., & Holmes, E.A. (2003). Psychological theories of Posttraumatic Stress Disorder. *Clinical Psychology Review, 23(3),* 339–376. https://doi.org/10.1016/S0272-7358(03)00033-3

Brewin, C.R., Reynolds, M., & Tata, P. (1999). Autobiographical memory processes and the course of depression. *Journal of Abnormal Psychology, 108*, 511–517. https://doi.org/10.1037/0021-843X.108.3.511

Brewin, C.R., Wheatley, J., Patel, T., Fearon, P., Hackmann, A., Wells, A., Fisher, P., & Myers, S. (2009). Imagery Rescripting as a brief stand-alone treatment for depressed patients with intrusive memories. *Behaviour Research and Therapy, 47,* 569-576. https://doi.org/10.1016/j.brat.2009.03.008

Boelen, P.A. & Huntjens, R.J.C. (2008). Intrusive images in grief: an exploratory study. *Clinical Psychology and Psychotherapy, 15*, 217-226. https://doi.org/10.1002/cpp.568

Carnelley, K.B., Wortman, C.B., Bolger, N. & Burke, C.T. (2006). The time course of grief reactions to spousal loss: Evidence from a national probability sample. *Journal of Personality and Social Psychology, 91*(3), 476-492. https://doi.org/10.1037/0022-3514.91.3.476

Clark, S. (2001). Bereavement after suicide – How far have we come and where do we go from here? *Crisis, 22*(3), 102-108. https://doi.org/10.1027/0227-5910.22.3.102

Clark, I.A. & Mackay, C.E. (20150). Mental Imagery and post-traumatic stress disorder: a neuroimaging and experimental psychopathology approach to intrusive memories of trauma. *Frontiers in Psychiatry, 6*(104), 1-13. https://doi.org/10.3389/fpsyt.2015.00104

Department of Health. (2012) Preventing Suicide in England: a cross-government outcomes strategy to save lives. London: Department of Health. (Report no.17680).

Dyregrov, K. (2002). Assistance from local authorities versus survivors' needs for support after suicide. *Death Studies, 26*(8), 647-668. https://doi.org/10.1080/07481180290088356

Dyregrov, K., (2009). How do the young suicide survivors wish to be met by psychologists? A user study. *Omega, 59*(3), 221-238. https://doi.org/10.2190/OM.59.3.c

Dyregrov, K., Nordaner, D., & Dyregrov, A. (2003). Predictors of psychosocial distress after suicide, SIDS, and accidents. *Death Studies, 27*(2), 143-165. https://doi.org/10.1080/07481180302892

Ehlers, A. (2006). Understanding and treating complicated grief: What can we learn from post-traumatic stress disorder? *Clinical Psychology: Science and Practice, 13*(2), 135–140. https://doi.org/10.1111/j.1468-2850.2006.00015.x

Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research & Therapy, 38*(4), 319-345. https://doi.org/10.1016/S0005-7967(99)00123-0

Ehlers, A., & Steil, R. (1995). Maintenance of intrusive memories in posttraumatic stress disorder: a cognitive approach. *Behavioural and Cognitive Psychotherapy, 23*(3), 217–249. doi:10.1017/S135246580001585X

Eng, J., Drabewll, L., Stevenson, F., King, M., Osborn, D. & Pitman, A. (2019). Use of alcohol and unprescribed drugs after suicide bereavement: Qualitative study. *International Journal of Environmental Research and Public Health, 16*(21), 1-12. https://doi.org/10.3390/ijerph16214093

Erlangsen, A., Runeson, B., Bolton, J. M., Wilcox, H. C., Forman, J. L., Krogh, J., … Conwell, Y. (2017). Association between spousal suicide and mental, physical, and social health outcomes: a longitudinal and nationwide register-based study. *JAMA Psychiatry 74*(5), 456–464. doi:10.1001/jamapsychiatry.2017.0226

Folkman, S. (2001). Revised coping theory and the process of bereavement. In M.S. Stroebe, R.O. Hansson, W Stroebe & H. Schut, (Ed.). *Handbook of bereavement research: Consequences, coping and care* (pp. 563-584). Washington DC: American Psychological Association. https://doi.org/10.1037/10436-024

Folkman, S. & Moskowitz, J.T. (2000). Positive affect and the other side of coping. *American Psychologist, 55*(6), 647-654. https://doi.org/10.1037/0003-066X.55.6.647

Fox, G.C., Reid, G.E., Salmon, A., Mckillop-Duffy, P., & Doyle, C. (1999). Criteria for traumatic grief and PTSD. *British Journal of Psychiatry, 174*(6), 560. https://doi.org/10.1192/S0007125000262703

Gaffney, M. & Hannigan, B. (2010). Suicide bereavement and coping: a descriptive and interpretative analysis of the coping process. *Procedia Social and Behavioural Sciences, 5*, 526-535. https://doi.org/10.1016/j.sbspro.2010.07.137

Golden, A.M.J. & Dalgleish, T. (2010). Is prolonged grief distinct from bereavement-related post-traumatic stress. *Psychiatry Research, 178*(2), 336-341. https://doi.org/10.1016/j.psychres.2009.08.021

Grad, O.T., Clark, S., Dyregrov, K., & Andriessen, K. (2004). What helps and what hinders the process of surviving the suicide of somebody close? *Crisis, 25*(3), 134-139. https://doi.org/10.1027/0227-5910.25.3.134

Hackmann, A., Clark, D.M. & McManus, F. (2000). Recurrent images and early memories in social phobia. *Behaviour Research and Therapy, 38*(6), 601-610. https://doi.org/10.1016/S0005-7967(99)00161-8

Hagenaars, M.A. & Arntz, A. (2010). Reduced intrusion development after post-trauma imagery rescripting; an experimental study. *Journal of Behaviour Therapy and Experimental Psychiatry, 43*(2), 808-814. https://doi.org/10.1016/j.jbtep.2011.09.005

Harvey, A., Watkins, E., Mansell, W. & Shafran, R. (2004). Cognitive behavioural processes across psychological disorders: a transdiagnostic approach to research and treatment. USA: Oxford University Press.

Holmes, E.A., Arntz, A., & Smucker, M.R. (2007). Imagery rescripting in cognitive behaviour therapy: images, treatment techniques and outcomes. *Journal of Behavior Therapy and Experimental Psychiatry, 38*(4), 297–305. https://doi.org/10.1016/j.jbtep.2007.10.007

Holmes, E.A., Bonsall, M.B., Hales, S.A., Mitchell, H., Renner, F., Blackwell, S.E., Watson, P., Goodwin, G.M., & Di Simplicio, M. (2016). Applications of time-series

analysis to mood fluctuations in bipolar disorder to promote treatment innovation: a case series. *Translational Psychiatry, 6,* 1-10. https://doi.org/10.1038/tp.2015.207

Holmes, E.A., Grey, N., & Young, K.A.D. (2005). Intrusive images and "hotspots" of trauma memories in posttraumatic stress disorder: an exploratory investigation of emotions and cognitive themes. *Journal of Behaviour Therapy, 36*(1), 3-17. https://doi.org/10.1016/j.jbtep.2004.11.002

Holmes, E.A. & Mathews, A. (2010). Mental imagery in emotion and emotional disorders. *Clinical Psychology Review, 30*(3), 349-362. https://doi.org/10.1016/j.cpr.2010.01.001

Horowitz, M.J. (1976) Stress response syndromes. In J.H. Harvey & E.D. Miller (Ed.). *Loss and Trauma*. Sussex: Brunner-Routledge.

Horowitz, M.J., Wilner, N.R., & Alvarez, W. (1979). Impact of Event Scale. A measure of subjective stress. *Psychosomatic Medicine, 41* 209-218.

Iyadurai, L., Visser, R.M., Lau-Zhu, A., Porcheret, K., Horsch, A., Holmes, E.A., & James, E.L. (2019). Intrusive memories of trauma: A target for research bridging cognitive science and its clinical application. *Clinical Psychology Review, 69,* 67-82. https://doi.org/10.1016/j.cpr.2018.08.005

Jackson, D., Peters, K., & Murphy, G. (2015). Suicide of a close family member through the eyes of a child: A narrative case study report. *Journal of Child Health Care, 19*(4), 495-503. https://doi.org/10.1177/1367493513519297

James, E.L., Bonsall, M.B., Hoppitt, L., Tunbridge, E.M., Geddes, J.R., Milton, A.L., & Holmes, E.A. (2015). Computer game play reduces intrusive memories of experimental trauma via reconsolidation-update mechanisms. *Psychological Science, 26*(8), 1201–1215. https://doi.org/10.1177/0956797615583071

Kaltman, S. & Bonanno, G.A. (2003). Trauma and Bereavement: Examining the impact of sudden and violent deaths. *Anxiety Disorders, 17*(2), 131-147. https://doi.org/10.1016/S0887-6185(02)00184-6

Kazdin, A.E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3*(1), 1–27. https://doi.org/10.1146/annurev.clinpsy.3.022806.091432

Kessler, H., Holmes, E.A., Blackwell, S.E., Schmidt, A.C., Schweer, J.M., Bücker, A., Herpertz, S., Axmacher, N., & Kehyayan, A. (2018). Reducing intrusive memories of trauma using a visuospatial interference intervention with inpatients with posttraumatic stress disorder (PTSD). *Journal of Consulting and Clinical Psychology, 86*(12), 1076–1090. https://doi.org/10.1037/ccp0000340

Kunze, A.E., Arntz, A., Morina, N., Kindt, M., & Lancee, J. (2017). Efficacy of imagery rescripting and imaginal exposure for nightmares: A randomized wait-list

controlled trial. *Behaviour Research and Therapy*, 97, 14-25. https://doi.org/10.1016/j.brat.2017.06.005

Lau-Zhu, A., Henson, R.N., & Holmes, E.A. (2019). Intrusive memories and voluntary memory of a trauma film: Differential effects of a cognitive interference task after encoding. *Journal of Experimental Psychology: General, 148*(12), 2154–2180. https://doi.org/10.1037/xge0000598

Levitan, A.A (2007). Chapter: Hypnotic death and suicide rehearsal. In, A.A. Sheikh, [Ed]; K.S. Sheikh, [Ed]. *Healing with death imagery*. (pp. 165-178). Amityville, NY, US: Baywood Publishing Co; US.

Li, J., Precht, D.H., Mortensen, P.B., & Olsen, J. (2003). Mortality in parents after death of a child in Denmark: A nationwide follow-up study. *The Lancet, 361*, 363–367. https://doi.org/10.1016/S0140-6736(03)12387-2

Lin Ji, J., Di Simplicio, M., & Holmes, E. (2019). Mental imagery in psychiatry: conceptual and clinical implications. *CNS spectrums, 24*(1), 114-126. https://doi.org/10.1017/S1092852918001487

Linde, K., Treml, J., Steinig, J., Nagl, M., & Kersting, A. (2017). Grief interventions for people bereaved by suicide: A systematic review. *PLoS ONE, 12*(6), 1-20. https://doi.org/10.1371/journal.pone.0179496

Lobb, E. A., Kristjanson, L. J., Aoun, S. M., Monterosso, L., Halkett, G. K. B., and Davies, A. (2010). Predictors of complicated grief: a systematic review of empirical studies. *Death Studies, 34*(8), 673–698. https://doi.org/10.1080/07481187.2010.496686

McDaid, C., Trowman, R., Golder, S., Hawton. K., Sowden, A. (2008). Interventions for people bereaved through suicide: systematic review. *British Journal of Psychiatry, 193*(6), 438–443. https://doi.org/10.1192/bjp.bp.107.040824

Mitchell, A.M., & Terhosrt, L. (2017). PTSD Symptoms in survivors bereaved by the suicide of a significant other. *Journal of the American Psychiatric Nurses Association, 23*(1), 61-65. https://doi.org/10.1177/1078390316673716

Murphy, S.A, Braun, T., Tillery, L., Cain, K.C., Johnson, L.C. & Beaton, R.D. (1999). PTSD among bereaved parents following the violent deaths of their 12- to 28- year-old children: a longitudinal prospective analysis. *Journal of Traumatic Stress, 12*(2), 273-291. https://doi.org/10.1023/A:1024724425597

Murphy, S.A., Das Gupta, A., Cain, K.C., Johnson, L.C., Lohan, J., Wu, L., Mekwa, J. (1999). Changes in parents' mental distress after violent death of an adolescent or young child: a longitudinal prospective analysis. *Death Studies, 23*(2), 129-159. https://doi.org/10.1080/074811899201118

Murphy, S.A., Johnson, L.C., Chung, I.J., & Beaton, R.D. (2003). The prevalence of PTSD following the violent death of a child and predictors of change 5 years later. *Journal of Traumatic Stress, 16*, 17-25. https://doi.org/10.1023/A:1022003126168

Nakajima, S., Ito, M., Shirai, A. & Konishi, T. (2012). Complicated grief in those bereaved by violent death: the effects of post-traumatic stress disorder on complicated grief. *Dialogues in Clinical Neuroscience, 14*(2), 210-214.

Neimeyer, R.A., & Levitt, H.M. (2000). What's narrative got to do with it? Construction and coherence in accounts of loss. In J.H. Harvey & E.D. Miller (Eds.). *Loss and trauma*. (pp. 401–412). Brunner/Mazel.

Ng, R.M.K., Di Simplicio, M., McManus, F., Kennerley, H. & Holmes, E.A. (2016). 'Flash-forwards and suicidal ideation: a prospective investigation of mental imagery, entrapment and defeat in a cohort from the Hong Kong Mental Morbidity Survey. *Psychiatry Research, 246,* 453-460. https://doi.org/10.1016/j.psychres.2016.10.018

Nilsson, J.E., Lundh, L.G. & Viborg, G. (2012). Imagery rescripting of early memories in social anxiety disorder: an experimental study. *Behaviour Research and Therapy, 50*(6), 387-392. https://doi.org/10.1016/j.brat.2012.03.004

Ochberg, F.M. (2006). Exorcising ghosts: the counting method and traumatic death imagery. In Rynearson, E. K. [Ed]. (2006). Violent death: Resilience and intervention beyond the crisis. (pp. 145-155). xxxiv, 389 pp. New York, NY, US: Routledge/Taylor & Francis Group; US.

O'Connor, M., Wellisch, D.K., Stanton, A.L., Eisenberger, N.I., Irwin, M.R., & Lieberman, M.D. (2008). Craving Love? Enduring grief activates brain's reward centre. *Neuroimage, 42*(2), 969-972. https://doi.org/10.1016/j.neuroimage.2008.04.256

Pajak, R., Langhoff, C., Watson, S. & Kamboj, S.V. (2013). Phenomenology and thematic content of intrusive imagery in bowel and bladder obsession. *Journal of Obsessive-Compulsive and Related Disorders, 2*(3), 233-240. https://doi.org/10.1016/j.jocrd.2013.04.005

Pajak, R., & Kamboj, S.K. (2014). Experimental single-session imagery rescripting of distressing memories in bowel/bladder-control anxiety: a case series. *Front Psychiatry, 15*(5), 1-7. https://doi.org/10.3389/fpsyt.2014.00182

Prigerson, H.G., Vanderwerker, L.C., & Maciejewski, P.K. (2009). Prolonged grief disorder as a mental disorder: Inclusion in DSM. In M.S. Stroebe, R.O., Hansson, W. Stroebe, & H.A.W. Schut (Ed.). *Handbook of bereavement research and practice: 21st century perspectives.* Washington, DC: American Psychological Association Press.

Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *Suicide 3*(1), 86-94. https://doi.org/10.1016/S2215-0366(14)70224-X

Pitman, A.L., Osborn, D.P.j, Rantell, K., & King, M.B. (2015). Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study

of 3432 young bereaved adults. *BMJ Open, 6*(1), 1-11. doi: 10.1136/bmjopen-2015-009948

Pitman, A., Putri, A.K., Kennedy, N., De Souza, T., King, M., & Osborn, D. (2016). Priorities for the development and evaluation of support after suicide bereavement in the UK: results of a discussion group. *Bereavement Care, 35*(3), 109-116. https://doi.org/10.1080/02682621.2016.1254457

Pitman, A., Stevenson, F., King, M., & Osborn, D. (2020). Self-reported patterns of use of alcohol and drugs after suicide bereavement and other sudden losses: a mixed methods study of 1,854 young bereaved adults in the UK. *Frontiers in Psychology, 11,* 1-12. https://doi.org/10.3389/fpsyg.2020.01024

Porcheret, K., Iyadurai, L., Bonsall, M.B., Goodwin, G.M., Beer, S.A., Darwent, M., & Holmes, E.A. (2020). Sleep and intrusive memories immediately after a traumatic event in emergency department patients. *Sleep, 43*(8), 1-12. https://doi.org/10.1093/sleep/zsaa033

Prigerson, H.G., Jacobs, S.C., Rosenheck, R.A. & Maciejewski, P.K. (1999). Criteria for traumatic grief and PTSD. *British Journal of Psychiatry, 174,* 560–561. https://doi.org/10.1192/S0007125000262715

Raphael, B. & Martinek, N. (1997). Assessing traumatic bereavement and posttraumatic stress disorder. In J.P.Wilson & T.M. Keane (Ed.). *Assessing psychological trauma and PTSD* (pp. 373–396). New York: The Guilford Press.

Renner, F., Ji, J.L., Pictet, A., Holmes, E.A., Blackwell, S.E. (2017). Effects of engaging in repeated mental imagery of future positive events on behavioural activation in individuals with major depressive disorder. *Cognitive Therapy and Research, 41,* 369–380. DOI 10.1007/s10608-016-9776-y

Rynearson, E.K. (1984) Bereavement after homicide: A descriptive study. *American Journal of Psychiatry, 141*(11), 1452-1454. https://doi.org/10.1176/ajp.141.11.1452

Rynearson, E.K. (2001). *Retelling Violent Death*. Brunner/Routledge.

Rynearson, E.K. (2018). Disabling reenactment imagery after violent dying. *Death Studies, 42*(1), 4-8. https://doi.org/10.1080/07481187.2017.1370411

Rynearson, E.K. (2012). The narrative dynamics of grief after homicide. *Omega, 65(3),* 239–249. https://doi.org/10.2190/OM.65.3.f

Rynearson, E.K. (2012a). Chapter: Invoking an alliance with the deceased after violent death. In, R.A. Neimeyer [Ed]. *Techniques of grief therapy: Creative practices for counselling the bereaved.* (pp. 91-94). New York, NY, US: Routledge/Taylor & Francis Group; US.

Rynearson, E.K., & Correa, F. (2008). Accommodation to violent dying: A guide to restorative retelling and support. Unpublished manuscript.

Shuchter, S.R., & Zisook, S. (1993). The course of normal grief. In M.S. Stroebe, W. Stroebe, &. R.O. Hansson (Eds.). *Handbook of bereavement: theory, research, and intervention* (pp. 23–43). Cambridge: Cambridge University Press. https://doi.org/10.1017/CBO9780511664076.003

Singh, L., Espinosa, L., Ji, J.L., Moulds, M.L. & Holmes, E.A. (2020). Developing thinking around mental health science: the example of intrusive, emotional mental imagery after psychological trauma. *Cognitive Neuropsychiatry, 25*(5), 348-363. https://doi.org/10.1080/13546805.2020.1804845

Steil, R., & Ehlers, A. (2000). Dysfunctional meaning of posttraumatic intrusions in chronic PTSD. *Behaviour Research and Therapy, 38*, 537–558. https://doi.org/10.1016/S0005-7967(99)00069-8

Steil, R., Jung, K., & Stangier, U. (2011). Efficacy of a two-session program of cognitive restructuring and imagery modification to reduce the feeling of being contaminated in adult survivors of childhood sexual abuse: a pilot study. *Journal of Behavior Therapy and Experimental Psychiatry***,** *42*(3), 325-9. https://doi.org/10.1016/j.jbtep.2011.01.008

Stroebe, M. & Schut, H. (1999). The dual process model of coping with bereavement: rationale and description. *Death Studies, 23*(3), 197-224. https://doi.org/10.1080/074811899201046

Stroebe, M. & Schut, H. (2001). In M. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Ed.). *Handbook of Bereavement Research: Consequences, Coping, and Care.* (pp. 375-404). Washington DC: American Psychological Association.

Szumilas M. & Kutcher, S. (2011). Post-suicide Intervention Programs: A Systematic Review. *Canadian Journal of Public Health, 102,* 18-29. https://doi.org/10.1007/BF03404872

Wheatley, J. & Hackmann, A. (2011). Using imagery rescripting to treat major depression: theory and practice. *Cognitive and Behavioural Practice, 18*(4), 444-453. https://doi.org/10.1016/j.cbpra.2010.06.004

Wild, J., Hackmann, A., Clark, D.M. (2007). When the present visits the past: updating traumatic memories in social phobia. *Journal of Behavior Therapy and Experimental Psychiatry, 38*(4), 386-401. https://doi.org/10.1016/j.jbtep.2007.07.003

Williams, J.L., Hardt, M.M., Milman, E., Rheingold, A.A., & Rynearson, E.K. (2020) Development and psychometric validation of the dying imagery scale-revised. *Death studies.* https://doi.org/10.1080/07481187.2020.1812135

World Health Organization (WHO) (2019). World Health Statistics 2019: Monitoring Health for the SDGs, Sustainable Development Goals. Geneva: World Health Organization.

Zisook, S., Chentsova-Dutton, Y., & Shuchter, S. (1998). PTSD following bereavement. *American Academy of Clinical Psychiatrists, 10,* 157-163. https://doi.org/10.1023/A:1022342028750

Part 2: Empirical Paper

Exploring the nature of the phenomenon of intrusive mental imagery after suicide bereavement: a qualitative study.

Abstract

Background: Each year millions of people are bereaved by suicide. Research has identified that people bereaved by suicide face an increased risk of adverse health and social outcomes, however still little is known about the subjective experience of those bereaved by suicide. Following a traumatic experience, such as suicide bereavement, the experience of intrusive mental imagery relating to the trauma is not uncommon, yet to our knowledge there is no research which explores the phenomenon of intrusive imagery experienced by those bereaved by suicide.

Aim: This phenomenological research study aims to explore the nature, experience and impact of intrusive mental imagery experienced by people bereaved by suicide.

Methods: Semi-structured interviews with 18 people bereaved by the suicide of a close contact were conducted. Thematic analysis was used to explore patterns and themes within the data, with particular consideration of the content of the intrusive images, how people experience and relate to the imagery, and the impact that the experience of imagery has on those bereaved.

Results: Analysis confirmed the occurrence of intrusive mental imagery, identifying common characteristics in the nature of imagery following bereavement by suicide. Whilst the majority of participants found the experience of intrusive imagery distressing or verbalised unhelpful aspects of the experience, paired with negative impacts and seeking ways to cope with the experience, participants also described positive attributes of the experience of intrusive imagery, such as supporting processing of their loss, post-traumatic growth, facilitating a connection with and providing memories of the deceased, that were of great value to them.

Conclusions: The findings inform our understanding of the experience of people bereaved by suicide. Theoretical and clinical implications are discussed.

Introduction

Suicide Bereavement

Each year nearly 800,000 people die due to suicide (WHO, 2019) exposing an estimated 48 million people to suicide bereavement across the world (Pitman et al., 2014). People bereaved by suicide face adverse impacts, including depression, post-traumatic stress disorder (PTSD), self-harm and suicide (Erlangsen et al., 2017; Pitman et al., 2014), the nature of which has been extensively researched. However, the cognitive, behavioural and biological factors that contribute to these negative outcomes remains poorly understood. Despite the increased risk of adverse impacts faced by those bereaved by suicide much of the support for this group of people falls upon charitable organisations with very little tailored, evidence-based support available within the health services. Furthermore, there is limited evidence for efficacy of interventions that are available for those bereaved by suicide (Adriessen et al., 2019; Linde et al., 2017; McDaid et al., 2008; Szumilas & Kutcher, 2011). The UK Department of Health (2012) has acknowledged that the development of evidence-based interventions to support people bereaved by suicide is essential, not only to support people in the grieving process but to prevent long-term emotional distress and to support recovery.

Intrusive Imagery

Intrusive mental imagery is a cognitive-perceptual phenomenon characterised by a sudden involuntary memory associated with the traumatic event (Ehlers & Clark, 2000); an often unwanted experience that is reported to be highly distressing and disruptive in activities of daily living (Holmes et al., 2005; Iyadurai et al., 2019; Steil

& Ehlers, 2000). Intrusive memories are a core feature of PTSD and although intrusive memories can be experienced in all sensory modalities, including audition and bodily sensations, visual intrusions, known as intrusive mental images, are the most common experience of intrusive memories following a trauma (Clark & Mackay, 2015; Ehlers & Clark, 2000; Ehlers & Steil, 1995). Posttraumatic stress disorder is a common reaction to traumatic events, characterised by repeated and unwanted reexperiencing of the traumatic event in the form of intrusive memories, hyperarousal, emotional numbing, and avoidance of stimuli which act as reminders of the trauma (Ehlers & Clark, 2000). In the aftermath of a traumatic event, many people will experience at least some of these symptoms, even if they do not meet full criteria for PTSD (Ehlers & Clark, 2000). Targeting intrusive mental imagery is often the focus of interventions for psychological trauma and is found to be highly effective (Singh et al., 2020).

Suicide loss is a traumatic experience (Pitman et al., 2016) and those bereaved by suicide face an increased risk of developing PTSD compared with other non-violent loss (Dyregrov et al., 2003; Erlangsen et al., 2017; Kaltman & Bonanno, 2003; Mitchell & Terhosrt, 2017). In small sample studies, people bereaved by suicide of a close contact report experiencing traumatic reminders such as flashbacks and nightmares that relate to the suicide (Dyregrov, 2002; Pitman et al., 2016) often associated with aspects of the death, in addition to the tendency to ruminate about the circumstances of the death (Baddeley et al, 2015; Jackson et al., 2015). Although intrusive mental imagery is reported by people bereaved by suicide and is often accompanied by high levels of distress (Brewin et al., 2009), still little is known about this specific phenomenological experience of suicide bereavement, and existing research remains broad in the context of traumatic death. As such, there is a

lack of qualitative research that explores the phenomenon of intrusive mental imagery experienced following suicide loss. In order to develop novel evidence-based cognitive-behavioural interventions (e.g., imagery rescripting) and support tailored to people bereaved by suicide, a greater understanding of the nature and impact of intrusive mental imagery experienced in suicide bereavement is essential.

The present study investigated the phenomenon of intrusive mental imagery after suicide bereavement by analysing qualitative data which explores individual experiences of intrusive mental imagery following the suicide of a close contact.

Method

This study was conducted as a joint research project (Jones, 2021) with ethical approval provided by UCL Research Ethics Committee (project ID number 16587/001, see Appendix A). Methods including recruitment and screening were conducted together and analytic support was provided (See Appendix B for an outline of individual contributions).

Participants

Recruitment

A self-selecting community sample from the general population was recruited through an advert distributed both online via suicide bereavement support charities and twitter, as well as being disseminated through Support After Suicide Partnership to their membership of suicide bereavement support groups and charities within the UK, using twitter and email. Online study recruitment was appropriate given that all

interviews would be held via an internet-based video call. This also allowed recruitment to take place across the UK.

Screening

Participants responding to the advert were initially asked to complete a short online questionnaire, which was used to screen for inclusion. The following were used as criteria for inclusion; adults aged 18 years plus, (although bereavement may have occurred during childhood); people who have experienced a bereavement by suicide of a close contact, where a close contact was defined for participants as a relative or friend who mattered to them and from whom they were able to obtain support, either emotionally or practically; with experience of intrusive imagery relating to that loss; living in the UK. Participants were also required to speak fluent English and be able to provide informed consent for participation. Exclusion criteria included bereavement by suicide within the last three months; a recent history of suicide attempt; presence of cognitive impairment. Twenty-three participants who met criteria for participation were selected using a purposive sampling approach, with the aim of achieving a diverse sample across age, gender, ethnicity, relationship to the deceased, time since bereavement and bereavement experience, and were invited to a screening call. Of those 23 participants who were contacted, 21 participants took part in the screening call, which further explored risk and suitability for participation. All 21 participants who completed the screening call were deemed suitable to participate. Of the 21 participants, 18 were interviewed. Three participants opted out of the study after screening.

Sample

A purposive approach was taken in sampling for this study to ensure that the sample captured different experiences of suicide bereavement across a range of age, gender, ethnicity, relationship to the deceased, and time since bereavement. Recruitment continued until saturation of themes within a diverse sample was achieved. Demographic characteristics of the sample are described in Table 1.

Table 1.

Demographic Characteristics of the Sample (n=18).

	N (%)
GENDER	
Male	3 (16.7%)
Female	15 (83.3%)
AGE	
18-25 years	2 (11.1%)
26-35 years	4 (22.2%)
36-45 years	5 (27.8%)
46-55 years	3 (16.7%)
56-65 years	3 (16.7%)
66-75 years	0 (0.0%)
76-85 years	1 (5.6%)
ETHNIC BACKGROUND	
White British	14 (77.8%)
White Irish	2 (11.1%)
Mixed Race	1 (5.6%)
Other Ethnic Group	1 (5.6%)
RELATIONSHIP TO THE DECEASED	
Mother	2 (11.1%)
Father	2 (11.1%)
Son	1 (5.6%)
Daughter	1 (5.6%)
Sister	3 (16.7%)
Granddaughter	1 (5.6%)
Partner or Spouse	4 (22.2%)
Ex-Spouse	1 (5.6%)
Close Friend	2 (11.1%)
Other Close Relationship	1 (5.6%)
TIME SINCE BEREAVEMENT	
Less than one year	2 (11.1%)

1-5 years	7 (38.9%)
5-10 years	5 (27.8%)
10-15 years	2 (11.1%)
15-20 years	0 (0.0%)
More than 20 years	2 (11.1%)

Materials

A semi-structured interview schedule was developed (see Appendix F) in which the following questions were considered in order to explore this novel phenomenon based on gaps identified in the literature:

What does intrusive mental imagery 'look like' in suicide bereavement, and how is this experienced? Specifically, the content of images, their form, triggers and sense of control in order to understand the phenomena.

Is the experience of intrusive mental imagery predominantly distressing? If so, is this something that individuals would seek to address through an intervention, such as imagery rescripting? Alternatively, is the experience of intrusive mental imagery experienced as comforting more so than it is distressing, and therefore rescripting interventions are not desired? Understanding the experience of intrusive mental imagery, drawing upon both distressing and comforting elements of the experience, and how this might influence an individual's relationship with the experience of intrusive mental imagery.

Does the experience and subsequent impact of intrusive imagery differ among certain kinship groups? Is this experience only distressing for specific kinship groups? Does the relationship between kinship or characteristics of the relationship influence the experience and impact of intrusive mental imagery for those bereaved?

Is there anything novel within the experience of intrusive imagery for those bereaved by suicide which sets the experience apart from other traumatic bereavement experiences and current thinking?

In developing the interview schedule, guidance from Support After Suicide Partnership, a suicide bereavement charity, was sought in considering appropriate interview questions and language, with input from people with lived experience of suicide bereavement.

Procedure

A self-selecting sample registered their interest in the study by completing an online screening questionnaire (see Appendix C). Participants who met inclusion criteria for the study were contacted initially via email inviting them to complete a screening call with the researcher and were provided with a full information sheet (see Appendix D) and consent form (see Appendix E) in advance of the call. During the screening call, suitability for the research was further explored, including questions regarding risk and wellbeing. Further information about participation was provided and participants had the opportunity to ask questions about participation. If suitable, participants were invited to take part in a semi-structured interview. Informed consent was provided prior to the interview taking place. The interview schedule guided the interview with each participant. Interviews were conducted using an online video platform and lasted up to 90 minutes. At the end of the interview, participants received a debrief and an email containing information for support services available to people bereaved by suicide. Interviews were audio recorded and

transcribed for analysis. One week following the interview, participants received a follow-up email which formed the final part of the debrief, marking the end of their participation.

Data Analysis

All 18 interview transcriptions were included in analysis. Thematic analysis was used to explore and identify themes within the data relating to the phenomenology of the experience of intrusive mental imagery; specifically, the content of the imagery, how the imagery was experienced, and the impact that imagery had on the individual. Although this was intended to be an inductive process, it is acknowledged that a semi-structured interview schedule imposes some priori constraints on the themes elicited. Furthermore, throughout analysis whilst the researcher's position as a white-British female without personal experience of suicide bereavement of a close contact and motivations to promote the development of evidence-based support for people bereaved by suicide were put to one side as much as possible, it is inevitable that this position would influence data analysis in some capacity. A process of personal reflexivity (Berger, 2015; Chinn, 2007; Dodgson, 2019) was employed in an attempt to increase one's awareness of this influence.

The established conventional approach to thematic analysis was taken, following analytic procedures set out by Braun and Clarke (2006). The interviews were transcribed verbatim by the author to ensure immersion in the data, identifying and holding in mind initial ideas within the data. NVivo (version 1.3.2) was used to support initial analysis of interview transcriptions carefully examining each transcript line-by-line enabling detailed notation of units of meaning and impression, developing initial codes for potential themes. Two transcripts were independently

coded by a research colleague (P.J) to verify analysis of data by K.Q, which provided good support of initial coding. Any differences in coding were discussed and addressed. Codes were collated into potential themes, bringing together all data relevant to each potential theme identified. All extracts for potential themes were then presented in a table for further analysis and development of a thematic framework. Analysis continued with refining themes, generating clear definitions and names of each theme with support from members of the research team throughout this process. The thematic framework was then discussed within the wider research team, which consisted of two experts on mental imagery and trauma and an experienced qualitative researcher, for accuracy. Any difference of opinion regarding the positioning of themes and subthemes identified was resolved through discussion, ensuring validity of the overall framework. (The process of achieving the final thematic framework is detailed in Appendix G). Lastly, using the final thematic framework, extracts were selected to provide evidence of the themes identified within the data and a report was produced in relation to the research question, reporting experiences, meanings and the reality of the participants' experiences (Braun & Clark, 2006) in relation to the research question.

Results

Participants spoke in detail about their experience of intrusive mental imagery following their bereavement by suicide of a close contact.

Themes identified

An in-depth analysis of the eighteen interview transcripts identified seven key themes representing the phenomenon and the experience of intrusive mental imagery following suicide loss of a close contact. The key themes included (1) Nature of imagery; (2) Degree of control over imagery; and (3) Imagery over time; which together describe the characteristics of intrusive mental imagery, and (4) Intrusive imagery is unhelpful and distressing; (5) Impact of imagery; (6) Ways of coping; and (7) Positive aspects of the experience of imagery, which together describe the emotional, cognitive and behavioural responses to the experience of intrusive imagery following suicide bereavement. The thematic framework is shown in Table 2.

Table 2.

Thematic Framework.

Themes | Sub-themes
1. Characteristics of intrusive imagery
1.1. Nature of imagery 1.1.1 Discovering the deceased 1.1.2 Suicide method as a key feature 1.1.3 Only the deceased is present in imagery 1.1.4 Picturing the deceased as dead 1.1.5 Piecing together what happened at the scene of the suicide 1.1.6 Questioning
1.2. Degree of control over imagery 1.2.1 Lack of control 1.2.2 Triggers for imagery
1.3. Changes in imagery over time 1.3.1 Reduced impact 1.3.2 The influence of control
2. Emotional, cognitive and behavioural responses to intrusive imagery
2.1. Imagery is unhelpful and distressing 2.1.1 Imagery as distressing 2.1.2 Intrusive imagery interferes with positive memories and images of the deceased 2.1.3 Fabricated imagery as unhelpful and impeding closure

2.2. Impact of imagery 2.2.1 The negative impact of imagery 2.2.2 Physical impact 2.2.3 Mixed emotional responses to imagery
2.3. Ways of coping 2.3.1 Distraction 2.3.2 Overwriting imagery 2.3.3 Attempts to avoid imagery
2.4. Positive aspects of the experience of imagery 2.4.1 Post-traumatic growth 2.4.2 Imagery as supporting processing 2.4.3 Imagery as important regardless of the distress 2.4.4 Imagery as facilitating a connection with the deceased 2.4.5 Fear of erasing the memory of the deceased

In presenting the thematic analysis, quotes are taken from the interview transcripts relating to the theme or subtheme discussed. Quotes have been presented ensuring they do not contain material likely to be triggering, as per Samaritans guidelines (Samaritans, 2020). The characteristics of the participants are shown in Table 3 for reference (age ranges are given in order to ensure anonymity). Percentages are given to denote the prevalence of different themes within the experiences of those who took part in the interviews (see Appendix H for distribution of themes). Data from some responses were coded under more than one theme.

Table 3.

Participant Characteristics.

Participant	Gender	Age range (years)	Relationship to the deceased	Time since bereavement
P1	Female	36-45	Ex-spouse	3 years
P2	Female	26-35	Close Friend	3 years
P3	Female	26-35	Sister	2 years
P4	Female	36-45	Sister	9 years
P5	Female	26-35	Close Friend	2 years
P6	Female	56-65	Spouse	6 years
P7	Female	56-65	Mother	3 years
P8	Female	36-45	Spouse	13 years
P9	Female	76-85	Sister	20 years
P10	Male	46-55	Father	6 months
P11	Female	36-45	Spouse	4 years

P12	Male	46-55	Father	5 years
P13	Female	46-55	Partner	23 years
P14	Female	36-45	Teacher	6 months
P15	Female	56-65	Mother	5 years
P16	Female	18-25	Daughter	2 years
P17	Male	18-25	Son	12 years
P18	Female	26-35	Granddaughter	9 years

1. Characteristics of Intrusive Imagery

All those interviewed for the study reported experiences of intrusive imagery following bereavement by suicide of a close contact and spoke in detail about the characteristics of the imagery they experienced including the nature of the imagery, the degree of control over imagery and imagery over time.

1.1 Nature of imagery

All participants spoke in detail about the nature of the intrusive imagery that they experienced following their bereavement by suicide. Their descriptions were divided into those who experienced the same image repeatedly, those who reported a limited number of images relating to the suicide, and those who perceived multiple images relating to the suicide. For some people these patterns seemed to change across the course of bereavement. There was substantial variation in the perceived frequency of the intrusive images as well as how much time was taken up by the replay of intrusive imagery. Participants often lacked a sense of the time spent engaged with the imagery or reported that this was influenced by other factors such as mood. Intrusive imagery was experienced as both static images and film-like imagery, and both were described as highly distressing. A key distinction in the nature of imagery appeared to be the experience of ‘real’ imagery experienced by those who were

present at the discovery of the deceased and 'imagined' imagery, which was experienced by both people that had been present and people that had been absent at the time of discovery. This appeared to be influenced to some extent by whether or not they had witnessed the discovery of the suicide but also by the degree to which they felt they had complete information about the suicide, and therefore the nature of the memories they had laid down about the event. Participants spoke of imagery being largely focused on the narrative of the suicide, such that their imagery described or told the story of the deceased's suicide. Key features identified are described.

1.1.1 Discovering the deceased

More than a quarter of participants (*n* = 5; 28%) described the discovery of the deceased as the core content of their intrusive imagery, providing clear imagery either of their experience and memory of discovering the deceased, or, where they were not present, how they imagined the discovery to have been.

"another one that pops into my head is running up the stairs and seeing [him]." (P3).

"I see my son when I found him lying there dead." (P10).

For those who were not present at the discovery of the suicide, this narrative was also described as feeling very real.

"The images in relation to the finding of him come and go, they're not so much, maybe because I know I'm imagining them, I'm, not necessarily real because I didn't see them with my own eyes, however they feel real." (P4).

1.1.2 Suicide method as a key feature

For nearly all participants (*n* = 15; 83%) the method was a key feature in the intrusive imagery experienced following the suicide bereavement. This imagery was described as very graphic for both those who witnessed the deceased following the suicide, as well as those who were absent at the time of discovery.

Often, intrusive images featuring the method were located at the scene of the suicide.

"They tend to be of scenes that I wasn't there for or didn't see, so I tend to, I tend to… the main image I get, I have the image of him." (P1).

"That other main one of just, [an] *image of her [lying dead] …It's just kind of, it's like a hypothetical image, based on what I sort of assume probably was what she looked like."* (P5).

The method used also featured more indirectly, such as in imagery of the deceased outside the context of the discovery either holding items used in the suicide or appearing with the scars or stigmata of the suicide.

Participants, both those present at the discovery and those absent, described how the method also featured in 'imagined' intrusive imagery.

"I was imaging [him] *walking down the hallway into the bedroom, but there was sort of like [items from the suicide method present]."* (P6).

1.1.3 Only the deceased is present in imagery

One key feature of the intrusive imagery that half of participants (*n* = 9; 50%) reported was that only the deceased was present in the imagery.

"Never anyone, not even the jogger that found him. …Nothing else, just [the deceased]. …But no, no nothing, nobody else at all. It all centred on him." (P9)

"I'm picturing, oh he walks into the hotel, there's never anyone, like there's never anything else that features in it, it's almost just like a spotlight on him and that's all I can visualise." (P16).

1.1.4 Picturing the deceased as dead

Nearly all of participants (*n* = 15; 83%) spoke of how their intrusive imagery featured an image or images of the deceased following their suicide. This was described as being the most intrusive of images or the clearest of images amongst participants, and for some it always formed part of the experience of intrusive imagery. Again, this was described by both those who witnessed the discovery and by those who were not present.

"I can visualise and replay in my head what I think that whole kind of couple of hours would have played out like, but that image that comes to me involuntary is almost like after he's died, in the scene, rather than kind of anything like mid-scene." (P16).

"I never saw it, but I think when you die like that, I always seem to picture his face [a certain way], which, I never saw that, but that's something will pop up in my head." (P18).

A few participants further spoke of how other parts of the imagery might vary, including aspects of them leading up to the death, but that their intrusive imagery would always come to focus on an image of the deceased after their death.

"[The images] *weren't always right from the beginning of the day, they would be sections of it, but … they would always concentrate eventually on what he looked like when he died."* (P9).

1.1.5 Piecing together what happened at the scene of the suicide

A key narrative in intrusive imagery following the bereavement, as described by two thirds of participants (*n* = 12; 67%), was piecing together what had happened at the scene of the suicide and in the last moments for the deceased.

"Erm like, one thing I really visualise is the very last moments, like I can see her now in my head [in the act of the suicide]." (P17).

For some this included elements of mentalising, considering how the deceased must have been experiencing these moments.

"one thing I remember was sort of picturing [the deceased] … when he was sort of thinking through what he was doing … and you know, what was going through his

mind. And he, he must have been scared and frightened and a whole host of emotions [tearful].” (P11).

1.1.6 Questioning

For many participants the suicide of someone close to them gave rise to many questions. Nearly half of participants (*n* = 8; 44%) spoke about the narrative that the imagery played out relating to unknown aspects or unanswered questions that they had in relation to the suicide of their close contact.

“So, although it’s a very short video, in my mind video, sort of moving image, you know it’s, lots of different variations of it. It’s various nuances. And I don’t know which is the right one. I don’t know which is the, I know how it ends [pause] but I don’t know which version is the right one. And I don’t know why it’s a really, why it’s important for me to know that.” (P6).

1.2 Degree of control over imagery

1.2.1 Lack of control

Unsurprisingly, given the focus on *intrusive* imagery, nearly all participants (*n* = 17; 94%) verbalised their inability to influence or control the onset of the experience of imagery, which was a pertinent feature of the experience.

“But before I worked out how to stop it, it was almost like I couldn’t stop it. And I would, I would even go back to the beginning and start again. Erm, because I got no satisfaction from it [pause]. I don’t really know what I expected when I look back now, it was just completely out of my control.” (P9).

For many, the lack of control was in itself a distressing feature of the experience.

"I was quite frightened by these [images] *because I had no control over it."* (P6).

The lack of control appeared to largely define the experience of intrusive imagery, such that imagery arising during times of reflection (i.e., when conjured up voluntarily) was experienced with less distress due to an increased sense of control, which contrasted with the experience of intrusive imagery.

"Whereas, when again it's just me by myself and I'm reflecting [pause] it's different, it's different because, yeah, I think I'm more in control of it, and it's a conscious thing that I'm doing, and I think there is that healing side of it which I've never really thought about before. And I think it's different because it's not such a, it's not like an attack, again it's more, it's me, myself in my personal space." (P18).

1.2.2 Triggers for imagery

Although many participants described the onset of intrusive imagery in the absence of a known trigger, more than half of participants (n = 11; 61%) also talked about common triggers that led to the onset of involuntary images, including objects referencing the context of the suicide, reminders of the deceased as an individual, or references to suicide more generally.

"Yes, it's like in my mind I have regular images, for example you know like if the word 'body', like 'oh the Police found a body', if I hear anything, I see my son when I found him lying there dead." (P10).

"One of the really stupid ones is I think about a friend of ours has a son who is a similar age and I saw him for the first time, and he was wearing shorts [tearful] and … seeing his knees just made me think of [my son]." (P7).

1.3 Changes in imagery over time

1.3.1 Reduced impact

Although the experience of intrusive imagery appeared to persist for some years following suicide bereavement, more than half of participants (*n* = 11; 61%) described a reduction in their intensity or frequency over time.

"So, I think you become deadened. Erm, you know, I think your emotions become depleted. So that actually you become, you know, a mixed of exhausted and accepting. So, in that I mean, it's so obviously my emotional response to visualisations and memories and events and so on, is less dramatic now. Erm, and more [pause] resignation I suppose. Whereas obviously in the early days it was incredible violent and very, very difficult. Very difficult. I couldn't breathe. I couldn't move." (P12).

While for some the reduction in impact was attributed to the process of time, others reflected on their ability to better manage the experience over time, which reduced the distressing impact of intrusive imagery.

"And I guess that's still, I still sometimes get that, but not, I guess not in, at the beginning it felt quite like, erm like life-debilitating because it meant that I would really struggle to go into particular bathrooms. Erm, now it's not, a guess a, I've kind of learnt to live with the image when it comes up." (P16).

1.3.2 The influence of control

For some, the attenuation of the distress of imagery over time appeared to be characterised by the degree to which they felt in control, with nearly a quarter of participants (*n* = 4; 22%) to some extent attributing change in intrusive imagery over time to their increasing sense of control over the imagery.

"And so, it was about being able to do that [experience imagery] *but in a safe way and a controlled way. And at the beginning I had no control and it just didn't feel safe because it could come out of nowhere."* (P6).

2. Emotional, Cognitive and Behavioural Responses to Intrusive Imagery

All of those interviewed spoke about their intrusive mental imagery in terms of a range of emotional, cognitive and behavioural responses to the experience in the context of the distress caused, their response to imagery and the impact that this has, and their ways of coping, as well as perceived positive aspects of the experience.

2.1 Intrusive imagery as unhelpful and distressing

The majority (*n* = 14; 78%) of participants spoke of intrusive imagery being disruptive or distressing.

2.1.1 Imagery as distressing

A large proportion of participants (n = 13; 72%) described their experience of intrusive imagery that followed their suicide loss as distressing. This distress was described by participants across varying stages of the bereavement.

"In the earlier days, you know I just wanted it to stop, you know, just very, very, very, very distressed and wanted it to stop. … they're still very distressing." (P15).

2.1.2 Intrusive imagery interferes with positive memories and images of the deceased

Many participants (*n* = 7; 39%) described how the experience of intrusive imagery relating to the suicide could often interfere with their recollection of autobiographical memories of the deceased. Participants described how this often made it difficult to recall happier memories of the deceased's life or experience more pleasant imagery relating to the deceased, which was something that they desired.

"I would at some stage be grateful for, for more of the images of the positive things in [the deceased]'s life, you know, the memories.... I think the negative thing with these [intrusive images] *being there, whether they're distressing or comforting, is the fact that they're taking the space … and preventing other images of when, when [the deceased] was young or, preventing those from being there. So maybe … if I didn't so desperately need that connection, maybe it would be better, maybe the*

images would slightly fade, possibly. And allow some of those other, more positive images to come back..." (P15).

Participants spoke of how they actively attempted to recall the more favourable and pleasant memories of the deceased, but that this was often ineffective because intrusive imagery relating to the suicide was more readily retrieved and powerful.

"I think I probably have more negative images than positive images. ...I suppose one thing that I tried to kind of do ... I would look through photos that we had from holidays, and you know, his Facebook profile and all the images and posts on there. ...I kind of force myself erm to, to review those to try and remember the happy times ... I'd say generally the images that come to mind are associated with his death rather than his life, probably." (P11).

2.1.3 Fabricated imagery as unhelpful and impeding closure

A number of participants (*n* = 5; 39%) described their fabricated or imagined intrusive imagery relating to the suicide as unhelpful, preventing closure because they impeded an acceptance of not knowing what the reality had been.

"There's two sides, I mean on one side they're not helpful at all, they don't make me feel any better. Erm, on the other side I think it would just give some closure if I knew the images were real. So, if I knew exactly what she would look like, it would just stop my mind from having so many other images. Because you just have one image to go off, and you know this image is real not several others, the

possibilities. … I think having real images, which I know will never happen … I guess that would help because then it stops my, it stops your imagination." (P17).

For those who had experienced the distress of having found the deceased after their suicide, this had provided them with a reality and level of information that felt somewhat helpful, despite the distress involved in that proximity to the event.

"I don't think I was left with anything sort of unanswered. I suppose in a way that was easier … for my actually having found him … I didn't have, I mean conversation like with his sister in particular, I think her not knowing means she's been more sort of vivid in her thoughts and whatever, so at least I know what the reality was to some extent if that makes sense. So, in some ways that's been awful, but it means I haven't, I haven't been bothered by things that might or might not have happened, in different ways. … So perhaps less sort of like, less greyness about it..." (P6).

2.2 Impact of intrusive imagery

2.2.1 The negative impact of imagery

A large proportion of participants (*n* = 11; 61%) spoke about the negative impacts that intrusive imagery had had on their lives, directly and indirectly preventing activities of daily living to the degree that it was quite debilitating.

"I had them for months and months and months, until I realised, I was back at work, I realised that these, these imaginings were destroying me. I was getting quite careless at work." (P9).

"So, I would say in the first month it was, more or less constant. I was really agitated. I was hyperactive…I wasn't getting much sleep. I remember like, going away for a night with a friend and saying, "I only sleep for twenty minutes that's all I need". I think I'm was a bit manic to be honest [laughs]." (P8).

"They're constant, it's like having somebody constantly stab you with a knife over and over and over again. But you're not, you're not bleeding to death. Whereas in the early days, you know, you'd be quite thankful if somebody stabbed you with a knife and you bled to death, you know, in the early days it was, it was erm horrific to feel, you know. You're just reliving it over and over and over again." (P15).

2.2.2 Physical impact

In a similar way, half of the participants (*n* = 9; 50%) described an unpleasant visceral impact to the trauma of the intrusive imagery, described as a sudden and uncontrollable experience.

"It like, I guess it takes my breath away kind of thing, because it's so unexpected you know I'm like 'owf!'It's like being punched in the stomach type thing, it takes my breath away." (P2).

"It was visceral yeah, and I remember sort of like [takes a big breath in] like as if you know you've been punched in your [inaudible] or something, and it was like, like that, it was just this feeling of you know feeling sick, very nauseous, and just knowing you need to, you're going it's sort of like a cry but it's not that, it's not that cry you know when you're watching, it's guttural, like gut-wrenching sobs, like you know that that's what it's going to be." (P6).

Some described how the imagery quite literally froze them in whatever they were doing at the time.

"Sometimes you, you erm, are frozen by them. [pause] You can't move. That image can be so powerful and the immediately kind of emotional response means that somehow or another you're, you know, quasi-paralysed. You can't get out of the chair for a moment, or whatever it might be. … It's so traumatic as to sort of freeze you on the spot. … I have been known to stand still in the street for no particular reason. Or be talking to someone and all of a sudden, I stop." (P12).

2.2.3 Mixed emotional responses to imagery

Linked with the unpleasant visceral impacts of the imagery described above, two thirds of participants (n = 12; 67%) described a range of distressing and conflicting emotional responses to the intrusive imagery, which impacted on them both physically and in their social functioning.

"Bereaved and just sad [tearful] [pause] and feeling like we somehow failed him. And also, really angry with why he didn't ask us to help. So, loads of conflicting stuff." (P7).

Some participants described an intense emotional experience, which could change in its nature quite quickly, and could leave them feeling out of control.

"And it, it's sort of nostalgic and then sorrowful and then angry and the images just provoke rapid emotional changes like instantly and there's no, there's no kind of control over that, because the triggers are so strong." (P4).

2.3 Ways of coping

Participants (*n* = 10; 56%) spoke of ways they had learned to cope with this distressing and intrusive experience of imagery relating to the suicide.

2.3.1 Distraction

Nearly a third of participants (*n* = 5; 28%) described actively using distraction in response to intrusive imagery as a strategy to cope with the experience.

"Yeah, I mean I'm very good at distracting myself. I've found that's been, I don't even know if that's the right way to deal with it, but working and being around, you know as soon as I'm around other people and I have to be a certain way, and I have to bring myself out of that space, then I do." (P3).

Many participants noted their success in coping through distraction, however effectiveness of strategies was also influenced by mood, such that distraction was not always a successful strategy when the experience of intrusive imagery was compounded by low mood or particular thinking styles arising from more distressed moods.

"[it's] playing almost constantly in the background but I think, whereas before it couldn't play in the background, it was just there, I think now maybe to pull away from it, and I suppose it will depend on my mood, depend on my state of mind on a particular day, and how, probably how engaged I am with something else. And if I'm not able to distract with other things then I think it will be more, less easily, less, harder to puller away from the tv screen [image], if you like." (P15).

2.3.2 Overwriting imagery

Another coping strategy commonly used by a third of participants (*n* = 6; 33%) was finding a way of overwriting the intrusive imagery, often attempting to swap intrusive images with more pleasant imagery or memories of the deceased, or more helpful alternative thought processes.

"Whenever I start imagining these things about [the deceased] being dead in his car, and what position he was in, what did he look like and this sort of thing, I would tell myself, 'no, I'm going to think about that day when we bought those coffee tables'." (P9).

"…it's now the case of that image is coming, and I immediately swap it unconsciously, but that for me that really works and I haven't been affected by it since. Or I'm not conscious that I have been. But it's something that for me that's a really strong technique." (P6).

2.3.3 Attempts to avoid imagery

Most commonly (*n* = 8; 44%) among participants that described ways of coping with the experience was an attempt to avoid the experience of intrusive imagery. It is noted among all participants that they had no control in the imagery coming to them, hence the intrusive nature of imagery, however participants engaged in attempts to avoid or block out the imagery when they experienced this, although this was not always successful.

"…it depends on what the image is, usually with the ones of him you know and the actual suicide, I'm actually quite good at shaking off or having that mental block." (P3).

2.4. Positive aspects of the experience of imagery

Despite the distressing experience of intrusive imagery, nearly all participants (*n* = 17; 94%) spoke of some positive or therapeutic aspects of their experience.

2.4.1 Post-traumatic growth

A third of participants (*n* = 6; 33%) recognised their bereavement by suicide as a life changing experience for which intrusive imagery helped them to reflect on the enormity of the event that they had coped with, such that the imagery was of value to them as it acted as a reminder of this.

"I suppose in part it reminds me of what I've been through and that I've survived … and that I've got this far." (P11).

"I think I would miss them, just because it's such a life changing thing that regardless of the character of the images, I need the reminder of that." (P4).

Some spoke of how the changes in the experience of intrusive imagery also served as a marker of their healing in the process of grief and bereavement.

"it's taught me resilience, it's helped me you know compartmentalise my thoughts and deal... it actually brings something tangible to work with, and measurable, and like, if I can feel it getting less and less frequently, I know I'm healing." (P1).

2.4.2 Imagery as supporting processing

A large proportion of participants (*n* = 12; 67%) spoke of the role that intrusive imagery had in processing their suicide loss.

"I think the imagery is important because it helps you process." (P14).

Intrusive imagery had helped to make meaning and come to understand the suicide of their close contact.

"rather than specific images, it's more like the story … I'm trying to make sense of kind of what happened." (P11).

Some implied that recognising the role that intrusive imagery played in processing of the suicide loss had been somewhat reassuring and helpful.

"at the beginning I was quite frightened by it but at the same time you're reading into it and sort of trying to understand why you think like this, it's sort of you realise actually it's your brain trying to, starting to process, you know, the whole thing that you've been through." (P6).

2.4.3 Imagery as important regardless of the distress

Nearly a quarter of participants (*n* = 4; 22%) spoke of the importance of intrusive imagery despite the distress that they experienced, recognising that through losing the imagery the distress would end but simultaneously this would also bring the loss of something that is of value to them. However, many struggled to reconcile this apparent contradiction.

"Even though it's horrendous when it takes me back and I see his face … I wouldn't trade that for not having those images … and not having been there. I don't know, it's very weird. [pause] Yeah that's an odd one." (P3).

"Should I miss the [image of] *'I love you dad' … should I be relieved that I'd not have that* [image] *… I don't know. At the moment I don't know … because it's love and pain. … so yeah, maybe I would be relieved not to have pain anymore, but I wouldn't like to not have them because of the love."* (P10).

2.4.4 Imagery as facilitating a connection with the deceased

Imagery for some participants (*n* = 7; 39%) provided the opportunity to connect with or feel close to the deceased. Participants spoke of the distress that the experience of intrusive imagery brought for them yet simultaneously provides comfort through

connecting with or feeling closer to the deceased as a result of the experience of intrusive imagery.

"I think my nostalgia sometimes for that, the time passing, like I said, I think that's because I feel closer to him, so I think that whilst those images are horrible and they make me shudder and I want them out of my head, I think if I didn't have them, I think, I think I would feel that loss of connection to [the deceased]." (P3).

Participants spoke of how the vivid characteristic of intrusive imagery facilitated this sense of connection or closeness, such that the intrusive imagery was the closest thing to having the deceased with them again.

"I wondered whether it's [imagery] *part of it is a desire, I know it sounds very strange to say it but, because it's a way to be connected to the person. … I still am not able really to connect, to focus on all the good memories of [the deceased] and, you know, the life she had before. … But in a sense, in one way, I think because they're so strong, the images, the imagery, it's almost as though she's still there. … Even though it's horrible, it's all you've got left. … I wonder whether the brain's trying to keep, keep connected in that way because they're such powerful images … because the imagery is powerful it may be a way of connecting to her."* (P15).

Participants further spoke of how losing or stopping the intrusive imagery would mean losing the connection with the deceased, which was not desirable.

"I think they [images] *are … the last tie I have to my grandpa, and if I didn't have those images, I wouldn't really have much to go on. You know, I wouldn't*

really have much to say that, you know I don't have a lot of memories with him because we didn't see him that much and stuff. Whereas these are things that I guess have kept me company for the best part of ten years and have allowed me to erm, have kind of some kind of tie or relationship. So, I don't think I'd want to lose them. …it would probably feel like really letting go of my grandad." (P18).

2.4.5 Fear of erasing the memory of the deceased

Participants (*n* = 6; 33%) described how eliminating the intrusive imagery would not be welcomed as for them this would be comparable to erasing the memory of the deceased or reducing the stock of memories that they had of the deceased.

"Well, there's part of me that would rather not have that memory, I'd rather have my son back, erm but I don't see the necessity of eradicating that memory from my psychology or my consciousness, no. In fact, on balance I think I would rather have it, because to not have it would be to diminish the stock of memories I actually have." (P12).

"I think I might miss them, because it's [pause] it's [his] last moments. Erm [pause] and anything related to him is still important. Like I would be forgetting him, or part of him. So, in that sense, yeah, they are important because they're part of [him]." (P6).

Discussion

This study aimed to explore the phenomenon of intrusive mental imagery experienced by people bereaved by suicide. A number of clinically important phenomenological features of intrusive imagery were identified and will be discussed, along with their implications.

Main findings

Interviews with people bereaved by suicide have identified a range of complex characteristics and experiences in relation to the phenomenon of intrusive mental imagery following the suicide of a close contact.

The content of imagery appeared largely to focus on aspects of the suicide and of the deceased, with a sense of trying to understand what had happened at the suicide. Participants who described a narrative of questioning or piecing together within their imagery appeared to be actively seeking to make sense of what had happened, which was experienced as interfering with the grieving process and recovery. This is somewhat different to the understanding that we have of intrusive mental imagery in PTSD, such that the content of intrusive imagery in PSTD is thought to be characterised by 'hotspots', which represent the most distressing or traumatic parts of the trauma for the individual (Ehlers & Clark, 2000; Holmes et al., 2005).

There appear to be similarities in the role of intrusive imagery in preventing processing of the traumatic event and subsequent recovery (Ehlers & Clark, 2000). Similarly to intrusive imagery or flashbacks experienced in PTSD (Brewin et al., 2010), intrusive imagery following suicide loss was experienced with a sense of lack

of control over its onset, often described as a distressing aspect of the experience. Many participants upon reflection were at times aware of triggers for their intrusive mental imagery, including contextual reminders, reminders of the deceased and reference to the traumatic event. Involuntary, automatic or environmental triggers for intrusive mental imagery are also a common feature of intrusive imagery in PTSD (Brewin et al., 201). However, participants also reported the experience of intrusive imagery in the absence of any identifiable triggers, further highlighting the intrusive and uncontrollable nature of the experience, which is again similar to that of intrusive imagery experienced in PTSD and other psychological disorders (Brewin et al., 2010). For many, there was an awareness of changes in the experience of intrusive imagery over time. Many participants recognised a reduction in the impact of the experience, rather than in the frequency of imagery, and for some this was understood to be influenced by an increase in their capacity to control the experience. This further highlights the role of control in the experience of this phenomenon.

Coding also highlighted a second key theme relating to the complexity of emotional, cognitive and behavioural responses elicited by the experience of intrusive imagery in suicide bereavement. Many participants described the experience of intrusive imagery as distressing and unhelpful in different ways, reporting negative impacts of the experience, including interfering with activities of daily living, the physical impact which accompanies imagery, and emotional challenges that the experience presented for them. This experience shares similar features with intrusive imagery of a trauma typically experienced in PTSD (Brewin et al., 2010; Ehler, 2006; Ehlers & Clark, 2000; Holmes et al., 2005; Iyadurai et al., 2019; Prigerson et al., 1999; Raphael & Martinek, 1997; Steil & Ehlers, 2000). Within this overarching theme, there was an expression of attempting to find ways to

cope with the experience of intrusive imagery. Among those who described active attempts to manage the experience, ways of coping took the form of escaping the experience of imagery either through distraction, attempts to overwrite or replace distressing images, or through attempts to avoid the experience entirely. Again, avoidance is a common reaction to intrusive imagery experienced in relation to a traumatic event as individuals find the content too unpleasant or distressing to attend to (Brewin et al., 2010). However, strategies used to avoid or escape the experience of intrusive mental imagery were not always successful and participants described how this could also be influenced by other aspects, such as mood.

Although attempts to find ways to cope with imagery primarily through avoidance perhaps suggests a wish to reduce the experience of intrusive mental imagery, in theme 2.4 participants also spoke of positive aspects of their experience, which in turn challenges the desire to reduce the occurrence of intrusive mental imagery. This significantly contrasts the experience of intrusive imagery in PTSD, which is found to be highly distressing and absent of positive experiences (Brewin et al., 2010). This finding may instead be understood as similar to the experience of intrusive imagery in complicated grief; such that imagery is thought to relate to the yearning for the deceased, and thus imagery can be experienced as comforting (Boelen & Huntjens, 2008). This conflicting experience of elevated distress and impairment followed by consequences that were experienced to some extent as comforting, however, appears to be unique to the experience of intrusive imagery in suicide bereavement. Positive aspects of the experience were reported to be somewhat of greater value to many participants, such that they would tolerate the distress of the experience in order to maintain these positive attributes. Imagery helped people to process their loss, recognise their strengths, often referred to as

post-traumatic growth following traumatic events including bereavement (Linley & Joseph, 2004; Michael & Cooper, 2013), and establish a way to maintain a connection with the person they had lost. For this reason, very few participants wished to eliminate the experience of intrusive imagery.

Findings indicate similarities in the phenomenon with that of intrusive imagery experienced in both PTSD and in complicate grief. These findings suggest that interventions such as imagery rescripting, whereby individuals focus on the content of their intrusive mental imagery and vividly construct an alternative, more desired image, which can include communicating with the deceased (Brewin et al., 2010), may be more sought after within this population. Imagery rescripting in post-trauma and bereavement by violent death (Hagenaars & Arntz, 2010; Rynearson, 2012; Singh et al. 2020) seeks to reduce distressing aspects of the experience, such as the intrusive nature of the imagery, and increase control of the experience of imagery, which would likely be of value in this population.

Although themes in the experience of intrusive imagery according to kinship categories with the deceased were not apparent in the data, there appeared to be a cross-cutting theme within a number of subthemes which highlighted a relationship between the experience of intrusive imagery for those bereaved and the nature or closeness of their relationship with the deceased. When talking about positive aspects of imagery, such as the importance of imagery, imagery as facilitating a connection with the deceased and fear of erasing the memory of the deceased, the way that participants described the imagery appeared to differ for those with close relationships to the deceased and those who conveyed strained or more difficult relationships with the deceased. As such, where relationships were relatively conflicted, imagery relating to the suicide was experienced as more unhelpful or with

less potential to provide comfort, creating a greater incentive for the bereaved to eliminate the imagery. However, for those participants who described close relationships with the deceased at the time of the suicide, they more often described that intrusive imagery is important, maintaining a connection with the deceased or providing important memories of the deceased despite the distress that accompanied the imagery. For those with less conflicted relationships to the deceased, the option of reducing intrusive imagery came at the price of losing other more positive aspects of their experience. These findings are akin to the somewhat limited research that looks at closeness as a mediating factor in the impact of suicide bereavement. Studies show that closeness of the relationship to the deceased increases the magnitude of psychiatric outcomes for the bereaved, with rates of anxiety and depression approximately twofold, and rates of PTSD nearly four times greater in those with close relationships to the deceased regardless of their categorical relationship (Cerel, et al., 2016, 2019). As such, the theme identified here, highlighting the association between the relationship with the deceased and the experience of intrusive imagery, would inform appropriate intervention for those experiencing intrusive mental imagery following bereavement by suicide.

These findings increase our understanding of the nature and factors contributing to the maintenance of distress and the impact of the complex grieving process which has been identified in those bereaved by suicide. Findings highlight similarities in the experience of intrusive mental imagery experienced in suicide bereavement with intrusive imagery experienced in both PTSD, complicated grief and other psychological disorders (Brewin et al., 2010). However, in line with the work of Baddeley and colleagues (2015), findings also suggest that there are factors in the phenomenon of intrusive mental imagery that are unique to people bereaved

by suicide. This would have important implications for further research and, in particular, studies that look to promote the development of tailored support and evidence-based interventions specific to this group.

Strengths and limitations

To our knowledge, this is the first qualitative study of the phenomenon of intrusive mental imagery experienced by people bereaved by suicide. As such, this paper presents novel ideas about the phenomenon as well as adding to the literature and understanding of intrusive mental imagery more broadly. Whilst it is acknowledged that qualitative studies such as this do not aim to generate findings that can be generalised on a wide scale, discussing clinical implications requires implying generalisation to some extent. It is therefore important to acknowledge that characteristics of this UK-based study, the methods in which participants were recruited and selected to participate in a purposive fashion, and the limitations that this presents when considering generalisation. Despite efforts to recruit participants from groups that are under-represented in research, the sample is over-representative of white females. Given cultural dimensions to the experience of intrusive mental imagery, particularly in the context of suicide bereavement, findings may not be generalisable to other ethnic or social groups cross-culturally but certainly provide a rich understanding of the phenomenological experience of those represented in this study.

Credibility checks were undertaken throughout the research, ensuring consensus within the wider research team among themes and subthemes within the data to improve validity of the findings. Discussions within the research team enhanced reflexivity and helped to gain conceptual clarity during the analytic

process. Input from experts by experience and suicide bereavement charities and organisations also supported the development of study materials with particular consideration for the interview schedule, ensuring use of appropriate and meaningful language during the interviews. Participant validation of interpretations made by the researcher was not sought due to limitations imposed by research ethics as well as time constraints, however it is noted that this would likely have provided fruitful discussions and further understanding of the phenomenon (Barker & Pistrang, 2005).

Clinical and theoretical implications

The findings of this study have important theoretical and clinical implications. The findings further contribute to our understanding of intrusive imagery in trauma and grief more broadly, whilst informing our understanding of a relatively novel phenomenon specific to the experience of intrusive mental imagery in suicide bereavement. This research also has implications for clinical work of mental health teams who both have contact with and provide support for those bereaved by suicide. This research highlights the need for practitioners and people providing support for those bereaved by suicide to ensure that intrusive mental imagery is explored with individuals and that a therapeutic space is provided to address intrusive imagery where needed. This research highlights the potential distress and impact of intrusive mental imagery on those bereaved by suicide, which is endured for years following suicide loss. Given the significant adverse impacts and increased negative health and social outcomes, as well as increased risks faced by people bereaved by suicide (Erlangsen et al., 2017; Pitman et al., 2014, 2020), development of evidence-based psychological interventions would not only better support people during the grief period but also reduce additional long-term emotional distress and thus promote

recovery, as identified in government strategies (Department of Health, 2012). This exploration of the phenomenon of intrusive mental imagery in suicide loss increases our understanding of the phenomenon, how it is experienced and in turn the help sought by individuals, which can inform the direction of future research in the development of evidence-based interventions and support discussed. The findings of this research suggest that an intervention such as imagery rescripting may be an appropriate means of reducing distress by addressing the phenomenon described in these interviews, carefully designed to retain positive aspects.

Future research

This research has addressed a significant gap in the literature which looks at the subjective experience of intrusive mental imagery experienced by those bereaved by suicide. However, this is only the first step in understanding the phenomenon of intrusive mental imagery experienced in suicide bereavement. Further research will inform the development of evidence-based support that would be desired by those who experience a suicide loss. As such, future research should focus on the development of imagery-based interventions informed by the findings of this study. It is noted that the sample in this study over-represents white females and therefore future research should look to seek an understanding of the phenomenological experience of people from social and ethnic monitory groups that are not adequately represented in this study, including the phenomenological experience of men. It would also be of value to seek a better understanding of the phenomenological experience of intrusive imagery for the largest suicide-bereaved groups (i.e., spouses and children), as well as seeking a greater understanding of the role of closeness and quality of the relationship with the deceased, which is neglected in the research to

date (Cerel et al., 2008). Given that suicide bereavement is experienced across the world, research globally would be of value in understanding variations in the phenomenon and experience of intrusive mental imagery following a suicide loss, informing our understanding of the support that would be valued cross-culturally. Further research may also seek to understand the neurocognitive basis for this phenomenon. Once an intervention has been designed and tested for acceptability within this population, a proof-of-concept study, feasibility studies and a full randomized control trial would also be required.

Conclusion

This qualitative analysis of data representing the subjective experience of intrusive mental imagery following bereavement by suicide of a close contact reveals both the characteristics of the phenomenon as well its impact and how it is experienced by those bereaved. Although the phenomenon may be experienced as distressing and unhelpful, further exploration and reflection uncovered an important and valued feature of intrusive mental imagery within this group that may influence the support sought by individuals bereaved. It is important to consider these aspects in the development of evidence-based interventions for intrusive mental imagery, and professionals providing support after suicide bereavement should explore individuals' experience of the phenomenon as it is an important aspect in determining the most appropriate and desired support.

References

Andriessen, K., Reavley, N., Krysinska, K., Hill, N.T.M, Reifels, L., Robinson, J., & Pirkis, J. (2019). Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. *BMC Psychiatry, 19:49,* 1-15. https://doi.org/10.1186/s12888-019-2020-z

Baddeley, J.L., Williams, J.L., Rynearson, T., Correa, F., Saindon, C. & Rheingold, A.A. (2015). Death thoughts and images in treatment-seekers after violent loss. *Death Studies, 39(2),* 84-91. https://doi.org/10.1080/07481187.2014.893274

Barker, C. & Pistrang, N. (2005). Quality criteria under methodological pluralism: implications for conducting and evaluating research. *American Journal of Community Psychology, 35,* 201-212. https://doi.org/10.1007/s10464-005-3398-y

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234. https://doi.org/10.1177/1468794112468475

Boelen, P.A. & Huntjens, R.J.C. (2008). Intrusive images in grief: an exploratory study. *Clinical Psychology and Psychotherapy, 15,* 217-226. https://doi.org/10.1002/cpp.568

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3(2),* 77-101. https://doi.org/10.1191/1478088706qp063oa

Brewin, C.R., Gregory, J.D., Lipton, M., & Burgess, N. (2010). Intrusive images in psychological disorders: characteristics, neural mechanisms, and treatment implications. *Psychological Review, 117*(1), 210-232. https://doi.org/10.1037/a0018113

Brewin, C.R., Wheatley, J., Patel, T., Fearon, P., Hackmann, A., Wells, A., Fisher, P., & Myers, S. (2009). Imagery Rescripting as a brief stand-alone treatment for depressed patients with intrusive memories. *Behaviour Research and Therapy, 47,* 569-576. https://doi.org/10.1016/j.brat.2009.03.008

Cerel, J., Brown, M.M., Maple, M., Singleton, M., Van De Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. *Suicide and life-threatening behaviour, 49(2),* 529-534. https://doi.org/10.1111/sltb.12450

Cerel, J., Jordan, J.R., & Duberstein, P.R. (2008). The impact of suicide on the family. *Crisis, 29(1),* 38-44. dio: 10.1027/0227-5910.29.1.38

Cerel, J., Maple, M., Van De Venne, J., Moore, M., Flaherty, C., & Brown, M. (2016). Exposure to suicide in the community: prevalence and correlates in one U.S. state. *Public Health Reports, 131,* 100-107. https://doi.org/10.1177/003335491613100116

Chinn, D. (2007). Reflection and reflexivity. *Clinical Psychology Forum, 178,* 15-18.

Clark, I.A. & Mackay, C.E. (2015). Mental Imagery and post-traumatic stress disorder: a neuroimaging and experimental psychopathology approach to intrusive memories of trauma. *Frontiers in Psychiatry, 6*(104), 1-13. https://doi.org/10.3389/fpsyt.2015.00104

Department of Health. (2012). *Preventing Suicide in England: a cross-government outcomes strategy to save lives*. London: Department of Health. (Report no.17680).

Dodgson, J.E. (2019). Reflexivity in Qualitative Research. *Journal of Human Location, 35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Dyregrov, K. (2002). Assistance from local authorities versus survivors' needs for support after suicide. *Death Studies, 26,* 647-668. https://doi.org/10.1080/07481180290088356

Dyregrov, K., Nordaner, D., & Dyregrov, A. (2003). Predictors of psychosocial distress after suicide, SIDS, and accidents. *Death Studies, 27,* 143-165. https://doi.org/10.1080/07481180302892

Ehlers, A. (2006). Understanding and treating complicated grief: What can we learn from post-traumatic stress disorder? *Clinical Psychology: Science and Practice, 13,* 135–140. https://doi.org/10.1111/j.1468-2850.2006.00015.x

Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research & Therapy, 38,* 319-345. https://doi.org/10.1016/S0005-7967(99)00123-0

Ehlers, A., & Steil, R. (1995). Maintenance of intrusive memories in posttraumatic stress disorder: a cognitive approach. *Behavioural and Cognitive Psychotherapy, 23,* 217–249. https://doi.org/10.1017/S135246580001585X

Erlangsen, A., Runeson, B., Bolton, J. M., Wilcox, H. C., Forman, J. L., Krogh, J., … Conwell, Y. (2017). Association between spousal suicide and mental, physical, and social health outcomes: a longitudinal and nationwide register-based study. *JAMA Psychiatry 74*, 456–464. doi:10.1001/jamapsychiatry.2017.0226

Hagenaars, M.A. & Arntz, A. (2010). Reduced intrusion development after post-trauma imagery rescripting; an experimental study. *Journal of Behaviour Therapy and Experimental Psychiatry, 43,* 808-814. https://doi.org/10.1016/j.jbtep.2011.09.005

Holmes, E.A., Grey, N., & Young, K.A.D. (2005). Intrusive images and "hotspots" of trauma memories in posttraumatic stress disorder: an exploratory investigation of emotions and cognitive themes. *Journal of Behaviour Therapy, 36,* 3-17. https://doi.org/10.1016/j.jbtep.2004.11.002

Iyadurai, L., Visser, R.M., Lau-Zhu, A., Porcheret, K., Horsch, A., Holmes, E.A., & James, E.L. (2019). Intrusive memories of trauma: A target for research bridging cognitive science and its clinical application. *Clinical Psychology Review, 69,* 67-82. https://doi.org/10.1016/j.cpr.2018.08.005

Jackson, D., Peters, K., & Murphy, G. (2015). Suicide of a close family member through the eyes of a child: A narrative case study report. *Journal of Child Health Care, 19*(4), 495-503. https://doi.org/10.1177/1367493513519297

Jones, P. (2021). *Cognitive availability of suicide following suicide bereavement: Unpublished doctoral thesis*. University College London Doctorate in Clinical Psychology.

Kaltman, S. & Bonanno, G.A. (2003). Trauma and Bereavement: Examining the impact of sudden and violent deaths. *Anxiety Disorders, 17,* 131-147. https://doi.org/10.1016/S0887-6185(02)00184-6

Linde, K., Treml, J., Steinig, J., Nagl, M., & Kersting, A. (2017). Grief interventions for people bereaved by suicide: A systematic review. *PLoS ONE, 12*(6), 1-20. https://doi.org/10.1371/journal.pone.0179496

Linley, P.A. & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17*(1), 11-27. https://doi.org/10.1023/B:JOTS.0000014671.27856.7e

McDaid, C., Trowman, R., Golder, S., Hawton. K., Sowden, A. (2008). Interventions for people bereaved through suicide: systematic review. *British Journal of Psychiatry, 193*(6), 438–443. doi:10.1192/bjp.bp.107.040824

Michael, C. & Cooper, M. (2013). Post-traumatic growth following bereavement: A systematic review of the literature. *Counselling Psychology Review, 28*(4), 18-33.

Mitchell, A.M., & Terhosrt, L. (2017). PTSD Symptoms in survivors bereaved by the suicide of a significant other. *Journal of the American Psychiatric Nurses Association, 23*(1), 61-65. https://doi.org/10.1177/1078390316673716

Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *Suicide 3*(1), 86-94. https://doi.org/10.1016/S2215-0366(14)70224-X

Pitman, A., Putri, A.K., Kennedy, N., De Souza, T., King, M., & Osborn, D. (2016). Priorities for the development and evaluation of support after suicide bereavement in the UK: results of a discussion group. *Bereavement Care, 35*(3), 109-116. https://doi.org/10.1080/02682621.2016.1254457

Pitman, A., Stevenson, F., King, M., & Osborn, D. (2020). Self-reported patterns of use of alcohol and drugs after suicide bereavement and other sudden losses: a mixed methods study of 1,854 young bereaved adults in the UK. *Frontiers in Psychology, 11,* 1-12. https://doi.org/10.3389/fpsyg.2020.01024

Prigerson, H.G., Jacobs, S.C., Rosenheck, R.A. & Maciejewski, P.K. (1999). Criteria for traumatic grief and PTSD. *British Journal of Psychiatry, 174*(1), 560–561. doi:10.1192/bjp.174.1.67

Raphael, B. & Martinek, N. (1997). Assessing traumatic bereavement and posttraumatic stress disorder. In J.P.Wilson & T.M. Keane (Ed.). *Assessing psychological trauma and PTSD* (pp. 373–396). New York: The Guilford Press.

Rynearson, E.K. (2012). Chapter: Invoking an alliance with the deceased after violent death. In, R.A. Neimeyer [Ed]. *Techniques of grief therapy: Creative practices for counselling the bereaved.* (pp. 91-94). New York, NY, US: Routledge/Taylor & Francis Group; US.

Samaritans. (2020). Top 10 tips for reporting suicide. Retrieved May 26, 2021, from https://www.samaritans.org/about-samaritans/media-guidelines/10-top-tips-reporting-suicide/.

Singh, L., Espinosa, L., Ji, J.L., Moulds, M.L. & Holmes, E.A. (2020). Developing thinking around mental health science: the example of intrusive, emotional mental imagery after psychological trauma. *Cognitive Neuropsychiatry, 25(5),* 348-363. doi:10.1080/13546805.2020.1804845

Steil, R., & Ehlers, A. (2000). Dysfunctional meaning of posttraumatic intrusions in chronic PTSD. *Behaviour Research and Therapy, 38*(6), 537–558. https://doi.org/10.1016/S0005-7967(99)00069-8

Szumilas M. & Kutcher, S. (2011). Post-suicide Intervention Programs: A Systematic Review. *Canadian Journal of Public Health, 102*(1), 18-29. https://doi.org/10.1007/BF03404872

World Health Organization (WHO) (2019). World Health Statistics 2019: Monitoring Health for the SDGs, Sustainable Development Goals. Geneva: World Health Organization.

Part 3: Critical Appraisal

Introduction

This critical appraisal is a reflection on my experience of this thesis with particular consideration for the selection of the research topic and the study described in Part 2, as well as the challenges I encountered in this process. The use of a bracketing interview facilitated my reflections and supported reflexivity throughout the research (Chinn, 2007). I finish by reflecting on the implications of this research.

Reflections on Selection of the Research Project

Trauma has always been an area of interest for me however prior to training I had little clinical experience working with trauma. During my first placement of the doctorate, I worked with a young woman with Posttraumatic Stress Disorder (PTSD). This work resonated with me for a number of reasons, not only because it was my first experience of working therapeutically with trauma, but the power of imagery was so striking for me. Her intrusive mental imagery was so debilitating and approaching work with imagery in treatment was greatly feared and somewhat resisted, yet our work with imagery was so powerful and rich, yielding positive outcomes beyond expectation. This further amplified my interest in imagery post-trauma and so when Dr Alexandra Pitman, a Consultant Psychiatrist with a special interest in suicide, presented the opportunity for research in the area of intrusive mental imagery in suicide bereavement I was instantly drawn to know more. Aside from choosing a research project that really interested me, I wanted to invest in something that could be taken forward in my career as a Clinical Psychologist. I have worked across many different services and with different populations prior to training and suicide has always been present in some capacity. I recognised how not

only meaningful, relevant and important this research was but also how much I could learn from this experience; how this work could influence my thinking and enable me to be a better clinical psychologist. Aside from this being a topic of interest, I also set out to use my thesis as an opportunity to delve into qualitative research whilst I had access to teaching, support and the level of supervision as a trainee, since all of my previous research experience had been that of quantitative research. Upon reflection, this is something that I have enjoyed most about the research; having the opportunity to speak to individuals about their experiences in a research capacity and to immerse myself in the data, which felt so rich in comparison to my previous quantitative research experience. This has also given me the opportunity to develop many skills in qualitative research, challenged ways of thinking and encouraged a reflexive approach to research (Chinn, 2007). I have gained so much from this part of the work and at the same time it was so fulfilling to hear how helpful this experience was for participants too.

Reflections on Methodology

To our knowledge, this is the first qualitative study of the phenomenon of intrusive mental imagery in suicide bereavement. Unlike much of the research within this area, this study did not use validated instruments to explore the phenomenon of intrusive mental imagery, but instead used open questions which gave participants the opportunity to describe their own experiences rather than respond to fix-format questions. Holding in mind effects of interviewer presence (Nederhof, 1985; O'Muircheartaight & Campanelli, 1998), this also allowed for further exploration of any themes identified during the interview. This method enabled the collection of large amounts of rich data to be gathered which reflects the broad subjective

experiences of those interviewed. Although the semi-structured framework of interviews imposes some prior constraints on the data elicited and thus themes identified at analysis, participants were given the opportunity to add anything they felt important to their experience at the end of the interview. This methodological approach felt particularly important given the aim and nature of the research and yielded important data, whilst also ensuring that any distress and presenting risk was managed immediately, providing appropriate support to participants during and immediately after participation.

As very little is known about the phenomenon of intrusive mental imagery in suicide bereavement, the nature of the research was exploratory. As such, we had conversations within the research team about how to recruit a diverse sample in order to fully explore the phenomenon. I was aware of the overrepresentation of young, White British females in research generally, and expected that given the topic of suicide bereavement I might face additional barriers to recruiting groups often marginalised in research. We agreed that a purposive approach would support recruitment of a diverse sample. Despite enrolling all of the men and individuals that identified as from other ethnic backgrounds that met inclusion criteria and were suitable for participation, these groups were still underrepresented in the sample. Efforts were made to promote the study in forums that we felt may increase the number of men and people from ethnic minority groups, unfortunately with limited success. I am aware that the timeframe for this research and the restrictions within the approved ethics application placed some limitations on how this issue could be addressed during recruitment; had I had more time there may have been more flexibility in attempting to address this shortfall. Although, I wonder whether the area of intrusive imagery and bereavement, and suicide bereavement more

specifically, poses some additional difficulties in recruiting these populations perhaps due to social and cultural differences in how this is experienced, understood and spoken about.

Of course, the COVID-19 global pandemic influenced the methods of this study. Initially interviews were to be held face-to-face, which meant that recruitment would be limited to London and surrounding areas. However, in light of the global pandemic, amendments to the research methods were made via the UCL ethics committee and all interviews were moved online. This meant that recruitment could take place across the UK and was no longer limited to those who could travel to central London for a face-to-face interview. Initially I was concerned about my ability to build rapport with participants and make them feel comfortable enough to talk in depth about their experience 'on screen' rather than face-to-face, perhaps a reflection of my own fears and reservations about starting online therapy in my clinical work. However, I was surprised at how little this appeared to be an issue. In fact, I wonder whether this made participation slightly easier for people both practically and emotionally. Although online studies will of course be less inclusive for some people such as those less familiar or comfortable with using technology to participate in a remote interview, in retrospect I felt that moving interviews online increased opportunities for participation and allowed for a more diverse sample to be recruited. It would be interesting to gain the perspective of those who took part.

Reflections on Processes of Data Collection

Although data collection was such a valued part of this research experience for me, it did present its challenges. I was particularly mindful of my role as a researcher when conducting the interviews and became aware of researcher-practitioner dilemmas at

times during data collection. On occasion it was challenging to hold the researcher position, ensuring an appropriate response and level of validation without stepping into a practitioner role, which I hold concurrently in training. One particular challenge was that of formulating hypotheses in relation to individuals' difficulties, ensuring that I did not step into a practitioner role by taking a psychotherapeutic stance and using Socratic questioning during interviews. It was also challenging to hold ideas about how individuals might manage their difficulties and not share my knowledge of ways to facilitate coping with them. This felt somewhat an ethical dilemma, withholding potentially helpful information from those experiencing distress. Reminding myself that I was not part of a care team where time had been taken to develop a full therapeutic formulation with the individual, which would identify the right support for them, was beneficial in this process. Although this felt challenging at times, stepping back from my role as a practitioner and embracing the role of researcher allowed me to listen to the experiences of the individual, without the need to actively formulate or think about 'next steps' during this time as I would in my clinical work. Despite its challenges, fulfilling the role of a researcher alongside my practitioner role, acknowledging the benefits that my practitioner skills lent to the processes of data collection, whilst maintaining the boundaries set out by my role as a researcher, has been a valuable learning experience that will be of benefit to me as I progress in my career as a Clinical Psychologist.

Having set out the research questions outlined in Part 2, it was hoped that this research would inform our understanding and development of the support needed and sought by people bereaved by suicide. Early in the process of data collection, I became aware of the potential impact of my own agenda and the lens of a psychologist that I was coming to the research with. I recognised that I was drawn to

thinking about distress reduction and similarly information that would support the development of a helpful intervention. Noticing my bias, I was aware that I needed to open up to the whole experience that was being shared with me, noticing different aspects and meanings of the phenomenon. Upon reflection, I also recognised that I had expected to find a response to imagery that is similar to that of how people relate to intrusive mental imagery in PTSD, a highly distressing and negative experience which is often wholly unwanted by the individual (Brewin et al., 2009). Instead, I noticed the meaningful and valued aspects of intrusive mental imagery for those I was interviewing. This was quite different to my experience of trauma and PTSD to date. Noticing this helped me to step away from my agenda and immerse myself in the interviews, also later benefiting the process of data analysis.

Although cognitively I was mindful of the distressing nature of the interviews and the potential impact that data collection might have on me, discussing ways to prepare and manage this together with Poppy, I was also aware that this was something I would not fully be able to prepare for, not knowing the gravity of the impact that this may have on me as an individual. Upon reflection, I was surprised at how able I was to manage distressing conversations and information provided during data collection. Perhaps my experience working clinically supported me to manage this, as well as embracing my role as a researcher rather than that of a practitioner in this context. I also reflected on the opportunities that working together with Poppy within a joint thesis project provided during data collection. Although data collection was undertaken independently this ran concurrently for both studies, providing opportunities to discuss and reflect upon interviews, and further supported opportunities to debrief when things felt more challenging. This certainly helped me to manage the potential impact of data collection. Furthermore, joint working was of

great value in maintaining a reflexive approach during data collection, noticing narratives that I was drawn to, particularly in those participants with whom I shared characteristics, or experiences which made their narrative more relatable for me. Discussing interviews, potential themes and the impact of interviews throughout data collection with Poppy enabled me to reflect upon and question these aspects in an attempt to maintain a reflexive approach.

Finally, during data collection I was very aware of my position of not having had a lived experience of suicide bereavement of a close contact, whilst I was also mindful of my relatively new position in this area of research. It felt not only inappropriate to offer personal information about my own experience of suicide loss, but I also found myself actively avoiding conversation that might lend itself to such questions or discussion. I recognised that this came from a place of fear, that this would be viewed as disadvantageous by participants; limiting my ability to understand and connect with their experience, potentially having a negative impact upon the rapport developed during the interviews. In fact, on the one occasion that I was asked candidly by a participant whether I had a personal experience of suicide loss myself, being exposed in this way later felt beneficial such that a great effort was made by the participant to expose me to their experience, to the benefit of the research. Further reflection helped me to notice the strengths of my position; prompting me to ask more questions as there was so much that I did not know or understand about the experience of suicide bereavement. I wondered whether having had a personal experience of suicide loss of a close contact might have led to assumptions about shared experiences and understanding by both myself and participants, which would potentially have influenced the interviews and perhaps the findings of the study to some extent.

Reflections on Processes of Data Analysis

As this study was exploratory with the aim of developing an understanding of a novel phenomenon, I was keen to use an analytic approach that focused on the data without inferring too many assumptions upon the data in relation to theory. I hoped that this would reduce bias in the exploration of the data and increase the opportunity of discovering things that had not been tentatively hypothesised. I felt that my position of not having had a lived experience of suicide bereavement of a close contact was beneficial to this process, such that processes of data analysis were not informed by my own experience of suicide bereavement. Rather my position increased my curiosity, reducing potential assumptions made about the data in connection to my own experience, allowing me to immerse myself in the data without the influence of the lens of my own experience of suicide loss. However, the processes of data analysis did not come without its challenges. During data collection, I was aware of the emotional responses evoked in me by certain participants, their stories and experiences. I found myself drawn to the narratives and experiences of those participants who shared characteristics and life experiences similar to mine, or whose experiences in some way resonated with me. I was also aware that this was further influenced by the rapport that developed during the interview between myself and the participant; where rapport was particularly good and had developed fairly effortlessly, yielding rich information in relation to the research questions, I found myself perhaps privileging these voices during processes of data analysis. Working as part of a joint project offered a space to reflect on these processes, which was incredibly helpful in identifying, naming and challenging this throughout. Given the nature of the topic and the stories of those I interviewed, I also found myself somewhat wedded to participants' narratives during data analysis; I

wanted to capture their story and felt that the process of 'coding' somewhat reduced their complex experience, which initially made it difficult to be objective in the processes of thematic analysis. The support from supervisors and the wider research team helped me to reflect on this and take a more objective approach to the thematic analysis. Furthermore, similar to the challenges noted early in data collection, I was also aware of my motivations to produce research that might inform the development of much needed interventions for people bereaved by suicide. Having become aware of the influence of this position during data collection, I was mindful of the influence in the coding and generating of themes from the data that this would likely have. It would be naïve of me to expect that this did not influence the analytic processes, and to some extent this lens is appropriate given my research questions outlined in Part 2. The role of third-party auditing of processes for generating codes and subsequent themes, credibility checks undertaken within the wider research team to improve validity of the findings, and ongoing discussions, enhanced reflexivity and helped to gain conceptual clarity during analysis. Due to limitations imposed by research ethics and deadlines imposed by the Doctorate in Clinical Psychology programme, participant validation of interpretations made by the researcher during analysis was not sought (Barker & Pistrang, 2005). However, it is of note that this would likely have provided helpful conversations and further understanding of the phenomenon, increasing validity of the findings in light of the challenges faced during analysis.

Reflections on the Implications of the Research

The above reflections are important to hold in mind when considering the implications of the findings of this study. Whilst I acknowledge that small-scale, qualitative studies such as this do not aim to generate findings that can be generalised

to influence policy decisions and the mental health system on a wide scale, simply discussing potential clinical implications implies generalisation to some extent and therefore consideration for validity of the findings is crucial. This is particularly key in qualitative research and I hope that these reflections support fellow researchers in considering how this study might inform future research and clinical practice.

During one of the interviews, a participant shared a story with me:

"A couple of years ago, I was subject to a very, very serious physical assault. And erm, someone smashed my head open… a completely unprovoked attack. …But anyway, the reason I mention that is because within forty-eight hours I was contacted … by the police, by counselling services, by legal support and so on and so forth. By victim support services… explaining, you know, what my rights were, where I could get counselling, where I could get therapy … signpost[ed] to experts and all the rest, within forty-eight hours. And yet when I lost [my son] …these enormous policemen, you know, came knocking at my front door, they sat at my dining table for ten minutes, told me my son was dead over their cackling radios, they were kind, and then they left. Nothing."

This extract powerfully demonstrates a lack of tailored psychological support available to people bereaved by suicide, which validates the underlying motivation for the current, and I hope future, research. It is essential, given the significant adverse impacts and increased negative health and social outcomes faced by people bereaved by suicide (Pitman et al., 2014; Erlangsen et al., 2017; Pitman, Stevenson et al., 2020), that evidence-based support is developed. This would not only provide tailored support during the grief period following suicide loss, but also support the

reduction of long-term distress and promote recovery for this group (Department of Health, 2012). Fundamentally, it is hoped that the findings of this study will inform research that supports the development of suitable and much needed evidence-based psychological interventions for people bereaved by suicide. Currently, much of the tailored support offered to those bereaved by suicide falls upon charities, highlighting a crucial gap in health care services at present.

I hope that these findings will inform future research into the phenomenon of intrusive mental imagery in suicide bereavement, increasing our understanding of the phenomenon, with particular consideration for groups under-represented in this study, including men and people from ethnic minority backgrounds. Future research might look at intrusive imagery in key kinship groups most often affected by suicide loss, such as parents and spouses. Further exploration of the impact of close relationships with the deceased on intrusive mental imagery, compared with those who have experienced disenfranchised relationships prior to their suicide loss, would also be of value. Given the nature of the phenomenon and the current findings in relation to positive aspects of intrusive mental imagery experienced by people bereaved by suicide, it would be of value to explore the role of social aspects such as culture, religion and spirituality in the experience of imagery. Research may also look at the genetic, anatomical and neurocognitive basis for this phenomenon.

Conclusion

I found the task of writing the final part of this thesis, the critical appraisal, helpful for reflecting upon the processes of the research, both positive and negative, further supporting a reflexive approach (Chinn, 2007) and attempting to challenge my 'intellectualist bias' (Bourdieu & Wacquant, 1992; Chinn, 2007). This felt somewhat

challenging, accessing unconscious assumptions and opening up to challenge the perspective of the academic field in which I find myself (Bourdieu, 2000; Kenway & McLeod, 2004), and has encouraged me to think more about my intellectualist bias and the assumptions that this brings to research moving forward from this work.

Overall, undertaking this research has required me to be curious and remain open-minded in order to fulfil an exploratory approach in examining a novel phenomenon. This was my first experience of conducting qualitative research formally, in addition to the exploration of a new phenomenon that had not been explored in research previously. I have gained so much more from this experience than I could have imagined, not only academically but both clinically and personally too. It has been a thought-provoking process, one which I have thoroughly enjoyed. My interest in trauma and intrusive mental imagery has grown further, and I find myself deeply interested in learning more about imagery in suicide bereavement specifically.

References

Barker, C. & Pistrang, N. (2005). Quality criteria under methodological pluralism: implications for conducting and evaluating research. *American Journal of Community Psychology, 35*, 201-212. https://doi.org/10.1007/s10464-005-3398-y

Bourdieu, P. (2000). *Pascalian meditations*. Cambridge: Polity Press.

Bourdieu, P. & Wacquant, L. (1992). *An invitation to reflexive sociology*. Cambridge: Polity Press.

Brewin, C.R., Wheatley, J., Patel, T., Fearon, P., Hackmann, A., Wells, A., Fisher, P., & Myers, S. (2009). Imagery Rescripting as a brief stand-alone treatment for depressed patients with intrusive memories. *Behaviour Research and Therapy, 47*, 569-576. https://doi.org/10.1016/j.brat.2009.03.008

Chinn, D. (2007). Reflection and Reflexivity. *Clinical Psychology Forum, 178,* 15-18.

Department of Health. (2012). *Preventing Suicide in England: a cross-government outcomes strategy to save lives.* London: Department of Health. (Report No.17680).

Erlangsen, A., Runeson, B., Bolton, J. M., Wilcox, H. C., Forman, J. L., Krogh, J., … Conwell, Y. (2017). Association between spousal suicide and mental, physical, and social health outcomes: a longitudinal and nationwide register-based study. *JAMA Psychiatry 74*(5), 456–464. doi:10.1001/jamapsychiatry.2017.0226

Kenway, J. & McLeod, J. (2004). Bourdieu's reflexive sociology and 'spaces of points of view': whose reflexivity, which perspective? *British Journal of Sociology of Education, 25(4),* 525-544. doi: 10.1080/0142569042000236998

Nederhof, A.J. (1985). Methods of coping with social desirability bias: a review. *European Journal of Social Psychology, 15,* 263-280. https://doi.org/10.1002/ejsp.2420150303

O'Muircheartaight, C. & Campanelli, P. (1998). The relative impact of interviewer effects and sample deisgn effects on survey precision. *Journal of the Royal Statistical Society, Series A, 161*(1), 63-77. https://doi.org/10.1111/1467-985X.00090

Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *Suicide 3*(1), 86-94. https://doi.org/10.1016/S2215-0366(14)70224-X

Pitman, A., Stevenson, F., King, M., & Osborn, D. (2020). Self-reported patterns of use of alcohol and drugs after suicide bereavement and other sudden losses: a mixed methods study of 1,854 young bereaved adults in the UK. *Frontiers in Psychology, 11,* 1-12. https://doi.org/10.3389/fpsyg.2020.01024

Appendices

Appendix A.

Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

10th February 2020

Professor Sunjeev Kamboj
Research Department of Clinical, Educational and Health Psychology
UCL

Cc: Poppy Jones & Katherine Quayle

Dear Professor Kamboj

Notification of Ethics Approval with Provisos
Project ID/Title: 16587/001: Understanding the experience of intrusive thoughts and images after s suicide bereavement: a qualitative interview study

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **1st July 2021.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report
At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email: ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

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

Appendix B.

Outline of Trainee Contributions

This thesis was a joint project with a fellow DClinPsy trainee, Poppy Jones (Jones, 2021). Poppy's project involved interviewing people bereaved by suicide to explore the influence of the deceased's suicide and the method used on the nature of the bereaved person's thoughts about suicide. The data was subjected to qualitative analysis.

Both Poppy and I contributed equally to the ethics application and later ethics amendment following restrictions imposed by the COVID-19 pandemic, including the development of study materials (e.g., study advert, participant information sheet, consent form). Participant recruitment, including initial screening for suitability for each project, was undertaken jointly by Poppy and myself. Screening calls with potential participants for each project were undertaken independently and subsequent data collection was completed separately, such that Poppy completed all interviews for her project, and I for mine. Qualitative analysis was also completed independently with the exception of supporting blind coding of two interview transcripts for each project (i.e., I blind coded two of Poppy's interview transcripts and Poppy blind coded two of my interview transcripts) to verify accuracy of coding. Thematic frameworks for each study were developed independently and discussed within the wider research team. Finally, the write-up of this empirical paper was completed independently, as was Part 1 (conceptual introduction) and Part 3 (critical appraisal).

Appendix C.

Screening Questionnaire

Thank you for your interest in taking part in this research project.
Below is a summary of the study aims and methods. Please click here to download the detailed participant information sheet.

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 relate 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 for an interview at University College London campus in central London (near Euston station). This will last up to 90 minutes and be audio-recorded. We are able to reimburse reasonable return travel costs to the interview. More details are available in the Participant Information Sheet. Any questions can be directed to either of the researchers:
Poppy Jones poppy.jones@ucl.ac.uk
Katie Quayle katherine.quayle18@ucl.ac.uk

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 are interested in learning more about the research and would like a researcher to contact you, then please complete the information below and one of our researchers will be in touch.

Name …….
Address …….
Contact number ……
Email …….
Preferred mode of initial contact: telephone □ email □

Best time to contact you [tick boxes]
Weekdays □
Weekends □
Morning □
Afternoon □
Evening □

Age [dropdown list]

Gender [open ended]

Ethnicity. Please tick 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

What relationship were you to the person who died? Please tick one of the following options.
i.e. He/she was my...
□ 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 (Free text)

How long ago did your relative or friend die? [free text]
……..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 in relation to intrusive thoughts or images.

If there are any details about the circumstances of the death of your loved one that you would like to mention, do please use the space below. [800 character limit]

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. [800 character limit]

Do you find that you spend time thinking about what led your loved one to consider suicide? If so, please provide details below [800 character limit]

Appendix D.

Participant Information Sheet

Participant Information Sheet for UCL Suicide Bereavement Study
UCL Research Ethics Committee Approval ID Number: 16587/001
YOU WILL BE SENT A COPY OF THIS INFORMATION SHEET

Project Title: Understanding the experience of intrusive thoughts and images after suicide bereavement: a qualitative interview study
Researcher: Poppy Jones (poppy.jones@ucl.ac.uk) and Katie Quayle (katherine.quayle18@ucl.ac.uk)
Principal Researcher: Dr Sunjeev Kamboj (sunjeev.kamboj@ucl.ac.uk)
Supervisors: Dr Alexandra Pitman (a.pitman@ucl.ac.uk) and Dr Martina di Simplicio (m.di-simplicio@imperial.ac.uk)
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 partake 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 partake in future research then you can indicate this on the consent form. Your contact details will be held on a secure database and you will be contacted via email with information about future studies which are been conducted by our research team.

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

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

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.

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 take away and keep.

Thank you for reading this information sheet and for considering partaking in this research study.

Appendix E.

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 (poppy.jones@ucl.ac.uk) and Katie Quayle (katherine.quayle.18@ucl.ac.uk)
Principal Researcher: Dr Sunjeev Kamboj (sunjeev.kamboj@ucl.ac.uk)
Supervisors: Dr Alexandra Pitman (a.pitman@ucl.ac.uk) and Dr Martina di Simplicio (m.di-simplicio@imperial.ac.uk)
Department: UCL Division of Psychology and Language Sciences
Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts data-protection@ucl.ac.uk

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 F.

Interview Schedule

Understanding the experience of intrusive images after suicide bereavement
Interviewer: Katie Quayle, Trainee Clinical Psychologist

Semi-structured interview topics/key questions:

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

- How did you find out about the death? Were there aspects of it that you did not find out about until much later?

- Were you aware of any circumstances around the death? For example, financial reasons, mental health, significant life event(s)

- 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.

- How frequently do you experience images relating to the suicide?

- How much control do you feel that you have over the experience of these images?

- Can you tell me a little more about the content of the images you experience?

- You mentioned that s/he had died using (insert method), to what extent does this feature in the images you experience?

- When you experience these image(s), how do you feel?

- When you experience these image(s), what does this mean to you?

- When you experience these image(s), how do you react or behave?

- When you experience these image(s), how do you cope?

- Do you find these images helpful or comforting in any way?

- Do you find these images unhelpful or distressing in any way?

- Are these images related to the deceased only or do you feature in the images in some way?

- If there any other way in which these images impact upon you positively or negatively?

- If you no longer had these images, would you miss them or feel relieved?

Appendix G.

Outline of the Process of Thematic Analysis

Initial Coding:

Initial Code | Sub Codes
Abandonment
Comfort
Content of imagery Making up your memory of the suicide Method Piecing together what happened Questioning
Coping
Desirable imagery
Experience of imagery Control Triggers Vivid experience
How imagery is experienced Comfort Imagery as unhelpful Not comforting
Imagery over time Frequency of imagery
Imagery as unhelpful or distressing Not comforting
Impact of imagery Emotions Physical response
Making sense of imagery Understanding
Miss imagery Connection or closeness Imagery is their legacy
Not telling others (non-disclosure)
Positive experience of imagery
Relief from imagery
Response to images
Succumb to imagery
Wanting closure

First Level Themes/Subthemes:

Initial Themes | Sub Themes
Comfort
Content of imagery Discovering the suicide Funeral Making up your memory of the suicide Method features Only loved one present Picturing loved one dead Piecing together what happened at the suicide Questioning Surroundings or context of suicide
Coping Distraction Overwriting image Therapy
Desirable imagery

Experience of imagery Control Triggers Vivid experience
Imagery over time Frequency of imagery Impact of control Reduced impact of imagery over time Strategies to cope
Images as unhelpful or distressing Blocking positive memories Not comforting Wanting closure Witnessing or wanting to know
Impact of imagery Emotions Physical response
Making sense of imagery Connection with loved one Understanding
Miss imagery Connection or closeness Imagery is their legacy
Positive experience of imagery
Relief from imagery
Response to images Attempts to escape

Initial Thematic Framework:

Themes | Sub Themes
1. Nature of imagery 1.1 Discovering the suicide 1.2 Method features 1.3 Only deceased one is present 1.4 Picturing the deceased dead 1.5 Piecing together what happened at the suicide (last moments) 1.6 Questioning
2. The experience of intrusive imagery 2.1 Lack of control in the experience of intrusive imagery
3. Triggers 3.1 Objects or reference to the suicide context 3.2 Reminders of the loved one 3.3 Reference to suicide
4. Imagery over time 4.1 The influence of control 4.2 Reduced impact 4.3 Strategies to cope
5. Imagery is unhelpful or distressing 5.1 Imagery is distressing 5.2 Suicide imagery blocks or interferes with positive memories/images of the deceased 5.3 Fabricated imagery is unhelpful, preventing closure
6. Positive experiences of imagery 6.1 Imagery prompts to remember the deceased 6.2 Imagery makes you feel closer to the deceased 6.3 Post-traumatic growth
7. Response to imagery 7.1 Attempts to avoid imagery
8. Impact of imagery 8.1 Negative impact 8.2 Physical impact 8.3 Complex emotional impact
9. Coping 9.1 Distraction

9.2 Overwriting imagery 9.3 Talking to the loved one
10. Making sense of imagery 10.1 Trying to understand 10.2 Processing 10.3 Sharing the suffering 10.4 Connection with the deceased
11. Imagery is important; not erasing imagery 11.1 Imagery is important regardless of distress 11.2 Not to have imagery would be erasing the memory of the deceased 11.3 Need to remember the impact; post-traumatic growth 11.4 Maintaining imagery for wanting to have a connection with the deceased
12. Relief from imagery 12.1 Not wanting the imagery relating to the suicide 12.2 Making space for pleasant imagery 12.3 Reducing the lack of control 12.4 Relief from the emotional experience and pain

Final Thematic Framework:

Themes | Sub-themes
1. Characteristics of intrusive imagery
1.1. Nature of imagery 1.1.1 Discovering the deceased 1.1.2 Suicide method as a key feature 1.1.3 Only the deceased is present in imagery 1.1.4 Picturing the deceased as dead 1.1.5 Piecing together what happened at the scene of the suicide 1.1.6 Questioning
1.2. Degree of control over imagery 1.2.1 Lack of control 1.2.2 Triggers for imagery
1.3. Changes in imagery over time 1.3.1 Reduced impact 1.3.2 The influence of control
2. Emotional, cognitive and behavioural responses to intrusive imagery
2.1. Imagery is unhelpful and distressing 2.1.1 Imagery as distressing 2.1.2 Intrusive imagery interferes with positive memories and images of the deceased 2.1.3 Fabricated imagery as unhelpful and impeding closure
2.2. Impact of imagery 2.2.1 The negative impact of imagery 2.2.2 Physical impact 2.2.3 Mixed emotional responses to imagery
2.3. Ways of coping 2.3.1 Distraction 2.3.2 Overwriting imagery 2.3.3 Attempts to avoid imagery
2.4. Positive aspects of the experience of imagery 2.4.1 Post-traumatic growth 2.4.2 Imagery as supporting processing 2.4.3 Imagery as important regardless of the distress 2.4.4 Imagery as facilitating a connection with the deceased 2.4.5 Fear of erasing the memory of the deceased

Appendix H.

Distribution of Themes Amongst Participants

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15	P16	P17	P18	(*N*)
1. Characteristics of intrusive imagery																			
1.1. Nature of imagery	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	18
1.1.1 Discovering the deceased			◆	◆						◆	◆						◆		5
1.1.2 Suicide method as a key feature	◆	◆	◆		◆	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆	◆		15
1.1.3 Only the deceased is present in imagery	◆	◆				◆	◆		◆	◆	◆	◆				◆			9
1.1.4 Picturing the deceased as dead	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆		◆		◆	◆	◆	◆	15
1.1.5 Piecing together what happened at the scene of the suicide	◆			◆		◆	◆		◆		◆	◆	◆	◆	◆	◆	◆		12
1.1.6 Questioning		◆		◆		◆	◆						◆	◆	◆		◆		8
1.2. Degree of control over imagery	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	18
1.2.1 Lack of control	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	17
1.2.2 Triggers for imagery	◆	◆	◆				◆	◆		◆	◆	◆	◆	◆			◆		11
1.3. Changes in imagery over time	▲	▲	▲	▲	▲	▲			▲		▲	▲			▲	▲			11
1.3.1 Reduced impact	◆	◆	◆	◆	◆	◆			◆		◆	◆			◆	◆			11
1.3.2 The influence of control	◆					◆			◆		◆								4
2. Emotional, cognitive and behavioural responses to intrusive imagery																			
2.1. Imagery as unhelpful and distressing	▲	▲		▲		▲	▲	▲	▲	▲	▲	▲	▲		▲	▲	▲		14
2.1.1 Imagery as distressing	◆	◆		◆		◆	◆	◆	◆	◆	◆	◆			◆	◆	◆		13
2.1.2 Intrusive imagery interferes with positive memories and images of the deceased				◆			◆	◆			◆		◆		◆	◆			7
2.1.3 Fabricated imagery as unhelpful and impeding closure	◆					◆		◆	◆								◆		5
2.2. Impact of imagery	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲		17
2.2.1 The negative impact of imagery	◆	◆		◆	◆			◆	◆	◆		◆	◆		◆	◆			11
2.2.2 Physical impact	◆	◆	◆	◆	◆	◆			◆			◆				◆			9
2.2.3 Mixed emotional responses to imagery	◆			◆	◆		◆	◆	◆	◆	◆		◆	◆	◆		◆		12
2.3. Ways of coping	▲	▲	▲			▲		▲	▲		▲				▲	▲	▲		10
2.3.1 Distraction			◆					◆	◆		◆				◆				5
2.3.2 Overwriting imagery	◆	◆				◆		◆	◆							◆			6
2.3.3 Attempts to avoid imagery		◆	◆			◆		◆	◆						◆	◆	◆		8
2.4. Positive aspects of the experience of imagery	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲		▲	▲	17
2.4.1 Post-traumatic growth	◆		◆	◆							◆	◆					◆		6
2.4.2 Imagery as supporting processing	◆	◆			◆	◆	◆	◆	◆		◆		◆	◆			◆	◆	12
2.4.3 Imagery as important regardless of the distress			◆							◆		◆					◆		4
2.4.4 Imagery as facilitating a connection with the deceased			◆	◆							◆		◆	◆	◆			◆	7
2.4.5 Fear of erasing the memory of the deceased						◆				◆		◆	◆	◆			◆		6