

EDINBURGH NAPIER UNIVERSITY

**Exploring the lived experiences of suicidality:
An interpretative phenomenological analysis
of the loved one's perspective.**

Submitted to Edinburgh Napier University in fulfilment of the requirement for
the degree of Masters by Research (MRes)

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April 2016

Author's Declaration

I hereby declare that I am the sole researcher of this Research Project.

This thesis has not been presented for any other academic award.

I authorise Edinburgh Napier University to lend this Research Project to other institutions or individuals for the purpose of scholarly research.

Rachel Hanson

Date

Acknowledgements

Firstly, I would like to thank each of the participants who were willing to take the time to participate in this study, each of your contributions were greatly appreciated. I would like to thank the service managers of each charity for being so accommodating and for informing their service users about my research.

Thank you to my fantastic supervisory team, Adele Dickson, Thanos Karatzias, Jennifer Murray and Rory O'Connor for all your support and guidance throughout this project. A particularly big thank you to Adele Dickson and Thanos Karatzias my directors of studies, for all your enthusiasm, encouragement and willingness to offer advice throughout the year. It was much appreciated and it really kept me going during the more challenging stages of the project. Thanks also to Sheena Moffat, Subject Librarian at Edinburgh Napier University for all of her excellent help and guidance on literature searching. Finally, I would like to thank Cal and my mum for your endless support this year, I could not have done it without either of you.

Abstract

Objectives. This study explored the lived experience of family members who were living with a suicidal loved one. The psychosocial impact that this experience had on the loved one, their views on support services and their support needs were all explored.

Design. This was a qualitative, interview study using interpretive phenomenological analysis (IPA).

Methods. Five adult participants were recruited through the use of a Gumtree recruitment advertisement. Each participant took part in a one-to-one, semi-structured interview. Four interviews were conducted in person and one telephone interview was conducted in line with participant preferences. Interviews were transcribed verbatim and analysed using IPA.

Results. Four master themes emerged from analysis of the interview data: 1) Emotional Turmoil, 2) Challenges, 3) Coping and 4) Support. Participants entered a state of emotional turmoil as soon as they discovered their loved one attempted suicide. Challenges that they experienced included unpredictability of their situation, strained family relationships, stigma and isolation. Participants engaged in hypervigilance, avoidance and increasing their awareness of mental health issues in attempts to cope with this experience. A range of supports were recommended by participants who generally felt unsupported and alone in this experience.

Conclusions. The findings are discussed in relation to the extant caregiver literature. Recommendations for practise and further research are highlighted.

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Glossary of Terms

Suicidal behaviour: The nomenclature of suicidal behaviour can vary. For the purposes of this study, suicidal behaviour is defined as self-inflicted injurious behaviours which are motivated by an intention to die.

Suicide: Suicide is the act of intentionally ending one's own life.

Aetiology: Aetiology is a medical term which refers to the causes or sets of causes of a disease or health condition.

Carer/ Caregiver: A carer or caregiver is a person who assists another individual of old age or an individual with a disability, illness, mental illness, with their daily activities. Carers or caregivers can be paid or non-paid.

Caregiver Burden: this term refers to the physical, psychological, emotional, social and financial stresses that individuals experience as a result of caring for another person.

Self-harm: Self-harm or self-injury is the act of deliberately causing harm to oneself by physical injury, neglect and/ or putting oneself in dangerous situations.

Social Constructivism: is a theory of knowledge which examines the development of jointly constructed understandings of the world.

Ontology: Ontology is the philosophical study of the nature of being, existence or the nature of reality.

Epistemology: Epistemology is a branch of philosophy referring to the nature and scope of knowledge which is often described as the theory of knowledge. It is concerned with what knowledge is and how it is acquired.

Interpretative Phenomenological Analysis: Interpretative Phenomenological Analysis is a psychological qualitative research approach which has an idiographic focus. It aims to gain an insider perspective into how an individual or group experiences a given phenomenon in a given context and how they make sense of that experience.

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Chapter 1 – Introduction

1.1 Introduction

This study explored the psychosocial impact that living with a suicidal loved one has on family members and loved ones. The aim is to develop an understanding of family members' lived experiences from their own perspectives. By taking a qualitative approach and employing Interpretative Phenomenological Analysis (IPA), participants were able to reflect on their personal experiences, understandings and perceptions of "*being there*" for or caring for their suicidal loved one.

1.2 Epidemiology

Suicide is a growing global problem. In the last 45 years, suicide rates have increased by 60% internationally (WHO, 2015). With nearly one million people worldwide taking their lives annually (WHO, 2015), suicide is now one of the leading causes of death worldwide (Pompilli, Innamprali & Tatarelli, 2009). In a British context, 6,233 suicides occurred throughout the UK in 2013; a 4% increase since 2012 (Office for National Statistics, 2015). In Scotland, 795 suicides took place in 2013.

Comparing suicide rates between countries is difficult due to differences in the recording and reporting of deaths (Gvion & Apter, 2012). An examination of suicide trends within countries provides a more reliable indicator of the scale and nature of the problem of suicide (Samaritans, 2015). In terms of suicide trends within the UK, the Office for National Statistics (2015) stated that suicide rates have increased since 2007 with male suicide is at its highest rate in the UK since 2001. Suicide rates among middle aged men, aged 45-49 years are at 25.1 per 100,000, the highest rate for this group since 1981 (Office of National Statistics, 2015). Furthermore, in 2013,

the male suicide rate was three times the rate for women in the UK (Office for National Statistics, 2015).

Statistics on non-fatal suicide attempts are even more difficult to quantify due to unreported and untreated suicide attempts. The WHO (1999) estimate that for every completed suicide there are between 10 and 40 suicide attempts while Maris (2002) approximates that there are between 10 and 25 suicide attempts for every fatal suicide. Although Pompilli, Innamorali and Tatarelli (2009) argue that no real reliable data exist on numbers or rates of attempted suicides, Buus *et al.* (2014) acknowledge that the number of suicide attempts is significantly higher than the number of fatal suicides and point out that one individual may make several suicide times. This is consistent with robust evidence which suggests that previous suicide attempts are the strongest predictor of fatal suicide (Brown *et al.*, 2000; Gvion & Apter, 2012; Joiner *et al.*, 2005; Nordentoft, 2007).

1.3 Aetiology

The aetiology of suicide is complex. Often there are a number of factors which increase someone's likelihood of suicide. One of the most common factors associated with suicide is a mental health condition and it is estimated that 90% of people who attempt or complete suicide have a mental health condition (Gvion & Apter, 2012). Severe depression, bipolar disorder and schizophrenia, are all associated with an increased suicide risk of suicide (O'Hare, Shen & Sherrer, 2014), as is borderline personality disorder (Gvion & Apter, 2012). However, the reasons someone chooses to die by suicide are multifaceted. Other contributory factors which may increase an individual's risk of suicide include: the experience of abuse or other interpersonal violence (O'Hare, Shen & Sherrer, 2014); lifestyle issues such as

alcohol misuse (Gvion & Apter, 2012; O'Hare, Shen & Sherrer, 2014), social isolation (Gvion & Apter, 2012; Joiner, 2009) and genetic factors (Bondy, Buettner & Zill, 2006). Subsequently, exposure to other people's suicidal behaviour has been found to increase a person's risk of suicide (Cerel, Roberts & Nilsen, 2005). Traits including increased levels of aggression and impulsivity have also been found to increase a person's risk of suicide (Gvion & Apter, 2012). In addition, feelings of hopelessness (Gvion & Apter, 2012), worthlessness (Bagge *et al.*, 2014), and the experience of a stressful event such as relationship breakdown, bereavement, unemployment or deterioration in health often precipitates suicidal behaviour (Krysinska, 2003). Furthermore, people with increased access to means of dying by suicide and those exposed to others' suicidal behavior, particularly close friends or family members (Cerel, Roberts & Nilsen, 2005), are also at an increased risk of suicide.

The above information demonstrates the difficulty in identifying common causes for suicide. It is clear that the reasons for choosing to end one's life are complex and wide ranging.

1.4 Theoretical Perspectives on Suicide

A number of theoretical perspectives on suicide have been proposed which span across sociological, psychological and medical disciplines, dating back to the 19th century. While Durkheim (1897) focused on social factors that contribute to suicidal behaviour, biologists such as Brent *et al.* (1996) emphasise genetic factors which may increase suicide risk. Within psychology, a range of theories of suicide have been developed. The most widely accepted psychological models are outlined briefly.

Stress-diathesis Model of Suicidal Behaviour

Mann et al.'s (1999) model combines psychosocial and biological factors of suicide, providing an insight into why some individuals who experience stressful life events engage in suicidal behaviours, while others do not. This model proposes that if an individual experiences a stressful life event and also possesses a predisposed or inherent vulnerability or *diathesis* which causes them to respond to stress in an abnormal manner, they reach a threshold which results in them engaging in suicidal behaviour (van Heeringen, 2012). Diathesis refers to genetic, biological, cognitive and personality-related factors, therefore abnormalities in genes, socio-economic status, attachment style and childhood experiences can all contribute to the development of diathesis (Sigleman & Ryder, 2009). According to this model, protective factors such as social networks, emotional resilience and self-esteem can decrease the negative impact of stressful or negative events (van Heerigan, 2012). Therefore, during an individual's lifespan, the level of diathesis may fluctuate. This model of suicidal behaviour has been widely accepted as it takes in to account the multiple factors that can contribute to suicidal behaviour.

Interpersonal Theory of Suicidal Behaviour

According to Joiner et al.'s (2005) interpersonal model, in order for someone to take their own life they must have the desire to die by suicide and the ability to do so (Joiner, 2009). A desire for death emerges from an individual's perception that their existence is a burden to others, combined with a low sense of belonging to a group (Joiner, 2009). In terms of acquired capacity to die by suicide, Joiner (2009) states that an individual must be able to willingly overcome their self-preservation instinct through overcoming their fear of death, injury and pain. This is usually developed

through habituation; repeated painful experiences including self-injury, accidental injuries, physical fights or exposure to others pain or injuries (Joiner, 2009). This theory may explain the association between self-injury and previous suicide attempts with completed suicides.

Three Step Theory

Finally, Klonsky and May's (2014) model proposes an "ideation-to-action" framework. It proposes that the development of suicidal ideation and the escalation of suicidal ideation to suicide attempts are two distinct processes with different explanations (Klonsky & May, 2015). Suicidal ideation is developed from a combination of pain (usually psychological) and a sense of hopelessness (Klonsky & May, 2015). Feeling connected to others or having a sense of purpose can protect individuals from escalating from ideation to attempts (Klonsky & May, 2015). While a lack of connectedness combined with pain and hopelessness, develops strong ideation and an intent to die which leads to suicide attempts. This theory proposes that dispositional, acquired, and practical factors contribute to the capacity to attempt suicide. Dispositional factors are heredity factors such as pain sensitivity while acquired factors refers to Joiner's construct of habituation pain, injury, violence or death. Practical factors are those that make a suicide attempt easier such as knowledge of and access lethal means.

Although a short overview of the major psychological theories of suicide has been provided, it is beyond the scope of this thesis to provide a detailed description or evaluation of these theories. Instead, the reader will be introduced to more relevant theory focussing on carers/loved ones, later in Chapter 2.

1.5 Increased Focus on Suicide Prevention

Given the rise in worldwide and national suicide rates and the wide-ranging reasons a person takes their own life, it is unsurprising that suicide and mental health have become increasingly topical issues and have gained increased coverage and media attention. For example, the BBC has aired two documentaries in the last year on suicide, *Life After Suicide* (2016) and *Suicide and Me* (2016) which explored the impact that suicide has on the loved ones left behind and the stigma surrounding it.

Similarly, suicide and mental health have become a priority for the UK government in recent years, with the coalition government launching the Crisis Care Concordat for Mental Health in 2014. This national agreement urges services and agencies who respond to people in mental health crisis to take a more joined-up approach to ensure people experiencing a crisis receive a high quality and timely support (Crisis Care Concordat, 2014). Additionally, mental health services in England received £1.25 million in the 2015 budget for youth services. These developments evidence that mental health and suicide are being taken seriously by government.

Furthermore, on a national level, suicide prevention was prioritised by the Scottish Government in 2002 which led to the development of their 10 year Choose Life plan to reduce Scottish suicide rates (Choose Life, 2015). This plan has been successful in reducing suicide rates by 20% from 2002 to 2013. It has now been extended to 2016 and focuses on responding to people in distress, talking about suicide, improving NHS suicide response and developing an evidence base (Choose Life, 2015).

1.6 Supports for Suicidal Individuals and their Loved Ones

With an increased focus from the media and governments on mental health and suicide, there are now a range of prevention and intervention services available for suicidal individuals including NHS crisis resolution teams at A&E departments, general practitioners, liaison psychiatry teams and community mental health teams. A number of helplines are also available for people who are feeling suicidal, including; Samaritans, NHS 24, Saneline, Breathing Space, Hopeline UK and Campaign Against Living Miserably (CALM).

The grieving process resulting from suicide bereavement is considered to be more complicated and lasts longer than other bereavements (Supiano, 2012). Feelings of loss, sadness and loneliness associated with regular bereavements are greatly increased (Young *et al.*, 2012) and are usually complicated by feelings of guilt, shame (Seguin, Kiely & LeSage, 1994), confusion, rejection and anger (Young *et al.*, 2012). Furthermore, family members bereaved by suicide have been found to be at an increased risk of suicide (Krysinka, 2003; Sugrue, Gilloway & Keegan, 2014).

Considering the devastating impact that a loved one's suicide has on family members, it is unsurprising that a number of supports are now available to families who are bereaved by suicide. However, there does not appear to be the same level of support available to family members of suicidal individuals until a fatal suicide occurs. This is surprising when one considers that a suicidal person significantly impacts six other people (Andriessen, 2009).

Limited support is available to this group. However, it primarily consists of online resources on how to begin a conversation with someone who may be suicidal.

Support to families living with a known suicidal loved one on a long term basis or advice on how to cope with the range of negative emotions they are likely to experience is not readily available. Consequently, it appears that non-bereaved family members of a suicidal loved one do not to have the same level of support available to them as bereaved family members and that the supports available to them may are not tailored to their needs.

1.7 Context of the Present Study

The proposed study aims to explore the loved one's experience of living with a suicidal family member. Despite the pressure and responsibility placed on family members to care for and safeguard their suicidal loved one (Buus *et al.*, 2014; McLaughlin *et al.*, 2014), there is a surprising lack of research into the experiences of these lay carers (McLaughlin *et al.*, 2014). The studies that do explore this area appear to have methodological limitations, which are discussed in Chapter 2.

The proposed study is interested in the psychosocial impact that attempted suicide has on familial caregivers, inter-family dynamics, the caregivers' sense of identity, their health and wellbeing, support needs, views on supports available to them and their experience of stigma. This is an important area of research due to the extraordinary pressure that these carers are under (McLaughlin *et al.*, 2014), their increased risk of suicide due to the exposure of suicidal behaviour (Cerel, Roberts, & Nilsen, 2005), the devastating effects that a completed suicide has on family members (Sugrue, Gilloway & Keegan, 2014) and the perceived lack of support available to them family members prior to a completed suicide.

Furthermore, this phenomenon is poorly understood (McLaughlin, *et al.*, 2014) and under researched (Buus *et al.*, 2014). It is hoped that by gaining a richer

understanding of carers' experiences and the challenges that they face, tentative implications can be made for more effective and appropriate support services. To the best of the author's knowledge, this is the first IPA study to explore familial members' experiences living with for a suicidal loved one.

Chapter 2 - Literature Review

2.1 Introduction

This chapter presents a critical review of the relevant literature exploring the impact that a loved one's suicidal behaviour has on those closest to them. This literature review identifies what is known and what is not known about this topic, framing the present study within the existing body of research and theory. The results and limitations of the relevant literature are summarised to examine how the present study can contribute to the extant research.

A paucity of literature exploring family members' experiences of living with a suicidal loved one exists. Consequently, studies which explored family members' experiences of living with individuals who engage in deliberate self-harm (DSH) are included as it is likely that these experiences would be very comparable to family members of suicidal individuals. It was not deemed relevant to include studies which focussed on family members' perspectives of caring for mentally ill loved ones within this literature review. However, for further information this topic Rowe's (2012) systematic review is recommended.

2.2 Search Strategy

This narrative review of the literature was conducted due to the limited research base exploring this topic. It was not feasible to conduct a systematic review of the literature within the timeframe allocated to this research project. However, the researcher ensured to take a systematic approach to searching the above databases. The review was developed through a series of individual searches of health, psychology and sociological databases: (MEDLINE (2005-2015), PsychINFO, The Cumulative Index to Nursing & Allied Health (CINAHL), The Cochrane Library,

The Applied Social Sciences Index and Abstracts (ASSIA). Major subject headings were identified and these terms were then grouped together with each database being searched individually using these search term groupings. Search areas covered carers, family members, experience and suicidal behaviour. For inclusion within the review, papers were required to focus on family members' perspectives of living with a loved one who engaged in suicidal behaviour. Papers which investigated suicide bereavement, suicide interventions or those which focused on the impact of patients' suicidal behaviour on healthcare staff were excluded from this review as they were deemed to be irrelevant to the research topic.

Table 1 Search Terms

Major Subject Search Terms
S1 Family
S2 Parents
S3 Siblings OR Sibling relations
S4 Spouses
S5 Caregiver OR Carer
S6 Self injurious behaviour OR Suicid* OR Self-harm
S7 Experience OR Managing OR Response
S8 Stress OR Burnout OR Burden

Manual searches were also conducted through examination of references within relevant papers. The results of the literature searches conducted using the aforementioned databases are provided in Table 2.

Table 2 Search Results

Database	No. of hits	No. excluded (irrelevant)	No. of abstracts reviewed	No. included
Medline	143	119	24	6
CINAHL	121	109	12	1
PsychINFO	44	42	2	0
ASSIA	34	28	6	2
Cochrane Library	66	66	0	0

Two additional studies were included in the review which was found through manual searching.

A total of 11 studies are included in this literature review. The key points of the 11 studies included are outlined in Table 3.

Table 3 Key Points of 11 studies included in the literature review

Author	Year	Database	Country of Origin	Aim	Sample	Data Collection	Analysis	Findings
Buss <i>et al.</i>	2014	Medline	Denmark	To explore parents' experiences caring for a son or daughter who attempted suicide	14 non-bereaved parents	Focus group	Thematic Analysis	<p><u>2 Major Themes</u></p> <ol style="list-style-type: none"> 1. Emotional responses and stress 2. Double trauma: Effects of families and relationships <p><u>4 Minor Themes</u></p> <ol style="list-style-type: none"> 1. Psychosocial Stress and strain 2. Effects on parental relationship 3. Effects of the family 4. Effects on relationships with others
Byrne <i>et al.</i>	2008	ASSIA	Ireland	To explore the needs of parents and carers of young people who engage in deliberate self-harm (DSH)	25 non-bereaved carers of children under 16.	Focus group	Conceptual analysis.	<p><u>7 Themes:</u></p> <ol style="list-style-type: none"> 1. Support 2. Emotions 3. Parenting 4. Family 5. Psycho-education 6. Managing Self Harm 7. Others: Beliefs, School & Internet.
Champlin	2009	Manual search	USA	To explore carer's relationship with mentally ill loved one and impact it has on family carer	12 carers - 10 parents, 2 friends	Semi-structured interviews	Descriptive Phenomenological Analysis	<p><u>8 Themes:</u></p> <ol style="list-style-type: none"> 1. Accepting the changed other and grieving the loss of who the other once was 2. Taking action in challenging circumstances 3. Recognising the ongoing, never-ending and sometimes unpredictable nature of the experience 4. Feeling isolated 5. Having ambiguity of the heart 6. Experiencing the tension of waiting

								7. Knowing the other well 8. Caring for the other
Daly	2005	Medline	Canada	To investigate the impact that caring for an adolescent with suicidal behaviour has on mothers	6 non-bereaved mothers	Unstructured Interviews	Thematic analysis	<u>6 Themes:</u> 1. Failure as a good mother 2. The ultimate rejection 3. Feeling alone in the struggle 4. Helplessness and powerlessness in the struggle 5. Cautious parenting 6. Keeping an emotional distance.
Grant <i>et al.</i>	2015	CINAHL	USA	To explore the issues faced by family carers of suicidal individuals	N/A	Literature review	N/A	Propose Creativity, Optimism, Planning and Expert information (COPE) Empowerment Model, Creativity, can be applied to family members of a suicidal individuals.
McLaughlin <i>et al.</i>	2014	ASSIA	UK	To explore family carers' experienced of caring for a loved one with suicidal behaviour	18 family members: 7 bereaved, 11 non-bereaved.	Semi-structured interviews	Thematic analysis	<u>4 Themes:</u> 1. Family Burden 2. Competing Pressures 3. Secrecy and Shame 4. Helplessness and Guilt
Nosek	2008	Medline	USA	To explore the process families use to care for their suicidal loved one at home	17 non-bereaved family members – spouses, parents and one adult daughter	Semi-structured Interviews	Grounded Theory	<u>8 Stage Theoretical Model</u> <u>"Maintaining Vigilance Through Managing;</u> 1. Not knowing 2. Identifying signs 3. Gaining awareness 4. Knowing and understanding 5. Taking Action 6. Watching and waiting 7. Reaching limit 8. Not wanting to know

Owens <i>et al.</i>	2011	Manual search	UK	Explore family members and friends ability to identify signs of suicidal intent and their ability to intervene	31 bereaved family members, friends and colleagues	Unstructured interviews	Thematic analysis	<u>3 Themes:</u> 1. Difficulties faced by the suicidal person in communicating distress 2. Difficulties in interpreting and heeding distress signals 3. Difficulties in taking action
Sun and Long	2008	Medline	China	Explore family members' and suicidal individuals' perceptions of caring for people who had previously attempted suicide at home.	15 family carers and 15 ex-suicidal individuals	Semi-structured Interviews	Grounded Theory: Open, axial and selective coding	<u>A theory to guide families and carers of people who are at risk of suicide:</u> 'Impending burnout' results from a combination of these inter-related factors: 1. Causal Conditions 2. Context 3. Intervening Factors 4. Action/ Interaction Strategies 5. Consequences 6. Support
Sun <i>et al.</i>	2009	Medline	China	Explore patient and family carers experiences of care at home following hospital discharge	15 ex-suicidal patients and 15 family carers	Semi-structured Interviews	Grounded theory: Open, axial, and selective coding	<u>3 Categories of Action/ Interaction:</u> 1 Guarding the person day and night 2 Maintaining the activities of daily living 3 Creating a nurturing environment
Sun <i>et al.</i>	2008	Medline	China	Explore patient and family carers experiences of care at home following hospital discharge	15 ex-suicidal patients and 15 family carers	Semi-structured Interviews	Grounded theory: Open, axial, and selective coding	<u>2 Conditions of Caring for suicidal loved one</u> 1. Context conditions: Family environment and Chinese culture 2. Intervening conditions: Provision of care in the home

2.3 Analysis of the Literature

Over the last ten years, there has been a shift in mental healthcare from hospital to community settings where possible. Nosek (2008) attributed this shift to the limited availability of mental health services to depressed and suicidal people, due to managing increasing costs of care. Nosek (2008) argued that this shift to community care has resulted in a significant reduction in the number of days that a depressed or suicidal person is hospitalised. This increases the likelihood of a patient experiencing acute symptoms of depression and suicidal ideation when they are discharged from hospital and in the care of their families at home (Nosek, 2008). Similarly, Champlin (2009) argued that this shift to community mental healthcare places increased responsibility on family members to support their loved one with mental illness to successfully live in the community.

Despite this increased pressure on family members to care for their loved ones, Champlin (2009) acknowledged that no phenomenological studies exploring caregivers' relationships with a seriously mentally ill family member existed at the time of her publication. Similarly, Nosek (2008), McLaughlin *et al.* (2014), Buus *et al.* (2014) all acknowledged that although the burden of safeguarding and caring for a suicidal loved one largely falls on family members, the impact that a loved one's suicidal behaviour has on familial carers is poorly understood and under-researched.

The findings of the above eleven studies are categorised into the following headings: Emotions; Relationship with Suicidal Loved One; Impact on Interfamily Dynamics; Hypervigilance and Unpredictability; Stigma, Secrecy and Isolation and Helplessness and Perceived Lack of Support.

2.3.1 Emotions

The majority of studies which explore the impact of a loved one's suicidal behaviour on family members tend to focus on parental perspectives, (e.g., Daly, 2005, Buss *et al.*, 2015) and Byrne *et al.*, 2008). Daly's (2005) study explored mothers' experiences of caring for suicidal adolescents using unstructured interviews while Buus *et al.* (2014) and Byrne *et al.* (2008) investigated parents' experiences of their children's suicidal behaviour using focus groups. These studies identify that parents experience a range of negative emotions including intense feelings of panic, horror, persistent anxiety and fear of repeat attempts. Likewise, in Champlin's (2009) study which investigated carers' experiences of "being there" for a loved one with serious mental illness, it was found that carers were constantly waiting anxiously for changes in their loved ones' behaviour which would indicate a further episode or downward spiral. This suggests that feelings of panic, worry, anxiety and fear are commonly felt by carers of loved ones with suicidal behaviour and/or serious mental illness.

Furthermore, McLaughlin *et al.* (2014), whose sample consisted of spouses, adult children and parents, found that negative emotions in response to a loved one's suicidal behaviour impacted family members' daily functioning, with carers reporting feelings of guilt over leaving the house, dread about coming home and fear of what they might come home to. This intense psychological pressure is evident in all of the aforementioned studies. In Buus *et al.*'s (2014) study, two of the 14 participants admitted to ideating about suicide due to the ongoing and unbearable pressure to keep their child safe. Furthermore, McLaughlin *et al.* (2014) both identified that family members felt their responsibility and caring role was ongoing and that there was no end in sight.

Subsequently, in Byrne *et al.*'s (2008) study, parents and carers of young people engaging in DSH expressed that they felt guilty about failing to recognise or prevent their child's DSH attempts and believed that they had failed as parents. Daly (2005) echoes Byrne *et al.*'s (2008) findings, identifying that self-recrimination and a total sense of failure as a mother were felt by mothers. Likewise, parents in Buus *et al.*'s (2014) study identified feelings of guilt due to the upbringing of their child being their responsibility and because they felt they had neglected their other children.

Furthermore, Byrne *et al.* (2008) found that caring for a suicidal child resulted in parents feeling angry and frustrated towards their child. Buus *et al.* (2008) further reporting that parents felt intense hate towards their suicidal child who they viewed as being partially responsible for setbacks and upsetting the whole family's wellbeing. Parents also experienced a lack of trust in their child due to broken promises (Buus *et al.*, 2014) and repeated attempts (Byrne *et al.*, 2008). In line with Buus *et al.*'s (2014) findings, Daly (2005) found that mothers experienced feelings of hate and anger towards their child. Daly (2005) also found that mothers interpreted their child's suicidal behaviour as them throwing life back at them because of their own actions as a mother. Mothers questioned whether dying was a more attractive option than living with their mother and, in some cases, admitted to wishing that their child had never been born (Daly, 2005).

2.3.2 Relationship with Suicidal Loved One

The anger, frustration, rejection and guilt that parents and carers experienced was found to negatively impact their relationships with their suicidal/self-harming child (Byrne *et al.*, 2008; Daly 2005). Confidence in parenting was greatly impacted by the suicidal behaviour of the child (Daly, 2005; Byrne *et al.*, 2008) and carers found parenting their child very difficult as their relationship with them was impaired by lack

of trust (Byrne *et al.*, 2008 and Daly 2005). Byrne *et al.* (2008), Daly (2005) and Buus *et al.* (2014) all found that parents struggled with disciplining their suicidal or self-harming child as they were fearful that disciplining them would lead to a further DSH or suicide attempt. Likewise, Daly (2005) found that fear of future attempts and guilt led mothers to develop a cautious style of parenting and felt that they were walking on eggshells around their child. Furthermore, parents in Buus *et al.*'s (2014) study felt that guilt and fear of future attempts caused them to grant the suicidal child special privileges. Fear and guilt made it very challenging for parents to discipline or confront their child and to revoke special privileges which compromised parents' values around upbringing. They identified that spoiling the suicidal child could negatively impact relationships with other family members and reported feeling guilty towards their other children who felt neglected due to their sibling's suicidal behaviour.

Difficulties in family dynamics were also highlighted within Nosek's "maintaining vigilance through managing" theory. According to this theory family members enter into a stage of "Reaching the limit" (Nosek, 2008). This refers to family members feeling that they needed to reduce their involvement with their loved one for their own self-preservation. Nosek's (2008) theory subsequently argues that family members also enter a "Not wanting to know" phase whereby they felt that they had reached a threshold and did not want to know about periods of increased risk of suicide (Nosek, 2008). This highlights not only the strain that the suicidal has on the relationship between the suicidal loved one and their family members but also emphasises the ongoing stress that family members are under.

The association between suicide attempts and the resulting strain in relationships between the suicidal loved one and their family members is particularly concerning when one considers Sun *et al.*'s (2008) findings. Sun *et al.* (2008) found that relationships within the family impacted the level and the quality of care that the suicidal loved one received. Close relationships within the family resulted in more time being spent with the suicidal loved one, increased communication with them and this facilitated caring for them (Sun *et al.*, 2008). On the other hand, distant relationships had the opposite effect. For example, anger and resentment resulting from carers' decisions to hospitalise their loved one often closed the lines of communication between the carer and suicidal loved one. Therefore, a negative or distant relationship with the suicidal loved one not only has a negative impact on the carer but appear to be detrimental to the suicidal loved one as it impacts the care that they receive (Sun *et al.*, 2008). Furthermore, Sun *et al.* (2008) found that family carers felt their ability to help their loved one depended on the loved one's willingness to accept help. Open channels of communication were seen as being integral to helping the loved one (Sun *et al.*, 2008) as they facilitated the caring process. On the other hand, closed communication channels between the loved one and carer made it difficult to offer helping skills.

Sun and Long (2008) extended Sun *et al.*'s (2008) findings and generated a theory to guide families and carers of people at risk of suicide. This theory emphasises the impact that the family environment, interfamily dynamics and family members' actions all have on the process of caring for a suicidal loved. Their theory states that five components: causal conditions, context, intervening conditions, action/interaction strategies and consequences give rise to impending burnout (Sun and Long, 2008). Causal conditions refer to suicidal patients' reasons for suicide while

context refers to family environment and Chinese culture. Family environment relates to the challenges in keeping the loved one safe at home while Chinese culture refers to the strong sense of responsibility to one's family and the pervasive stigma around suicide in China (Sun & Long, 2008).

According to Sun and Long's (2008) theory, intervening conditions such as family members use of action-orientated coping mechanisms and the loved one's ability to engage in helping skills can facilitate caring can facilitate provision of care. Equally, lack of support available to family members, lack of coping mechanisms and refusal to accept help tends to constrain caring (Sun & Long, 2008). Family action or interaction strategies consist of family members being on guard day and night, instilling hope in their loved one and creating a nurturing environment (Sun & Long, 2008). These strategies interact with the aforementioned components and give rise to either positive or negative consequences. Positive consequences refer to the suicidal individual redeveloping a desire to live (Sun & Long, 2008) while negative consequences include suicidal ideation and attempts leading to the cyclical process of caring and safeguarding the loved one (Sun & Long, 2008).

According to Sun and Long's (2009) theory, these five components interact and relate to one core category, impending burnout. This core category is central to their theory and refers to the combined physical and emotional exhaustion that family carers experience when caring for a suicidal loved one. This is discussed below in further detail in section 2.3.6 Helplessness and Perceived Lack of Support.

2.3.3 Impact on Inter-family Dynamics

Byrne *et al.* (2008) found that family dynamics were disrupted and family functioning was impeded (Byrne *et al.*, 2008), while McLaughlin *et al.* (2014) identified that the

physical and mental wellbeing of the whole family was negatively impacted by the loved one's suicidal behaviour. Relationships within the family and with others were identified by McLaughlin *et al.* (2014) to be negatively impacted by their loved one's suicidal behaviour.

Siblings were reported to be devastated by their brother or sister's DSH attempts and parents found it difficult to explain to siblings why the DSH was occurring (Byrne *et al.*, 2008). Carers felt that the loved one's DSH and suicide attempts had become a focal point of family life which revolved around this one person as if the rest of the family did not matter (Byrne *et al.*, 2008). As a result, it was felt that the child holds the power in the household (Byrne *et al.*, 2008) and that they controlled what was going on at home (McLaughlin *et al.*, 2014). While family carers in Sun *et al.*'s (2009) 'tip-toed' around their homes in fear of stressing their loved ones and exacerbating their condition, Daly (2005) reported that the suicidal adolescent became the focus of the household and that this overshadowed all other problems. Similarly, Buus *et al.* (2014) found that while some siblings felt sensitive and protective towards their suicidal sibling, others felt neglected and experienced feelings of hatred towards their sibling. This could easily lead to conflicts between siblings and parents and siblings and the suicidal loved one (Buus *et al.*, 2014). Parents attributed siblings' psychological and physical problems to the neglect and poor family dynamics caused by the suicidal child (Buus *et al.*, 2014).

In terms of marital relationships, Buus *et al.* (2014) found that carers who were in long term relationships, viewed their child's suicide attempts as a "double crises" referring to the secondary trauma it had on their family and marriage (Buus *et al.*, 2014). They felt that arguments and conflict around the suicidal child could easily

lead to divorce and found maintaining a giving relationship with their partner challenging. Parents felt manipulated by the suicidal child and played off against each other (Buus *et al.*, 2014). Ways of managing the child's behaviours, breaking agreements regarding their child and assigning blame were further sources of conflict between partners (Buus *et al.*, 2014). Marital relationships with partners do not appear to be explored to the same extent by McLaughlin *et al.* (2014), Daly (2005), Byrne *et al.* (2008) or Champlin (2009). Consequently, this area is likely to be worthy of further research.

2.3.4 Unpredictability and Hypervigilance

The unpredictability of suicidal behaviour was repeatedly emphasised as adding to the challenge of caring for a suicidal loved one (Buus *et al.*, 2014; Byrne *et al.*, 2008; Daly, 2005). Likewise, Nosek (2008) identified that family members enter an initial phase of "Not knowing" where they are completely unaware that their loved one was at risk of suicide which then gives rise to shock and disbelief when their loved one attempted suicide. Additionally, Daly (2005) and Buus *et al.* (2014) found that identifying signs or triggers of suicide attempts was a challenge for family members.

These results are consistent with Owens *et al.* (2011) who found that in the aftermath of their loved one's suicide, loved ones identified odd and disturbing behaviours exhibited by the suicidal individual prior to their suicide. However, significant others were unable to identify that these behaviours were odd or interpret them as distress signals at the time. This was due to distress signs such as quietness, being withdrawn and drunkenness being exhibited alongside countersigns such as making plans for the future, socialising, going to work, laughing and joking and giving reassurances that they were okay. Consequently, this resulted in a

tendency for loved ones to heed the positive signals and to disregard the negative signals. Other factors such as competing pressures, self-preservation and maintaining one's own mental health also contributed to loved one's tendency to disregard warning signs of suicidal behaviour (Owen's *et al.*, 2011).

The difficulty in identifying signs or triggers to subsequent attempts resulted in family members feeling anxious and fearful of future attempts. In response to this, family members engaged in a state of hypervigilance to keep their loved ones safe (McLaughlin *et al.*, 2014; Buus *et al.*, 2014; Nosek, 2008;). Mothers were constantly checking on the whereabouts and safety of their child due to their lack of trust in them (Daly, 2005). While family members in Sun *et al.*'s (2009) study guarded their suicidal loved one day and night. Sun *et al.* (2008) identified keeping their loved one safe was very challenging due to the fact that they could leave the home at any time. Likewise, in Champlin's (2009) study, family members felt that they were required to be on call for support 24/7. Similarly, Nosek (2008) reported that family members entered a "watching and waiting" phase where they felt they must attend vigilantly to changes in their loved one's behaviour and monitoring to see if their actions or interventions were effective (Nosek, 2008).

Family carers who participated in this state of hypervigilance struggled to cope with competing pressures and felt unable to meet the demands of other aspects of their lives including work, studies, leisure activities, socialising with others and meeting the needs of other children (McLaughlin *et al.*, 2014). This is unsurprising when one considers that in Sun *et al.*'s (2009) study, family carers were providing basic care including washing and cooking to loved ones, ensuring the home environment is tranquil, ensuring the loved one participates in their medical treatment, being there for their loved one physically and emotionally and guarding them day and night.

Furthermore, Daly (2005) found that mothers admitted to feeling torn between two children, being unable to meet their needs due to their focus on the suicidal child. Similarly, parents in Buus *et al.*'s (2014) study confessed that siblings felt neglected due to the increased focus on their brother or sister which led to conflict between the siblings and their parents and healthy siblings and the suicidal sibling. However, despite these findings there does not appear to be any studies that explore how family members cope in work when dealing with suicidal behaviour at home, the impact a loved one's suicidal behaviour has on family member's social life, their relationships with others and their ability to care for others.

Given the challenges experienced in caring for their loved one at home, it is unsurprising that Sun *et al.* (2009) found that family carers did not know how to treat their suicidal loved one at home. They therefore attempted to support their loved one by encouraging them to take part in remedial activities such light housework and physical exercise, keeping the home environment as tranquil and calm as possible, continuously conveying care and support and ensuring treatments including medication and even hospitalisation (Sun *et al.*, 2009). Despite not knowing how to treat suicidal loved ones at home, family members went to great lengths to keep their loved ones safe. Champlin (2009) reported that their attempts ranged from hospitalising loved ones to phoning the police to manage their behaviour. Similarly, Buus *et al.* (2014) reported that attempts to keep the loved one safe ranged from having in depth conversations with them about the cause of their distress to standing guard at night and even physically intervening to stop the suicidal behaviour (Buus *et al.*, 2014). However, although family members were willing to take action, often they were not confident in terms of knowing if their actions were effective or appropriate (Nosek, 2008).

2.3.5 Stigma, Secrecy and Isolation

Secrecy, isolation and stigma were experienced by carers (Byrne *et al.*, 2008; Daly, 2005; McLaughlin *et al.*, 2014; Buus *et al.*, 2014; Champlin's, 2009). McLaughlin *et al.* (2014) identified that secrecy and shame were common to the experience of caring for a suicidal loved one with participants feeling pressurised by their loved one to keep their suicidal behaviour a secret. This resulted in family members feeling isolated and feeling unable to seek support. Consistent with McLaughlin *et al.* (2014), Daly (2005) identified that mothers caring for suicidal adolescents were feeling alone in the struggle. They reported feeling isolated from their spouses, other family members and other mothers of healthy and happy children. Similarly, Buus *et al.* (2014) found that parents felt isolated after the suicide attempt as they felt no one else would be able to understand the event. Furthermore, Champlin's (2009) study reports that carers felt isolated and alone as they watched other people withdraw their support over time due to living further away from their loved one, being busy with their own lives and not wanting to be associated with the stigma of the other's mental illness.

Stigma around suicide and mental health was also identified in both McLaughlin *et al.* (2014) and Buus *et al.*'s (2014) studies. Carers in both studies were fearful of other people learning of their loved one's suicide attempts due to the resulting negative perceptions of their family and the stigma around suicide. Parents and carers regularly referred to their attempts to manage societal beliefs about their family which were perceived by parents to be negatively impacted by their child's suicide attempts (Buus *et al.*, 2014). They strived to be accepted as "morally adequate and responsible parents" (p. 829), who were not to blame for their loved one's suicidal behaviour. However, they felt that challenges to their social standing

were out of their control. In line with this, parents in Byrne *et al.*'s (2008) study admitted to not informing schools of their child's DSH as they viewed them as unhelpful and unsupportive. Subsequently, carers in Byrne *et al.*'s (2008) and Buus *et al.*'s (2014) studies identified that family members' feelings of isolation were due to the stigma attached to DSH and suicide and in Byrne *et al.*'s (2008) study, it was felt that this stigma was exacerbated by the lack of support services available to families. Furthermore, Daly's (2005) study showed that mothers felt their feelings of isolation were exacerbated by stigma of suicide and hurtful or thoughtless comments from others.

Due to the secrecy and fear of others finding out about their loved one's situation, McLaughlin *et al.* (2014, p. 239) found that many loved ones "activated a veil of secrecy and feigned normality" which increased their experiences of shame and stigma. In some cases, McLaughlin *et al.* (2014) found that although carers wanted help and support, the suicidal loved one pressurised them not to speak to anyone about their suicidal behaviour. This finding is echoed by Owens *et al.* (2011) who found that suicidal individuals often confided in a single person and pressurised them not to share this information, placing an "unbearable strain" on the loved one who is "sworn to secrecy" (Owens *et al.*, 2011; p.347). Therefore, an unwillingness to access support due to the stigma surrounding suicide attempts and a perceived need to be trustworthy caused many family members not to access support from services or from people within their social network. Sadly, following the completed suicide of a loved one, many family members viewed not sharing information with others in the social network or with mental health services as missed opportunities for intervention (Owens *et al.*, 2011).

2.3.6 Helplessness and Perceived Lack of Support

Feelings of helplessness, powerlessness and hopelessness were identified in McLaughlin *et al.* (2014), Buus *et al.* (2014), Champlin (2009), Daly (2009) and Byrne *et al.*'s (2008) studies. Feelings of helplessness were identified by McLaughlin *et al.* (2014) with carers feeling a strong responsibility to keep their loved one safe but also feeling that they were unable to do enough to do so. Similarly, Buus *et al.* (2014) reported that despite the huge efforts parents made to save their children, they often felt that their efforts were futile with further attempts and more broken promises resulting in feelings of powerlessness and hopelessness. Champlin (2009) describes similar feelings of anxiety and self-doubt, experienced by carers of mentally ill loved ones who felt uncertain about how they responded to their loved one's behaviour, often second-guessing their decisions around hospitalising their loved one or calling the authorities. Likewise, Nosek (2008) identified that within the "Taking action" phase of the caring process, where family members took an active role in responding to their loved ones' suicidal behaviour, they were not confident in knowing how to respond to signs of suicidal behaviour. Consequently, they used a process of trial and error to identify which actions were effective and were unable to know if they yielded improvement in their loved one or not (Nosek, 2008).

Hopelessness was identified by Champlin (2009) and Nosek (2008) who found that carers were convinced that their loved one would experience another mental health crisis and that managing and caring for their loved one was an ongoing and never-ending cycle. Subsequently, McLaughlin *et al.* (2014) emphasise the cyclical nature of caring for a suicidal loved one, describing familial members' experiences as a heavy and unrelenting burden resulting in high levels of stress and persistent anxiety for the family member.

A recurring theme across a number of studies (Buus *et al.*, 2014; Byrne *et al.*, 2008; Champlin, 2008; Daly, 2005; McLaughlin *et al.*, 2014; Nosek, 2008; Sun *et al.*, 2008 & Sun *et al.*, 2009) discussed the need for increased support for carers and family members from mental health services. Byrne *et al.* (2008) reported that parents and carers felt support was greatly needed and identified a lack of adequate and appropriate support from services for carers of children who engage in DSH. Furthermore, they felt that the care pathway for 16-18 year olds was unclear. This finding is consistent with Owens *et al.*'s (2011, p. 347) results which show that family members and friends were unsure of "when, where and how to seek help outside the social network" and had no knowledge of available pathways. Worryingly, family members' negative perceptions of mental healthcare based on previous bad experiences deterred them and their suicidal loved ones from seeking support (Owens *et al.*, 2011). Interestingly, Byrne *et al.*'s (2008) participants viewed the lack of support services available to carers and parents as a contributory factor in the stigma they experienced.

According to Byrne *et al.* (2008) parents desired information on young people's mental health, DSH statistics, causes, trends and treatment services and advice on how to prevent DSH, how to manage future attempts and information on triggers and interventions. Similarly, Sun and Long (2008) argue that the lack of support for family members prior to their loved one's discharge not only negatively impacts family members' wellbeing but also their suicidal loved one's safety. They found that families were spending entire days worrying about and attending to their loved one as a result of a lack of psycho-education around preventative strategies (Sun & Long, 2008). At some points when family members could no longer tolerate their feelings of burnout, they could no longer care for their loved ones and this resulted in

family members making further suicide attempts (Sun & Long, 2007). This is particularly relevant to the present study as it demonstrates that caregiver burnout is not only a great concern for the wellbeing of family carers but also for the safety of the suicidal family member in their care.

Furthermore, Nosek (2008) found that although follow up care was provided to the suicidal loved one after their discharge, family members received no support from mental health services. Similarly, McLaughlin *et al.* (2014) found that family members felt overlooked by support services that were engaging with their suicidal loved one. Consequently, McLaughlin *et al.* (2014), Daly (2005) and Nosek (2008) all argue that family members of suicidal individuals clearly require mental health support and that often this support need is not being met. Nosek (2008) emphasises the need for family carers to be involved in care planning for patients with depression and suicidal behaviours. As many family members in Nosek's (2008) study were unable to obtain information from mental health professionals which could have helped them to understand their loved one's needs, due to confidentiality, many of them had to find the information they needed to increase their awareness alone using the internet and books.

In line with Nosek (2008) McLaughlin *et al.* (2014) and Daly (2005), in Grant, Ballard and Olsen-Madden's (2015) literature review, they highlight that lack of inclusion in treatment planning and feelings of powerlessness are key challenges for family members caring for suicidal loved ones. Their review was conducted on the following topics; 1) Family caring for suicidal loved ones, 2) Approaches of family involvement in their loved one's care, 3) Family involvement in treatment planning, 4) Families as risk and protective factors and 5) The impact of caring on family members. Based on this review, they propose that the Creativity, Optimism, Planning and Expert

Information (COPE) model which was created by Houts *et al.* (1996) for caregivers of cancer patients, can be successfully applied to caregivers of suicidal loved ones.

The COPE model emphasises creative problem solving and realistic optimism is encouraged with family members setting manageable goals for themselves and their loved one (Grant, Ballard & Olsen-Madden, 2015). Planning refers to obtaining facts about a situation, collaborating with mental health workers to put a plan in place to address the problematic situation, evaluating and revising the plan. Expert information refers to carers gathering reliable information, knowing their limits and being aware when professional intervention is required. Grant, Ballard and Olsen-Madden (2015) outline in detail how this model can be infused with suicide prevention education such as Mental Health First Aid proposing that caregiver efficacy, competence, satisfaction and increased and caregiver burden is decreased (Grant, Ballard & Olsen-Madden, 2015). Grant, Ballard and Olsen-Madden (2015) recommend that as the COPE model involves family members in treatment planning and educating carers on suicide prevention, it is likely to empower family members and thereby decrease their feelings of powerlessness and the resulting caregiver burden (Grant, Ballard & Olsen-Madden, 2015).

2.4 Limitations of Extant Research and Rationale for the Present Study

It is pertinent to discuss the limitations of the extant research. First, a number of these studies employ a biased sample. Champlin's (2009), Buus *et al.*'s (2014) and Daly's (2005) samples all consisted of carers who attended a support group. Buus *et al.* (2014) acknowledged that, as their participants attended the NEFOS counselling programme prior to data collection, it was likely that new ways of thinking had been developed by participants which would emerge in the focus group, impacting

participants' responses. Likewise, Champlin (2009) recruited participants from one support group and suggested that they may therefore be more comfortable sharing their accounts as they are experienced in doing this regularly at support groups. The primary researcher feels that exploring the experiences of carers who do not attend a support service may be useful to explore why they do not access services, their feelings towards support services and what may increase their chances of gaining support. The present study therefore, aims to find a mix of participants, those accessing support services and some that are not as none of the aforementioned studies have done this.

A subsequent issue with sampling is observed in McLaughlin *et al.*'s (2014) study. McLaughlin *et al.*'s (2014) sample consisted of family members who were bereaved by suicide as well as family members who were currently living with a suicidal loved one. For bereaved participants, their knowledge of the outcome of their loved one's suicidal behaviour is very likely to impact their retrospective accounts of caring for their suicidal loved one as shown in Owens *et al.*'s (2011) study. As a result, their experiences may not be directly comparable to participants' experiences of caring for a loved one that is suicidal but has not completed suicide. The proposed study aims to employ a sample similar to Buus *et al.*'s (2014) and Sun *et al.*'s (2009), consisting of family members living with a suicidal loved one who has attempted but not completed suicide.

Daly (2005), Byrne *et al.* (2008) and McLaughlin *et al.* (2014) all used thematic analysis to analyse their data. Thematic analysis focuses on identifying patterns across the participant's narratives rather than interpreting the individual account of each participant. Its focus is descriptive and therefore has limited interactive power unless used within a theoretical framework. As no theoretical or conceptual

framework is referred to in these studies, this method of analysis is deemed to be a limitation. Therefore, it is felt that IPA would be a more appropriate methodology for an in-depth exploration into the subjective and individual experiences of caring for a loved one with suicidal behaviour as it would focus more on the interpretation of the unique characteristics of each participant's experience.

Both Buus *et al.* (2014) and Byrne *et al.* (2008) used focus groups for data collection. It is felt that semi-structured interviews would be a more appropriate methodology for this topic and as this method would result in a more in depth and rich account of their experiences than a focus group method. A subsequent limitation to Buus *et al.*'s (2014) study is that the facilitators of the focus group limited their involvement allowing participants to negotiate the conversation topics themselves. As a result of this Buus *et al.* (2014) felt that certain issues in individual's stories were unexplored and that these open-ended issues were not investigated further. This limitation is directly relevant to the proposed study. It is hoped that with data collection involving semi-structured interviews in the proposed study, open-ended issues can be explored in more detail than in a focus group setting.

The studies conducted by McLaughlin *et al.* (2014), Daly (2005), Byrne *et al.* (2008) Nosek (2008) and Buus *et al.*'s (2014) are all subject to inconsistencies in the definition of suicidal behaviour. McLaughlin *et al.*'s (2014) defined it as the experience of suicidal ideation, suicidal attempts and self-harm behaviours while Daly's (2005) broad definition includes suicidal ideation, suicidal attempts and suicidal gestures. Buus *et al.* (2014, pp.825) offer a more specific definition categorising suicidal behaviour as being "a type of self-harm with a high level of potential lethality or danger regardless of the person's suicidal intention". It is interesting that McLaughlin *et al.* (2014) include suicidal ideation and deliberate self-

harm (DSH) in their definition of suicidal behaviour. Although carers of loved ones with suicidal ideation and those engaging in DSH are likely to have similar experiences as carers of loved ones who have made suicidal attempts, it is likely that suicide attempts will be more stressful and upsetting for family members than disclosures of suicidal ideation or lower level DSH attempts. Consequently, it is felt that a study investigating carer's experiences of family member's suicidal attempts only, would be informative as there is so little research published exploring this topic.

McLaughlin *et al.*'s (2014) inclusion of self-harm in their definition of suicidal behaviour raises further questions also. There is an inconsistency in the literature regarding definitions of suicidal behaviour with some research including DSH as suicidal behaviour while others view DSH as a different concept. For example, Suyemoto (1998) suggests that DSH does not necessarily involve suicidal ideation or intent and is often engaged in as a coping strategy to modulate negative emotions. Similarly, Himber (1994) argues that in some cases DSH can even prevent suicidal ideation. Although McLaughlin *et al.*'s (2014) study does not outline the severity of loved ones' DSH attempts or whether or not the attempts involve suicidal intentions, it is felt that the findings are relevant to the proposed research as it explores familial caregivers' experiences and support needs in caring for loved ones who are a danger to themselves. As a result, their experiences are likely to be similar to the experiences of family members caring for a loved one who has attempted suicide.

Furthermore, a limitation observed in Sun *et al.* (2008) and Sun *et al.*'s (2009) studies is that although their samples consist of family carers of loved ones who have attempted but not completed suicide, all data was collected six weeks after their loved one's discharge. Therefore, the caring experience over time may not be

captured in this data. The present study aims to address this limitation by interviewing loved ones at a range of points in their experience of living with a suicidal loved one.

It is pertinent to evaluate the theories perspectives developed from Nosek (2008), Sun and Long (2009) and Grant, Ballard and Olsen-Madden's (2015) research and to identify how these theories inform the present study. Firstly, it is felt that Nosek's (2008) "Maintaining Vigilance through Managing" theory does not offer much insight into how family members can improve the efficacy of their care or how their stress and negative emotions can be decreased. However, it acknowledges that further research on caring for suicidal loved ones is required in order to test this theoretical perspective. Although Nosek's (2008) theory is not analytically generalizable, it contributes to our knowledge of family carers experiences of caring for a suicidal or seriously mentally ill loved one and are therefore is directly relevant to the present study.

Although Sun and Long's (2009) theory is complex and detailed, it offers a model that can be applied to most families as it highlights intervening conditions and how family care can have positive and negative consequences for carers and suicidal loved ones. Therefore, it is applicable to the family members who are capable of providing effective care and prevention to their loved one or those who are not. It highlights the importance of the relationship between family carer and the suicidal individual and how this can result in positive or negative consequences for both the carer and the suicidal person.

Although there is evidence which supports the COPE model's effectiveness for increasing carer's self-efficacy and wellbeing and decreasing caregiver burden for

carers of cancer patients (Grant, Ballard & Olsen-Madden, 2015), there is little evidence to support its application to carers of suicidal people. Therefore, further research is needed to investigate the efficacy of this model when it is applied to caregivers of suicidal loved ones. On the other hand, this model addresses a range of issues that the extant research has highlighted including; the need for stronger collaboration between family members and healthcare professionals emphasised by Nosek (2008), carers feeling of powerless and isolation (Daly, 2005) and their struggle with managing competing pressures (McLaughlin et al. 2014).

Additionally, this empowerment model can be tailored easily to suit the individual needs of family caregivers (Grant, Ballard & Olsen-Madden, 2015). However, it assumes that family members and their suicidal loved ones want them to be involved in their care and that the loved one is engaging with professional support. Therefore, it may not be applicable to all family members of suicidal loved one such as those in Owens *et al.*'s (2011) study whose suicidal loved one's did not engage with mental health services prior to their suicide. Furthermore, Grant Ballard and Olsen-Madden (2015) make their recommendations about the COPE model based on a review that does not appear to be systematic. Therefore, although they make a strong case for the application of the COPE model to carers of suicidal loved ones, a systematic review of the literature is necessary to identify all issues and challenges faced by family carers. In conclusion, this model identifies and appears to address a number of issues faced by carers of suicidal loved ones, however, further research is required in order for it to be considered effective in decreasing caregiver burnout for carers of suicidal loved ones.

It is evident that each of the discussed theoretical perspectives on family members caring for a suicidal loved one requires further research to assess their analytic

generalizability. However, it is important to note that two of these theories were developed from individual qualitative studies and therefore do not set out to find nomothetic or generalizable truths. Instead, they aim to reveal interpretative or conceptual possibilities about the experience of family members caring for suicidal loved ones (Cutcliffe *et al.* 2006). In the case of Sun and Long's (2008) theory, to guide family members through their journey as carers and to decrease levels of burnout. As a result, they are relevant to and can inform the present study as they give insight into the process that the family carer experiences. Subsequently, they reinforce some key points that were highlighted in the extant research which are central to the experiences of caring for a suicidal loved one. For example, they reinforce how the cacophony of negative emotions or emotional sequelae (Sun *et al.*, 2008) which family members experience, can give rise to caregiver burden (Grant, Ballard & Olsen-Madden, 2015), how family members are often excluded from treatment planning (Nosek, 2008 and Grant, Ballard & Olsen-Madden 2015).

Furthermore, these theories emphasise family members' lack of confidence, knowledge and support in how to identify triggers and signs of suicidal behaviour and how to respond effectively to these (Nosek, 2008; Owens *et al.* 2011; Sun & Long, 2008). The theoretical perspectives emphasise family members' need for psychoeducation around suicidal behaviour (Sun & Long. 2008; Byrne *et al.* 2008; Sun *et al.* 2008) and their experiences of the stigma associated with suicide. Therefore, it is felt that despite the absence of an overarching theory of caring for a suicidal loved one, the emerging theories from Nosek (2008) and Sun and Long's (2008) grounded theory studies and Grant, Ballard and Olsen-Madden's (2015) research can inform the present study by highlighting key issues within the caring

experience and subsequently because they make some tentative recommendations on how these challenges can potentially be addressed.

2.4.1 Rationale for Present Study

The studies and theories evaluated in this literature review highlight the lack of research on the psychosocial impact that a loved one's suicidal behaviour has on family members. This is surprising given that over 6,122 suicides occurred throughout the UK in 2014 (Office for National Statistics, 2015), the devastating impact that suicidal behaviour has on families (Sugrue, Gilloway & Keegan, 2014) and the increased suicide risk that family members are at due to exposure to their loved one's suicidal behaviour (Cerel, Roberts & Nilsen, 2005).

In agreement with Champlin (2009) and Nosek (2008), the researcher feels that as community care is becoming a more popular option for people with mental illness there is a stronger responsibility placed on family members to ensure that their loved one can live successfully in the community (Champlin, 2009). Robust evidence exists suggesting that a previous suicide attempt is the strongest predictor of a completed suicide (WHO, 2014). The implications of this are serious for familial caregivers who are frequently required to adopt a preventative and caring role in the aftermath of their loved one's suicide attempt (McLaughlin *et al.*, 2014). This experience is particularly challenging for family carers when one considers the vigilance required in recognising signs and preventing future suicide attempts (Nosek, 2008; Buus *et al.*, 2014; McLaughlin *et al.*, 2014) and the fact that carers are also juggling other demands of everyday life such as working and raising families (McLaughlin *et al.*, 2014; Owens *et al.*, 2011). Furthermore, an additional challenge to the role of caring and safeguarding the loved one is the risk that intervention can

pose to their relationship with their loved one (Owens *et al.*, 2011). This was observed in Sun *et al.*'s (2008) study which showed the anger and resentment suicidal ex-patients felt toward their family carers due to their decision to hospitalise them.

All of the above studies and theoretical perspectives found that family members felt alone, isolated and were highly aware of the stigma associated with their family members' suicidal behaviour. It is concerning that this was observed in Daly's (2005) research ten years ago and is still felt, in the US and the British Isles in recent years (Champlin, 2009; McLaughlin *et al.* 2014). Despite the prevalence of attempted suicide in the British Isles, very few studies exist investigating the impact that a loved one's suicide attempt has on family members. The results from the discussed studies inform the proposed study. However, it is worth noting that these studies were conducted in Taiwan, Denmark, Canada and the US where cultural or social norms and healthcare systems are structured very differently. For example, in Sun *et al.*'s (2008) study, carers engaged in folk therapies such as fortune tellers for support with managing their loved one at home. This is unlikely to be observed in UK carers' experiences as folk therapies are not a common part of UK culture. Therefore, Owens *et al.* (2011) and McLaughlin *et al.*'s (2014) studies may provide more culturally comparable results to the proposed study.

Subsequently, it is acknowledged that the few studies exploring family members' experiences of caring for a suicidal loved one do not employ an IPA methodology. Given the subjective nature of a family member's relationship with their loved one and the unique causes of why someone attempts suicide, it is felt that an IPA study would allow the researcher to gain a rich and in-depth account of each individual's idiographic experience of caring for a suicidal loved one. Additionally, Buus *et al.*

(2014) felt that in their study, loose ends were not explored and open-ended issues remained unexplored due to the focus group design. Semi-structured interviews proposed in this study would allow the researcher to follow up on these issues.

Furthermore, of the eleven studies reviewed above, only Sun *et al.* (2008), Sun *et al.* (2009), Daly (2005), Nosek (2008) and Buus *et al.* (2014) explored the experiences of family members caring for a suicidal loved one with a non-bereaved sample. Very little research has been conducted to understand non-bereaved family members' experiences of their loved one's acute suicidal phase. The studies that do explore this have found that family members felt overlooked by healthcare professionals (McLaughlin *et al.*, 2014), identified a great lack of support and isolation (Byrne *et al.*, 2008) and felt no one could understand their struggle (Daly, 2005, and Buus *et al.*, 2014). Furthermore, it appears that this group do not have the same range of supports available to them as family members who are bereaved by suicide. The proposed study aims to firstly to gain an understanding of loved ones' experiences of living with a suicidal individual. Additionally, it aims to gain insight into their perceived support needs with a view to informing practitioners on appropriate supports for family members and carers.

Finally, although the above research can inform the present study, very few studies explored how loved ones cope with living with a suicidal individual and managing other competing pressures such as raising other children, functioning in work and maintaining relationships with other family members. This is surprising given the difficulties that participants in the above studies reported in these areas. It is surprising also that these areas have not been researched considering that unemployment, relationship breakdown and isolation are often cited as contributory factors for suicide in addition to exposure to a loved one's suicidal behaviour. The

impact that a loved one's suicidal behaviour has on the relationship between the suicidal person and their familial carer is also under researched despite the responsibility that is often placed on family members to care for and safeguard their loved one and Sun *et al.*'s (2008) findings that the quality of the relationship can impact the level of care provided. Given the range of emotions that family members experienced toward their suicidal loved ones in the above studies and how this can give rise to burnout (Grant Ballard, & Olsen-Madden, 2015), it is felt that exploring the relationships between the carer and the suicidal loved one, how this changes over time and what factors affect it, is worthy of investigation as it is currently poorly understood.

2.5 Research Question

Based on the gaps in the extant literature and the primary researchers interests the following research question was developed;

“What are family members' experiences of living with a loved one who is suicidal?”

As this was an exploratory qualitative study employing an Interpretative Phenomenological Analysis approach, no formal directional hypotheses was made. The research question was therefore framed broadly and openly to allow the researcher to gain an in-depth understanding of participants' experiences of living with a loved one who is or has been actively suicidal. However, the researcher was particularly interested in how living with a suicidal loved one impacts on the dynamics and relationships between other family members, the impact of the loved one's suicidal behaviour on family members' identities, the support needs of the family members and what supports they believe would be helpful.

2.6 Aims and Objectives of Present Study

The overall aim of this research was to explore people's experiences of living with a family member who has attempted but not completed suicide. Using a qualitative approach, the study aimed to gain an in-depth understanding and insight into the "lived experience" of suicidality from a loved one's perspective.

The main objectives of this research are:

- To gain a rich and detailed understanding of loved ones' lived experiences of living with a loved one who is suicidal.
- To explore the psychosocial impact of living with a loved one who is suicidal.
- To draw conclusions from the research which may highlight some tentative implications on the support needs of those living with suicidal family members in Scotland.

Chapter 3 - Methodology

3.1 Introduction

As the primary aim of this research was to explore loved ones' lived experiences of living with a suicidal individual, a qualitative methodology was deemed to be the most appropriate. This chapter gives an overview of the main research paradigms adopted in social research, the rationale for choosing the present study's paradigm and the theoretical and practical reasons for employing a qualitative research design. The rationale for choosing Interpretative Phenomenological Analysis for the present study is discussed and a systematic account of the sampling strategy is provided. Participant recruitment methods are summarised and methods of data collection and analysis are outlined. Ethical issues which were taken into consideration when designing and executing the present study are subsequently discussed.

3.2 Research Paradigms:

A paradigm is an understanding of reality which is accepted by scientific community or the way in which reality is understood through research (Clarke, 1998). Madill and Gough (2008) acknowledge that paradigms can be defined as scientific worldviews or as epistemological stances which involve assumptions being made about realities and theories of what is classed as knowledge. They can also be defined as beliefs shared by small research communities (Madill & Gough, 2008). These definitions are not mutually exclusive.

A wide range of research paradigms or theoretical perspectives exist within the social sciences. Guba and Lincoln (1994) identify four main research paradigms of inquiry: Positivism; Postpositivism; Critical Theory; and Constructivism.

Positivism is rooted in the principals of empiricism, objectivism, observations, and control (Guba 1990) and is concerned with establishing causality between variables (Gray, 2004). Positivism assumes that there is a simple and bias-free relationship between the world and our perception of the world (Langdrige, 2004). The researcher is therefore assumed to be external or separate to the directly observable and measurable, sensory data being studied (Gray, 2004). This paradigm aims to find objective, impartial and unbiased knowledge about a phenomenon (Langdrige, 2004). Postpositivism is equally concerned with prediction and control but accepts that humans' perceptions of reality are not free from biases, values and beliefs. Therefore, the researcher's interpretation of reality is accepted and controlled for by subjecting every inquiry to peer judgement in the academic community (Guba & Lincoln, 1994). Both positivism and post-positivism tend to rely on quantitative methodologies and are routed in epistemological stances of objectivism and empiricism (Gray, 2004). In contrast, Critical Theory argues that reality is shaped by social, political and cultural forces which develop into structures that are deemed by people, including, researchers, to be natural or real (Guba, 1990). This paradigm accepts that the known is intertwined with the interaction between the researcher and the object or experience; therefore, researchers cannot be separated from the phenomena that they inquire into.

The present study adopted the social constructivist or interpretivist, paradigm (Gray, 2004). This paradigm assumes that people's various realities and experiences are socially constructed through interactions with the social world (Gray, 2004). Constructivism aims to understand subjective, lived experiences as they occur within various contexts (Ormston *et al.* 2014). Knowledge and

understandings are assumed to be contingent on social and historical factors and can therefore take multiple forms and can be altered over time (Ormston *et al.*, 2014). Their form and content is shaped by the individuals or groups which construct them (Guba & Lincoln, 1994).

Rejecting the argument that social realities can be understood by the same methods as natural realities, this paradigm contests the concept that the researcher is separate from the phenomena being researched (Gray, 2004). In contrast to positivism, it proposes that researchers also construct meanings and interpretations based on participants' meanings and interpretations (Ormston *et al.*, 2014). Consequently, the researcher's own understandings and views of the concept being explored are significant (Ormston *et al.*, 2014) and they are acknowledged to impact the research process (Langdrige, 2004).

In terms of ontology, constructivism argues that reality is *relative*. Within constructivism, ontology and epistemology are not differentiated between as the inquirer and the object of inquiry are interactively linked to the point where the results of the study are created through the process of investigation (Guba & Lincoln, 1994). As this paradigm is concerned with individuals' subjective experiences and understandings, it favours the qualitative approach. Interpretivist and dialectical methodologies facilitate interpretation and existential understanding by eliciting and refining the variable and personal, social constructions of knowledge through an examination of the interaction between and among the researcher and participants (Guba & Lincoln, 1994).

The rationale for adopting the interpretivist paradigm for the present study was based on a number of considerations. First, this paradigm facilitates the

construction of reality, based on the interaction between the participants' and the researcher's values and the researcher's and participants' interpretations of the data. Subsequently, the constructivist perspective accepts that people construct their own meanings even in regards to the same phenomenon (Gray, 2004) and that these meanings can evolve over time. The present study is interested in exploring the commonalities between loved ones' experiences of living with a suicidal individual. Furthermore, the present study is an explorative study, therefore a paradigm which takes into account the ever-changing and problematic nature of reality was deemed to be necessary. Finally, the constructivist paradigm allows a more sophisticated and accurate measure of multiple realities than positivism or postpositivism provides (Guba, 1990).

3.3 Research Design – Qualitative Research

In relation to Kuhn's (1962) argument, which states that paradigms are different rationales underpinning research procedures, the theoretical underpinnings of the constructivist paradigm rely upon a qualitative research design. According to Wilmot, 2005, p.23):

“Qualitative research aims to provide an in-depth understanding of the world as seen through the eyes of the people being studied. It aims not to impose preordained concepts; hypotheses and theory are generated during the course of conducting the research as the meaning emerges from the data.”

In line with Wilmot (2005), Mason (2002) acknowledges that qualitative research allows us to explore a variety of dimensions of the social world; the understandings, experiences and imaginings of our research participants, the

way in which social processes, relationships and institutions function and the meanings that they generate.

Psychology has experienced a long-lasting debate over which research design is more suitable, qualitative or quantitative research. Although both designs have advantages and disadvantages, the decision about which design is more appropriate for a study should be made based on the research question. The differences between these two approaches are outlined below:

Table 4 Differences between qualitative and quantitative research designs.

Adapted from Langdridge (2004)

Qualitative Research	Quantitative Research
Focuses on meaning or text of a phenomenon	Focuses on the quantity or measurement of a phenomenon
Inductive method adopted to formulate theory	Hypothetic-deductive method adopted to test pre-existing theory or constructs
Recognises subjective nature of participants	Oversimplifies the complexity and subjectivity of human nature
Data collection methods: focus groups, in-depth, unstructured or semi-structured interviews, participant observation	Data collection methods: experiments, structured interviewing, structured observation and questionnaires with fixed response options
Analysis is primarily concerned with analysis of text	Analysis employs statistical tests
Smaller samples used to gain in depth information	Larger samples used to gain breadth of information
Reliability and validity is based on the skills of the researcher	Reliability and validity is based on the measurement device used
Focus is on subjective	Focus is on objective
Aims to inform existing theory	Aims to make claims about analytic generalisability
Requires justification as it is still not widely accepted in psychological research	Dominant approach in psychology

As the primary aim of this study was to explore the lived experiences of loved ones living with a suicidal individual, the present study adopted a qualitative

design. This design was deemed to be most appropriate as the present study was concerned with the quality and the essence of loved ones' experiences of living with a suicidal individual. Subsequently, the qualitative design accepts that the researcher helps to create the knowledge, meaning and reality that he/she is investigating. This design facilitates the exploratory nature of the research aim as it is based on a bottom up or inductive process whereby the researcher builds concepts, abstracts and theories as the data is being collected (Thomas, 2003).

Subsequent advantages of the qualitative design are that it accounts for the subjective experience of participants, facilitates the inclusion of unexpected insights or contributions by participants and enables the researcher to gain an insight into the world of the participants (Langdrige, 2004). In conclusion, the qualitative design is the most suitable research design for this exploratory research question which focuses on meaning, understanding and insight into lived experiences of loved ones living with for a suicidal individual.

In terms of qualitative approaches, the present study considered a number of approaches including interpretative phenomenological analysis, grounded theory and thematic analysis. The decision on what approach to employ was based on the best fit with the research question and the aims of the present study. First, it was felt that due to this topic being under-researched and poorly understood, an inductive approach was required to acquire depth of information on participants' perspectives. Additionally, as suicide attempts are complex and unique and loved ones' relationships with their suicidal family member are also complex and unique, an idiographic approach was needed. Subsequently, as the aim of this study was to generate a rich insight into loved ones' idiographic

experiences rather than to develop theory, grounded theory was deemed to be an inappropriate approach. Furthermore, due to the lack of epistemological background to thematic analysis, it was felt that this approach would not provide the richness and depth of insight or the rigour of analysis that this study required. Finally, it was felt that Interpretative Phenomenological Analysis could add more to the research base by exploring the idiographic experience of loved ones, gaining a rich insight from participants themselves and linking cognition and language to explore how participants make sense of this experience.

3.4 Methodology - Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) provides the methodology for this study. IPA is an experiential qualitative research approach which is a suitable phenomenological method when understandings of a particular concept are complex, poorly understood, or previously unexplored. Originally introduced by Jonathan Smith in 1996, IPA aims to explore participants' experiences of their social and personal world, how they make sense of these experiences and the meanings that they attach to these experiences (Smith, 2004). IPA is derived from three key theoretical perspectives: phenomenology, interpretation (or hermeneutics) and ideography. In terms of its phenomenological origins, IPA is concerned with the individual's "lived experience". It views participants as experts in their own lives and therefore involves a detailed, in-depth exploration of a participant's perceptions, experiences and views of a phenomenon (Smith & Osborn, 2007).

The interpretative focus of IPA assumes that the lived experience of a person is experienced in a distinct and individual way while also existing in a shared context (Smith, Flowers & Larkin, 2009). Heidegger's work which integrates phenomenology

and theories of hermeneutics, is central to the IPA methodology. Accepting that human experience exists within a world of people, relationships, language and culture (Smith, Flowers & Larkin, 2009), Heidegger argues that a researcher or participant cannot truly detach themselves from these factors to explore the truth about lived experience (Larkin, Watts & Clifton, 2006). The beginning of enquiry therefore starts with the researcher's perspective, from the basis of their experience (Smith, Flowers & Larkin, 2009). A dyadic interpretative process or double hermeneutic develops with the researcher actively contributing to the exploration of the participants' experience. This involves the participant striving to make sense of their experience while the researcher attempts to make sense of the participant making sense of their reality or experience (Smith & Osborn 2007). The researcher's own conceptions are necessary in exploring this meaning-making process. Consequently, IPA researchers attempt to identify their preconceptions about a phenomenon prior to data collection and accept that awareness of these preconceptions may not emerge until data collection and analysis, when the phenomena have begun to emerge (Smith, Flowers & Larkin, 2009).

In terms of the idiographic focus, IPA is interested in how each individual participant makes sense of their distinct experience of a given phenomenon within a particular context (Smith, Flowers & Larkin, 2009). The IPA researcher aims to find out as much as possible about one person's experience before analysing the next participant's experience. A loved one's experience of living with a suicidal individual is a complex, subjective experience and each person's relationship with their loved one is unique. Furthermore, an individual's suicidal behaviour is likely to hold various meanings to each of the individual's loved ones. Therefore, it is felt that IPA methodology is ideally suited to the present study as it takes into account the

idiographic and unique characteristics of each participant and the context that their experience takes place within. Furthermore, it is likely that a loved one's experience of living with a suicidal loved one is not interpreted in isolation but within the context of their own views, their relationship with the suicidal individual and their identity as a mother/spouse/brother as observed in Daly's (2005) study.

Finally, within IPA, the researcher is required to be open, empathetic and reflective. He/she must strive to set aside their scientific or theoretical assumptions, preconceptions, knowledge and beliefs in order to gain a truly reflective exploration. IPA research therefore urges researchers to adopt a "sensitive and responsive" approach to data collection and analysis which allows the researcher's prior knowledge of the phenomena to be adjusted and shaped by the data (Larkin, Watts & Clifton, 2006, p.108). As the topic of investigation for the present study was likely to be emotive for participants, it was felt that the empathic and open manner that the IPA methodology requires the researcher to adopt was highly appropriate for this study. Similarly, it was felt that the reflective, sensitive and responsive approach to data collection is very suitable for this study as it urges the researcher to distance themselves from preconceptions and knowledge about the phenomena, namely how loved ones cope with living with a suicidal loved one. As a number of the aforementioned studies in the literature review outline, suicidal behaviour is still highly stigmatised. Therefore, it was thought that participants would be more amenable to discussing their own experiences of their loved one's suicidal behaviour with a researcher who is open, non-directive, empathetic and reflective. The primary researcher who collected the data is a trained and experienced cognitive behaviour therapist. As a result, she is experienced in using techniques such as active listening, reflecting and paraphrasing and discussing emotive topics in a sensitive,

non-judgemental and empathetic manner. This was advantageous for the present study as the researcher was able to put participants at ease quickly, to probe for further information diplomatically and to show empathy and warmth towards the participant which was mutually beneficial for the participants and the researcher.

3.5 Sampling Strategy

According to Smith, Flowers and Larkin (2009), purposive sampling is theoretically consistent with IPA. The present study therefore employed a purposive sampling strategy. Purposive sampling is a form of non-probability or “criterion- based” sampling (Ritchie *et al.*, 2014). This means that participants are selected to be part of the sample because they have particular characteristics which allow for an in-depth exploration into the phenomena that the researcher wants to investigate and understand (Bryman, 2012). The characteristics or criteria that individuals must possess in order to be included in the sample are therefore based on the study’s research question (Ritchie, Lewis, Elam, Tennant, & Rahim, 2014) which is informed a priori by an existing body of social research (Curtis *et al.* 2000). Consequently, the aim of the chosen sampling strategy was not to generalise the results to a wider population but to inform wider theory by assessing how the experiences of this study’s sample map onto theories and findings of previous studies which attempted to generalise their findings.

3.5.1 Inclusion and Exclusion Criteria

The methodology for the present study, IPA, required a homogenous sample (Smith, Flowers & Larkin, 2009). In order for participants to be included in the present study they 1) must have experienced living with an immediate family member or spouse who has made a suicidal attempt(s) without actually completing suicide. This

included spouses, parents, adult children, siblings and partners of a loved one who attempted suicide. For ethical reasons participants: 2) must be 18 years of age or older; 3) must be able to read and speak English fluently and 4) be willing to take part in a 1-hour interview as part of the study.

Exclusion criteria included family members, partners or spouses who experienced living with a loved one who completed suicide. It was felt that the experience of being bereaved by suicide and being aware of the outcome of their loved one's suicidal behaviour would heavily influence participants' retrospective narratives of the acute phase when the loved one was actively suicidal. Similarly, loved ones of individuals who engage in deliberate self-harm (DSH) that did not include suicidal intent or was not life-threatening were not included in this study. As previously discussed, DSH does not necessarily involve suicidal intent (Suyemoto, 1998) and in some cases can even prevent suicidal ideation (Himber, 1994). As a result of this, family members of loved ones who engage in DSH that is not life threatening or does not involve expressed suicidal intent have been excluded as it is unclear whether their DSH attempts could be categorised as suicidal behaviour or not.

Extended family members who have or were currently experiencing a loved one's suicide attempts including cousins, aunts, uncles and grandparents were excluded from this unless they are/were living with the suicidal loved one while they were suicidal. Extended family members who were not living with the suicidal loved one are excluded as IPA requires a homogenous sample. Therefore, it is important that participants have the shared experience of living with their loved one while they were/ are suicidal.

3.5.2 Sample

As this study adopted an IPA approach, it was highly committed to providing detailed interpretative accounts for each participant. Therefore, breadth of data was sacrificed for depth. Smith, Flowers and Larkin (2009) advise that a sample which is “too large” may overwhelm an IPA researcher due to the amount of data that is generated and is therefore more problematic than a sample which is “too small”. Smith, Flowers and Larkin (2009) therefore recommend a sample size of 3-6 participants for a master’s level study. As primary researcher was experienced in IPA research and wished to complete two pilot interviews prior to data collection, a sample size of five participants was proposed for the present study.

Demographic information about each participant and details of their loved one’s suicide attempts is presented to contextualise the lived experiences of the sample in Table 5 (overleaf).

Table 5 Participant Demographics and information on loved ones' suicide attempts (SAs)

Participant Pseudonym	Gender	Age	Ethnicity	Marital Status	Religion	Relationship to Suicidal Individual	Participant Accessing Support Services During SAs	Loved One's Age During SAs	No. of SAs made	Nature of SAs	Estimate of Last SA	Accessing Support Services During SAs
Tom	Male	35	White Scottish	Single	Atheist	Son	Inpatient and outpatient MH services 10 years later.	40-52	10+	SA by gas in family home	16 years	No
Tim	Male	29	White Irish	Single	Atheist	Brother (Older)	No	17-18	2	Overdose of painkillers	4 years	Yes. GP and counsellor.
Callum	Male	19	White Scottish	Living with Partner	Atheist	Partner	No	17-22	2	Overdose of painkillers	2 weeks prior to interview	A&E immediately after attempt
Claire	Female	44	White Irish	Living with partner	Roman Catholic (lapsed)	Ex-partner	No	37	1-5	Severe cutting on chest and abdomen	Estimates 5 years,	No
Kyle	Male	30	White Scottish	Single	No religion	Brother (Older)	No	15-16	1	Overdose of painkillers	6 years	A&E immediately after attempt. Attended NHS counsellor once.

3.6 Recruitment

On receipt of ethical approval from Edinburgh Napier University's Ethics Committee (Appendix 7), participants were recruited via an advert placed on Gumtree.com. They were asked to contact the researcher via Gumtree mail with their contact details and the researcher subsequently contacted them by phone to arrange an interview. The entire sample was recruited via this Gumtree advert.

3.7 Procedure

11 mental health charities were contacted and informed of the research. Provisional support for recruitment was obtained from; Scottish Recovery Network, Lothian Bipolar Society, Edinburgh Carers Council, Voices of Carers Across the Lothians, Penumbra Self-harm Project and Community Renewal. Once ethical approval was obtained, the researcher emailed these services with an advert which provided an overview of the study, eligibility criteria and the researcher's contact details. This was disseminated to services users through mailing lists, websites and noticeboards within the services' premises. The advert asked service users to contact the researcher to express their willingness to participate or if they had any questions about the research. However, no participants were recruited by this method.

3.8 Data Collection

The most appropriate way to collect data for an IPA study is through the use of semi-structured interviews (Smith & Osborn, 2007) as they tend to produce richer data than other qualitative methods. Consequently, data for the present study was collected using semi-structured interviews. Semi-structured interviews involve the compilation of a list of pre-prepared questions prior to the commencement of the interviews. An advantage to this method is that it allows the researcher to elicit in-

depth information on relevant topics while also keeping the interview as close to normal, comfortable conversation as possible. This method of data collection therefore allows the researcher and participant to begin a dialogue and permits the researcher to guide the content of the interview through the use of open-ended questions and prompts (Smith & Osborn, 2007). The structure of the interview is not overly rigid and open-ended questions are used to guide rather than dictate the content of the interview (Smith & Osborn, 2007). Participants are given the opportunity to give in-depth accounts of their lived experiences and the space to determine how their interview progresses. A further advantage of semi-structured interviews is that they facilitate the collection of unanticipated data by affording the participant the flexibility and space to share unexpected but relevant data with the researcher. Often it is the unexpected or unanticipated which is more interesting to the researcher (Mayoux, 2005).

As semi-structured interviews allow the researcher to facilitate a rapport and show empathy (Smith & Osborn, 2007), this was the most appropriate data collection method for the present study given the understudied, personal and sensitive research topic (Mason, 2002) and the perceived stigma attached to suicidality as reported in the aforementioned studies in the literature review.

Four participant interviews were conducted in a face to face capacity in meeting rooms at Edinburgh Napier University. One interview was completed over the phone. Descriptive information was obtained from participants in order to contextualise participants' experiences. With participants' permission, semi-structured interviews were audio recorded and transcribed by the primary researcher. The data were anonymised by assigning pseudonyms to participants and their loved ones.

3.8.1 Interview Schedule

An interview schedule (Appendix 6) was created prior to data collection which included open-ended, non-leading questions and prompts for questions that may have been difficult for participants to answer. This was developed to guide the researcher within the interviews. However, in line with IPA, the interview schedule was not followed in a strict or rigid way by the researcher. Instead it aimed to begin a dialogue with the participant. The interview schedule was structured into a list of seventeen open-ended questions which covered a range of broad topics. The sequencing of questions involved the researcher beginning with the least sensitive topics first and progressing to more sensitive questions towards the end when the researcher was likely to have built a rapport with each participant. These broad topics included:

- Overall experiences of living with a suicidal loved one
- Participants thoughts and feelings in response to the suicide attempt(s)
- The impact they had on participants' wellbeing, sense of self, self-confidence and their identity.
- The main challenges participants faced and their support needs during most challenging times.

The researcher used a process of reflecting and paraphrasing back to the participant to probe and encourage them to tell their own story in their own words "You mentioned earlier there that..." or "Can you tell me more about that?".

As the topic of investigation in the present study is sensitive and was likely be emotive for the participants, the interview schedule was prepared to allow the researcher to identify appropriate wording of questions to decrease the chance of

upsetting any participants and to loosely determine the manner in which the interviews would proceed. As recommended by Smith and Osborn (2007), the researcher familiarised themselves with the interview schedule prior to conducting the interviews so that the participant would have the researcher's undivided attention during the interview and that the focus of the interviewer was on the content of what the participant was saying.

3.8.2 Pilot Interviews

Two interviews were conducted, transcribed and analysed before completing the remaining interviews. The data were shared with the supervisory research team to provide feedback on the interview schedule and the resultant interview technique. The content and structure of the interview schedule were deemed to be satisfactory by the supervisory team and consequently no revisions were made to the interview schedule. However, suggestions were made regarding the researcher's interview style and technique. Suggested amendments included increasing the use of paraphrasing and reflecting back to participants in order to prompt them to expand on certain topics. It was also advised that the researcher ensure that questions were stated clearly and one at a time.

In conducting pilot interviews, the researcher aimed to develop and assess the adequacy of the data collection and analysis methods and to discover any potential problems with these. Furthermore, the pilot interviews provided an opportunity for the researcher to gain constructive feedback on interview technique and to build confidence as an interviewer. Finally, it was felt that by conducting two pilot interviews, the researcher would be familiarised in the research process and could incorporate this preliminary data into the full study.

3.9 Data Analysis

The present study employed IPA as the method of data analysis in line with Smith and Osborn's (2007) recommendations. IPA views data analysis as a two-stage process whereby the participant makes sense of their reality while the researcher makes sense of the participant making sense of their reality. IPA aims to explore in detail an area of interest or concern rather than make general claims and as a result, it emphasises theoretical rather than empirical generalizability (Smith & Osborn, 2007). This method of data analysis was deemed to be the most suitable as it complemented the study's exploratory aim, the use of semi-structured interviews and a purposive sampling strategy.

Each interview was fully transcribed verbatim at a semantic level including pauses, emotional responses, (e.g., laughter, tears and similar features). Data were analysed by following the steps outlined by Smith, Flowers and Larkin (2009) which include reading and rereading the interview transcripts, taking initial notes, developing emergent themes, moving to the next case and then looking for patterns across cases.

Each transcript was reread several times in order for the researcher to be fully immersed in the data. Throughout the transcribed text, comments such as summaries, associations and preliminary interpretations were written in the left hand margin of each transcript (please see Appendix 9). On rereading the transcript, emerging themes were inserted on the right hand margin. An initial list of themes within each transcript was compiled and similar themes were clustered. As these themes were clustered the transcripts were repeatedly referred to, to ensure that the clusters were relevant to the primary source material. A table of themes in which

each cluster or theme was named and recognised as a superordinate theme was created for each participant's transcript. The superordinate themes and subthemes were the result of the interaction between the researcher's interpretation of the interviewee's experiences and the interviewees personal experiences described in their own words (Eatough, Smith & Shaw, 2008).

Finally, a coding matrix outlining the key themes for the group of participants was created, including common themes found within each transcript and individual themes that were found in particular transcripts. A data extract verifying each of the themes and subthemes is given along with pseudonym of each interviewee. This is provided in Appendix 10 to ensure that if necessary, an external researcher can follow the present researcher's analysis of the raw data to the end result. Furthermore, a sample of transcripts (n=2) was also independently coded by a members of the supervisory team with expertise in IPA. Two members of the supervisory team also provided credibility checks on all of the codes that the primary researcher's coding.

3.10 Ethical Considerations

The wellbeing of each participant was considered to be of highest priority throughout the research process. Ethical issues were continuously considered and the necessary precautions were followed to decrease the chances of any ethical matters arising. The following precautions were taken.

Participants were made aware that participation was voluntary. Each participant was given an information leaflet (Appendix 1) stating the title and aim of the study and an outline of what participation would involve. Contact details for the primary researcher, academic supervisor and an independent supervisor were included on

the information leaflet. Participants were given up to 24 hours to decide if they would like to take part in the study. The primary researcher then contacted participants by phone to arrange an interview.

Verbal and written consent was obtained from all participants. A consent form (Appendix 2) stating that participation could be withdrawn at any time and that participants may pause the interview at any time, was signed by each participant. Participants were informed and consented to their interviews being recorded and transcribed verbatim.

Participants were debriefed after the interview to investigate how they found the process. They were given a debriefing document (Appendix 3) which provided contact details for the Samaritans Helpline, Breathing Space Helpline and NHS 24 in case any of them were distressed by discussing this sensitive topic.

Only the primary researcher had access to the audio recordings of the participants' interviews. The anonymised transcripts were shared with the supervisory team. Hard copies of transcripts were kept in a locked filing cabinet which only the primary researcher had access to. Soft copies of recordings and transcripts were stored on a USB stick which only the researcher had access to. All files were password protected.

Finally, following each participant interview, the primary researcher had a debrief meeting with a member of the supervisory research team either in a face to face capacity or over the phone, to discuss how they found the process. If the researcher was upset by the interview content she agreed with the supervisory team that she would access the student counselling service at Edinburgh Napier University.

3.11 Credibility

Establishing credibility is paramount to enhancing rigour and trustworthiness of qualitative research. A set of evolving guidelines for qualitative research in psychology and the social sciences was developed by Elliot, Fisher and Rennie (1999), and are outlined in Table 5 (overleaf).

Table 6 Guidelines for high quality qualitative research

Guidelines for Qualitative Research (Elliot, Fischer & Rennie, 1999)	Explanation of Guidelines
1. Owning one's own perspective	The researcher acknowledges their theoretical position and their personal understanding of the phenomenon including their values and assumptions and how these influence their understanding of the phenomenon.
2. Situating the sample	The researcher offers relevant descriptive data for each participant to inform the reader of the sample's relevant characteristics and to provide the context to participants' data.
3. Grounding in examples	Examples of data are given to demonstrate the analytical process employed and to allow the reader to assess the fit between the data and the researcher's understanding of it.
4. Providing credibility checks	Credibility checks such as checking the themes with participants or using multiple qualitative coders, are used to ensure the credibility of the researcher's themes or categories.
5. Coherence	The understanding of a phenomenon is depicted in a framework that offers coherence and

	integration and also maintains the nuances in the data.
6. Accomplishing general versus specific research tasks	When a general understanding of a phenomenon is proposed, it is based on a suitable number of informants or situations. When a specific understanding of a subject matter is intended it is systematically and comprehensively described to allow the reader to achieve an understanding of it. In both cases limitations to the generalizability of results are outlined.
7. Resonating with readers	Results are presented in a manner which resonates with the reader. Readers view the material as being an accurate depiction of the phenomenon and their understanding or appreciation of the subject matter or experience is increased.

Elliot, Fisher and Rennie's (1999) guidelines aim to legitimise qualitative research by developing these explicit methodological guidelines, to control quality control issues within qualitative research and to act as a reference point for future developments and variations in qualitative approaches and methods. Furthermore, acknowledging that qualitative research is often evaluated using standards of quantitative research standards, Elliot, Fisher and Rennie's (1999) (1999, p. 218) "integrated, itemized and evaluative guidelines" provide a more valid evaluation of qualitative research. An outline of how the present study meets Elliot, Fisher and Rennie (1999) guidelines is summarised in Chapter 5. In line with the "Owning one's own perspective" guideline the researcher presents her position and personal understanding of the subject matter below.

3.12 Reflexivity

As this research is exploratory, it does not take a strong theoretical position. Instead, it aims to increase understandings of the impact that living with a suicidal person has on loved ones. However, the researcher holds personal views on this subject matter which are likely to influence her understanding of the phenomenon.

I have seen first-hand the impact that a loved one's suicidal behaviour has had on the wellbeing of friends and family members in my personal life. I have supported friends and family members through periods of caring for a suicidal loved one and also in the aftermath of a completed suicide. I have witnessed their feelings of isolation, stigma and helplessness. Subsequently, I have worked in mental health roles with adolescents with suicidal behaviours and learned about the various factors that contribute to suicidal thoughts and behaviours. These experiences and the increasing rates of suicide have shaped my passion and interest in this topic. They

have also led me to develop my own personal beliefs, values and attitudes to suicide and the impact suicidal behaviour has on families and loved ones. Therefore, I felt that a research paradigm which acknowledged the impact of my own values and experiences had on the research process was the most appropriate. The advantages of having personal experience with this topic meant that I developed empathy, compassion and knowledge of the challenges faced by loved ones living with a suicidal loved one.

These personal experiences may also be viewed as researcher bias as my preconceived beliefs and values about loved ones' experiences of living with a suicidal individual may influence my interpretation of the data. In order to address this potential bias, I ensured to engage in reflexivity. Reflexivity is defined as the process where a researcher "engages in self-aware meta-analysis" (Finlay, 2002, p.209). Through introspection, I identified my own motivations, values and biases and recognised how these may influence data collection and analysis. Subsequently, I made every attempt to recognise how my values were revised through reflexive engagement with the literature as new understandings and insights emerged.

Furthermore, credibility checks using multiple qualitative coders were used to ensure credibility of the primary researcher's themes. Both the primary researcher and a member of the supervisory team with expertise in IPA, analysed and coded two of interview transcripts separately. Inter-rater reliability was gained through comparing these separate analyses and resulting themes and subsequent negotiation between the two researchers through discussion. Furthermore, the primary researcher and a second member of the supervisory team who is experienced in qualitative research, analysed and interpreted the remaining interview transcripts independently. Again

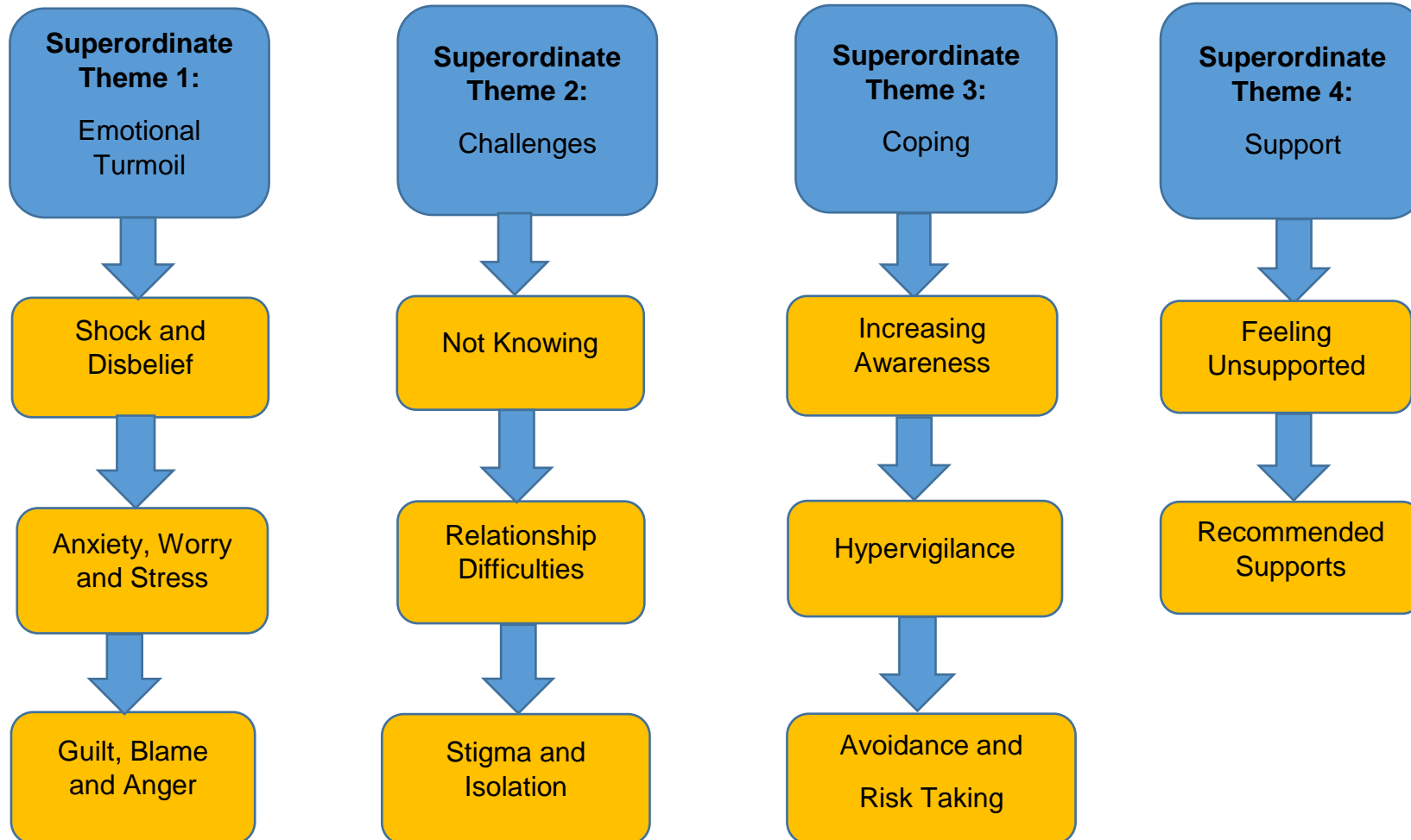
the results of this independent analysis were discussed and negotiated to enhance inter-rater reliability.

Chapter 4 – Results

4.1 Introduction

Narratives of five loved ones of suicidal individuals are presented. This chapter presents four master themes that emerged from the researcher's IPA of the data: 1) Emotional Turmoil; 2) Challenges; 3) Coping Strategies; and 4) Support. These themes and the related subthemes are outlined in Figure 1 (overleaf). Master themes are shown in blue and subthemes are depicted in orange. Each master theme and their related subthemes are described in detail. Quotes or extracts from the interview transcripts are provided to illustrate each theme.

Figure 1: Superordinate Themes (and their related subthemes)



4.2 Results

4.2.1 Emotional Turmoil

We begin at the point of the suicide attempt, a time of shock and extreme crisis. All loved ones reported experiencing a range of negative emotions from the moment they became aware of their loved ones' attempted suicide. The immediate reaction however, was reported to be one of shock and disbelief.

Shock and Disbelief

Tim identified shock as the main emotion he experienced on learning that his younger sister had attempted suicide, both in terms of his emotional and physical reactions. He described the pure unsolicited shock he experienced:

“You can't really describe your reaction it's like (pauses) it was just shock like. And you never really think that something like that is will to happen so close to home it's like, you know what I mean like (pauses). And then (pauses) yeah it ah, it's just, to be honest I probably went through a bit of almost disbelief as well like.. [].... “But it was shock really to be honest, more than anything else but I eh eh I think I just, I think my body actually went into shock.” (Tim)

Here, Tim's description was peppered with a sense of physical trauma. He appeared to grapple with making sense of what happened and seemed suspended in the moment as if everything had stopped. Tom also described the shock he experienced from finding his mother unconscious after she attempted suicide:

“And I was actually (pauses), I thought I was numb, I was getting pins and needles in my hands and up my arms and em it turns out I was breathing kind of fast.” (Tom)

Here, Tom experienced paraesthesia from the trauma and shock of finding his mother unconscious. The idea of being temporarily 'frozen' in time was echoed in other participants' accounts. It was evident across all participants' accounts that a suicide attempt was something that they never thought would happen so close to home, which gave rise to a strong sense of disbelief initially.

Even for Callum, (who was aware his partner had attempted suicide in the past), there was an ongoing sense of disbelief that his partner would not make a subsequent suicide attempt:

“...until the second suicide attempt there was still a but he wouldn't actually do it or he wouldn't go that far. I just hadn't been in that situation so in the back of my head I was like well it's probably not going to happen hopefully you know” (Callum)

Here we ponder if Callum was perhaps telling himself this because the threat of his partner making a subsequent suicide attempt is too difficult to deal with. Callum attributed his partner's previous attempt to social isolation and exam stress while he was at university. Callum perhaps believed that as his partner and he were in a committed relationship, and his partner was no longer socially isolated, a subsequent suicide attempt therefore, was not something that he contemplated.

Claire's account also featured feelings of disbelief. However, unlike Tim and Tom, her feelings of disbelief were not regarding her partner's suicide attempts; instead they seemed to be internalised. Claire's account was expressed at a more intrapersonal level as opposed to the other participants' feelings shock and disbelief which were experienced on a more interpersonal level. Claire was shocked at the impact that her partner's suicide attempts had on her housing situation, her career

and her emotional wellbeing. She described the drastic change in her circumstances over the course of twelve months while her partner was suicidal:

“Em, I you know, I had to go then and look for social welfare and all of that. And it took just, yeah, it just it was, it was really hard. I just found it to be really humiliating and just thinking what have I come to, you know. Em and having gone from being in a really nice house and a good job em, within less than a year, you know, good relationship, thought we were going to get married, have kids and all of that, just to being, basically going in and begging for social welfare and social housing.” (Claire)

Helplessness and a complete loss of control were highlighted here. Claire’s partner’s suicide attempt resulted in major biographical disruption and a loss of anticipated future. Indeed, the stress of living with her suicidal partner spiralled so out of control that eventually Claire ended up with no home and no income. Her plans to marry her partner and start a family were also lost as a result of his suicidal behaviour. She was reflecting back here and struggled to make sense of how her life had become changed to the point where it was unrecognisable.

Anxiety, Worry and Stress

Following the initial shock of their loved one’s suicide attempt, participants turned their attention to assessing risk of future attempts. A range of negative emotions then ensued including; anxiety, persistent worry, panic and stress. Tim, Callum, Kyle and Claire all referred to feelings of extreme worry, stress and panic when they were not in regular contact with their loved one, in close proximity to them or unaware of their whereabouts. Tim explained the persistent worry and anxiety he felt when his sister was not near him in the months following her suicide attempt:

“And yeah when she wasn’t very close to me I worried like fucking mad like you know. Em I was like, even two or three months later after when she was kind of getting back to normal and she wanted to go out again to parties and stuff. The thoughts running through my head were you know yourself, girls can be so bitchy, what if she gets in a fight with someone or in an argument with one of her friends or something like that and you know goes off the fucking deep end again? So yeah I was still worrying about that like.” (Tim)

The lack of control over the situation and helplessness was clear in Tim’s account. He was fearful of the volatility of the situation and the unpredictability of what may trigger a subsequent suicide attempt. It appeared that Tim was constantly living “on edge”. This experience was echoed by Kyle:

“You’re just like constantly on edge all of the time in terms of worrying about it (pauses). Yeah everyone was just petrified it was going to happen again.”
(Kyle)

Constant and persistent worry and fear of a future attempt left participants feeling ossified and, yet again, emotionally paralysed. For most participants (Tom, Kyle, Tim, Claire), this worry and fear was constant and persisted for years following the initial attempt. Kyle elaborates:

“Yeah I mean I wanted to work, like I wanted go abroad and work at the time. It was a path that I was on, looking to go away to work. And yeah I’ve never even contemplated it since. So I’ve had opportunities to go abroad, I’ve had kind of em. That’s always been at the back of my mind, you know I want to be close in case something goes wrong.” (Kyle)

The long term, prolonged and constant worry for his sister's wellbeing and safety had a serious impact on Kyle's life as it caused him to change his future plans to work abroad as he feared that his sister may make a future attempt. Like Claire, Kyle experienced biographical disruption and a loss of anticipated future as a direct result of his sister's suicide attempt.

Claire explained how her partner disappeared for days at a time after threatening suicide. The helplessness that was evident elsewhere reappears here. The following extract highlights her feelings of intense panic and stress at being left with no explanation or no knowledge as to whether her partner was still alive:

“And then em, when, when things got very, very bad, em, you know where he was saying he was going to just crash the car into a wall and, or crash it into the back of a truck. Em, you know he would just say this and then take off in the car and just the sheer panic I suppose, was you know what do I do?”

(Claire)

Constant worry and stress had a serious physical impact on the participant's wellbeing. Participants reported a range of physical consequences of stress including insomnia, weakened immune system functioning, amenorrhea, rapid weight loss and loss of appetite:

“Yeah, yeah, completely I mean I was very, very run down. Like my immune system was never the best anyway but it you know I was just, things like physically, I mean my periods stopped for a number of months. And when I went to that therapy centre the time you know. I saw a nurse there and she was like you're so, so stressed. And yeah just the physical impact of it all, I

lost a lot of weight at the time, yeah it did completely it had an impact on my physical health too.” (Claire)

The psychological impact that the loved ones’ suicide attempts had on participants was far reaching and even included the development of post-traumatic stress disorder in one participant;

“It left me with (pauses and clears voice) I was only diagnosed with a few of years ago, with post-traumatic stress relating back to that one particular episode as well as just the build up to it.” (Tom)

It is clear from these accounts that the ongoing worry and fears of repeated attempts were ever present and could not be ignored. In many cases this ongoing fear was felt constantly for several years after the loved one’s suicide attempt(s). The extreme and ongoing stress of this resulted in participants feeling both physically and emotionally traumatised.

Guilt, Blame and Anger

After the initial shock of the situation had resided, feelings of guilt, blame and anger ensued. The nature of guilt varied across participant’s accounts and it is therefore outlined in a case by case format here. Callum felt guilty about leaving the home as he would not be there to care for his suicidal partner. This resulted in him limiting his socialising outside of their home.

Kyle also experienced feelings of persistent guilt. He explained that he was out enjoying life in his early twenties and was totally unaware of what his sister was going through:

“So I’m having the absolute time of my life and I’m completely kind of sheltered to maybe what my sister’s going through while I’m having an absolute ball.. []... But I wasn’t there at home enough because I was out just being a typical young student”

It is clear that Kyle felt that he and his sister were at two extremes in terms of their lives at this point. For Kyle, he was doing very well, enjoying life as a young adult and was unaware that his sister was in so much difficulty that she felt her only option was to take her own life. Kyle’s guilt had a long-term impact on his relationship with his sister and he explained that he will often do as she asks and avoid confronting her due to his guilt and his fear of her response.

Unlike the other participants, Tom internalised his guilt and attributed personal blame. This is considered to be the result of misunderstanding the cause of his mother’s illness and her resulting suicide attempts.

“For a long time I actually blamed myself for her being ill, for her illnesses which I suppose tarnished it in a way, if that’s the right word..[]..Em and instead of admitting to folk that she had multiple sclerosis she said em that the reason that she was ill was the fact that an epidural went wrong when I was born. And she said this in front of me once when I was about eight or nine and I picked up on it. But when you’re that age an epidural could be something you ate right. Em so for (sighs) seven years I carried that around with me that I caused her illness.” (Tom)

The language Tom used in this quote suggests that he felt he alone was responsible for his mother’s suicide attempts. He “carried” this weight on his shoulder for years and was unable to escape the feeling of self-recrimination. This had a profound and

long-term, detrimental impact on Tom. Indeed, the impact was so profound that it eventually led to him attempting suicide himself years later:

“...at one point I took an overdose myself. I just I’d had, I’d absolutely had enough and that was a, that was a dent in the road. But since then there has been improvement time on time. Yeah that was, I just didn’t like who I had become more or less sorry. And em I didn’t like what had become of me. I thought I was going, I thought I had just had enough.” (Tim)

Again, the wording that Tom chose to explain his suicide attempt suggests that his mother’s suicide attempts changed him in a way that he could not escape. This is likely to explain why Tom placed such a high value on “being free”. Throughout his account, there was a sense of feeling trapped by circumstances and later trapped by his own self-blame and guilt.

Blame was also reported in Claire’s account. Although Claire did not blame herself for her partner’s multiple suicide attempts, she felt family and friends blamed her for them. She felt angry and frustrated that people were attributing her partner’s behaviour on difficulties within their relationship:

“And I think a lot of it as well (breathes), which really annoyed me was the fact that they seemed to be putting it down to relationship problems. You know it must just be something to do with the relationship, you know.” (Claire)

This isolated Claire further from family and friends and acted as a communication block which increased her feelings of helplessness and isolation.

It was evident from participant’s accounts that their guilt surrounding their loved one’s suicide attempts prevented them from moving on with their own lives. This was encapsulated best in Claire’s account:

“He still wanted me to be in the house and to be very much in my life and yeah (pauses) at the same time telling me he didn’t want a relationship and he didn’t love me anymore and em, that makes no sense and you know, we had to move on, this isn’t right and (pauses). You know, any time I made an attempt to move out or anything again it was the whole emotional side of things, I just felt I couldn’t move out because if I move out, who’s going to look after him.” (Claire)

This inability to move on from their loved one’s suicide attempts resulted in further biographical disruption. Claire was convinced to stay living in their home despite no longer being in a relationship with her ex-partner due to her strong sense of responsibility to him and her fear of who would take care of him if she left.

Biographical disruption was also evident in other participants’ accounts. As previously mentioned Kyle changed his plans to work abroad as a result of his sister’s suicide attempt while Tom moved abroad and travelled for ten years as a result of his mother’s suicide attempts. This is discussed in further detail within the Coping theme.

Some participants responded to their loved one’s suicide attempt with feelings of anger. Tim and Tom both identified feeling angry in response to their sister and mother’s respective suicide attempts. For Tim, this was caused by his initial belief that his sister was being selfish:

“And anger as well. I was angry, really, really angry like. Em I thought she was being a bit selfish initially like and it was like, this is putting everyone through stress and maybe its not like (pause).” (Tim)

Interestingly, Tim's feelings of anger shifted when he increased his understanding of suicide and depression through online research. This is discussed in further detail within the Coping theme. Like Tim, Tom identified that he felt angry when his mother attempted suicide. However, unlike Tim who expressed his anger and felt his sister's behaviour was the cause of it, Tom admitted to internalising his anger as he felt he was to blame for his mother's suicide attempts:

“I thought well okay but a lot of it was anger diverted in a way because I couldn't speak to anyone about it and I couldn't vocalise it out of the way so I turned a lot of anger in towards myself if that makes sense?” (Tom)

In summary, the loved one's suicidal behaviour appeared to have a profound emotional, psychological and physical impact on participants from the moment they discovered that their loved one was suicidal. However, this had a much longer term impact on loved ones' physical and mental wellbeing. The suicide attempts made by the participants' loved ones actually interrupted participants' own lives to a large extent and negatively impacting their plans for the future and their ability to move on. Despite this, a strong sense of empathy and love for their suicidal loved one was evident in participants' accounts. These are later outlined under the coping mechanisms master theme.

4.2.2 Challenges

Participants were faced with a number of challenges in the aftermath of their loved ones' suicide attempts. The most salient challenges that they experienced included unpredictability or 'not knowing', strained relationships within the family and stigma and isolation.

Not Knowing

Uncertainty or not knowing was evident throughout all participants' accounts. Not knowing refers to the uncertainty regarding the level of risk for subsequent attempts; an uncertainty of what may have led to subsequent attempts; not knowing the causes of the loved one's suicide attempt(s) and not knowing as to how they should respond to a further attempt. This spectrum of uncertainty was captured eloquently by Tim:

“Em (pauses) a lot of it as well, the not knowing thing, just not knowing what to do, where to go, if she was going to do it again. Em it's just really fear of the unknown like because you just didn't know what to think, what to do really like other than take her to the doctor to talk to..[]..So its fear of the unknown more than anything else it was just really terrifying. It was really scary like because obviously I love my sister and you wouldn't want her to do something stupid you know.” (Tim)

This level of uncertainty greatly exacerbated Tim's feelings of stress and fear and left him feeling helpless and powerless. In this extract, Tim stated that he loves his sister deeply but was aware that this was not enough to help her or support her because he had not received any support or guidance in how to respond to or manage her suicidal behaviour.

Meanwhile, for Kyle, the not knowing about the causes or reasons for his sister's suicide attempt aggravated his anxiety and concern for his sister.

“Because she'd wrote a note em about taking her life. But the hospital can't give it to you unless the person dies. Cos it's not their note to give away, it

was still Emma's property. So Emma took the note and no one ever seen it again which was her right, it was her note. So that was the hardest thing for me to take, after like obviously worrying about my sister. Because there was something there that if they could have just told us what had happened to give us maybe an insight into how we could be better for her." (Kyle)

Kyle believed that there may have been answers and clues as to why his sister attempted suicide and what support she may have needed from his family within her suicide note. This was a source of frustration for Kyle. Despite this, he never asked his sister why she attempted suicide. It is likely that this was a coping mechanism.

It was evident across participants' accounts that they all struggled to find a definitive cause of their loved ones' suicide attempts. The majority of participants were unable to recognise reasons or signs of distress prior to their loved one's suicide attempt. However, they suggested a range of potential causes of their loved one's suicidal behaviour in retrospect. Participants tended to attribute their loved ones' suicide attempt(s) to a combination of traumatic or distressing events which their loved one experienced in their childhood and a more recent event which was perceived to be a trigger of stress. For example, Tim believed that their father leaving the family home and residing in Asia caused his sister to develop "a lot of abandonment issues". He believed that the combination of her longstanding abandonment issues and a recent fight with her friend caused her to attempt suicide:

"So yeah I think eh that had a lot to do with it as well, with the gestures you know, yeah the fighting with the friends and again her abandonment issues. And I reckon you know she kind of maybe got it into her head you know no

one loves me kind of thing. Em I reckon that could have been the cause of it but then again I'm not really in her head so I don't know." (Tim)

It is clear here that Tim was attempting to make sense of his sister's attempt by estimating that his parents' break up and his father's subsequent emigration had a negative impact on his sister's resilience and mental wellbeing. However, he was aware that his views were expressed from an outsider's perspective and that he lacked any certainty. Within this extract it is felt that Tim believed only his sister truly knew the reasons as to why she attempted suicide which further contributed to his sense of uncertainty and not knowing.

Not knowing what signs or triggers to be aware of was a further challenge for participants. The extent to which loved one's hid signs of feeling suicidal was outlined by Tom:

"She was the world's best actress. Em she could be (pauses) absolutely fine laughing and joking one minute and then take an overdose the next." (Tom)

This extract highlights the unpredictability of loved one's suicide attempts and the resulting difficulty that loved one's experienced in terms of recognising and preventing attempts. This caused participants to desperately attempt to identify potential triggers to future attempts. This is discussed in further detail within the Coping theme.

The extreme stress caused by this great uncertainty of whether their loved one would make a subsequent attempt was described by Tom:

"In a way the only reservation I've got about the suicide attempts are I just wish she had been successful the first time so we could have got it out of the way. That might sound heartless but it always hung over the top of you. Just

this wee bit at the back of your mind. Today? Who knows? Em or if she just went it would have been easier on everyone around her em so yeah (pauses) so that was that.” (Tom)

This highlights the severe impact that the extreme and ongoing stress and anxiety associated with the uncertainty, had on participants. It emphasises the severe negative impact that “living on edge” had on participants. Indeed, the experience of living on edge was so unbearable for Tom, that although he knew it may sound unfeeling, he wished his mother completed suicide the first time she made an attempt. Dealing with the loss of his mother would have been easier than coping with the unpredictability and uncertainty surrounding her next attempt. It **is** as if Tom believed that her loss would have set him free from the burden of living with this ongoing uncertainty.

It is clear from the above extracts that very little was known or certain for loved ones. They were faced with uncertainty in terms of when their loved one may make another attempt, why they made attempts, how to respond if another attempt would be made and where to go or how to look for support if this occurred. This not knowing exacerbated the stress, anxiety and fear that participants experienced. It also highlights the complete the lack of control that they had over this situation which led to acute feelings of helplessness. ‘Not knowing’ was therefore an extremely challenging aspect of the experience of living with a suicidal loved one.

Strained Relationships

Strained or difficult relationships within the family were identified as a major challenge for participants when living with a suicidal loved one. Strained

relationships were evident both before loved ones attempted suicide and following their attempt(s).

Strained relationships were central to Tom's experience. He explained how his mother's suicide attempts and her bitterness at having MS tarnished his relationship with her. His mother's wish to die had a negative impact on her relationship with her husband and subsequently on Tom's relationship with his father:

"It made (pauses) in a way it made my father very bitter because he couldn't help her and (pause) she use to wake up in the mornings crying because he hadn't killed her in the night. That was what she asked him every night "put a pillow over my face" and of course you're not going to do. So that did make him quite resentful, quitter bitter and hard to be around actually." (Tom)

The negative impact of his mother's suicide attempts was enduring. At the time of the interview, ten years after his mother had died from natural causes, Tom admitted to speaking to his father only six times in the last twelve months. It is likely that the distance that developed within their relationship was a direct result of his mother's suicide attempts. Being in each other's company perhaps reminded Tom and his father of these incidents and therefore caused them to avoid each other to avoid these painful memories.

Strained relationships within Claire's partner's family made it challenging for her to get anyone to take her concerns about his behaviour seriously. As Claire was an unmarried partner rather than a spouse, she was unsure what her rights were in terms of finding support for her partner or contacting his GP on his behalf. Consequently, she communicated her concerns about her partner to his family and felt that her concerns were not taken seriously:

“And the father contacted this older sister who just said no, he’s fine, it’s just that they’ve split up..[].. I don’t know what they maybe thought but just I felt they’re maybe not believing me or they’re not taking it seriously, you know.”

(Claire)

As Claire’s partner’s family members went for long periods of time without speaking to each other due to arguments, they were unaware of his concerning behaviour. Instead of contacting his son, who he has not spoken to for nearly twelve months, the father contacted his daughter who believed that his behaviour was due to problems in his and Claire’s relationship. This left Claire feeling even more isolated and as if she were to blame for her partner’s suicide attempts.

Difficulties in familial relationships tended to have a direct impact on communication levels and styles. Although Tim described his relationship with his sister as good, it was tumultuous at times. He reports that arguments between him and his sister are short lived but he described them as “screaming matches”. This confrontational communication style may have been a contributory factor to his sister’s refusal to share her reasons for her suicide attempt. Tim found this refusal to respond very difficult to deal with and this led him and his family to have emotive and intense family meetings to get to the bottom of his sister’s attempt:

“Because it was probably very intense for her because it was literally for the initial first week anyway it was literally two and three hour inquiries by me, my mam and my brother with everyone fucking crying and like so it must have been so intense for her like.” (Tim)

Difficulties in the parental relationship and within the father-daughter relationship were also observed in Kyle’s account. Kyle’s parents split up in the months

preceding his sister's suicide attempt. Kyle reported that their relationship was "dreadful". Indeed, the relationship was so strained that they stayed in separate parts of the hospital when his sister overdosed and was being resuscitated. Kyle also described a strain on his sister's relationship with her father who recently left the family home:

"So my dad was away and wasn't around that much. Emma stopped going to see my dad because she had kind of fallen out with him a little bit. I think she struggled with his new partner, not because there was anything wrong with her it was just too much of a change for her. So she didn't really have any male em figures that she seen regularly enough I don't think in terms of a father figure." (Kyle)

Kyle cited his father leaving the family home as being a major change for his sister due to the age she was at when it happened. It is likely that this change had a major impact on his sister when combined with their uncle's suicide and her history of injuries and allergies. The strained relationship between Kyle's mother and father was emphasised in them staying in different areas of the hospital during the crisis of their daughter's suicide attempt. It is likely that their strained relationship made caring for their daughter when she was discharged from the hospital difficult due to limited and strained communication between the two of them.

It is clear that strained relationships within families present a major challenge when caring for a suicidal loved one. In some case the loved one's persistent suicide attempts caused a persistent distance in interfamily relationships. In other cases, where family members were estranged, they were unaware of the difficulties their loved ones were having and buried their head in the sand. Furthermore, tumultuous

family relationships resulted in confrontational communication styles which may have done more harm than good in terms of supporting the suicidal loved.

Stigma and Isolation

Isolation and stigma related to suicidal behaviour (and mental health more generally) was felt across the loved ones' lived experiences. Participants (Kyle and Tom) were isolated within their own families due to being shut out from conversations about their suicidal loved one.

“Like my sisters are like a very strong, like a really strong unit. I mean like it’s probably something I’ll never understand but the three of them and my mum are like a wee team. So quite often they drip feed information to me that I need to know.[].. Aye so I’m always on the outside of the loop” (Kyle)

For Tom, this resulted in him overhearing bits of conversations which increased his sense of self-recrimination:

“And that was the first attempt that I know of because they hid a lot of her illness from me so as not to affect me, despite the fact that that was the worst thing they could have done because in fact, I was picking up on the things and not getting the full story and turning it out to be my fault for a long time.”

Tom’s sense of isolation was exacerbated as he lived in a rural area, his family kept people at arm’s length and because he isolated himself from his peers at school. With no one to communicate his feelings to, Tom internalised the negative emotions he felt in response to his mother’s suicide attempts. This is likely to have caused Tom’s “anger turned in” and his search for “something I could outlet the anger on”.

Isolation was central to Claire's lived experience also. She explained that her partner's suicidal behaviour had such a negative impact on her physical and emotional wellbeing that she began to withdraw socially:

"I just felt I couldn't participate in you know, if friends were going out or and then I just didn't want people to see me just so sad and so stressed and (pauses). Em, yeah so just, and even one time I actually just spent Christmas on my own. Yeah, he just took off in an awful state, I kind of pretended to different family members that I was you know, pretended to one person that I was spending it with him and to someone else that I was going somewhere else because I know they wouldn't have wanted me there on my own but I just couldn't face it." (Claire)

Her sense of isolation was reinforced by her partner forbidding her to have visitors in their home. Claire was the only participant who went to great lengths to access support for herself. Despite finding and attending a support group for partners and family members, she felt further isolated within these groups:

"Em, then I tried to go to a you know, a relative support group, and again, it was people, older, much older women who's again, like husbands had been (breathes), you know in and out of, had been sectioned numerous times when they were in the system or in care of psychiatrists. And again that was very isolating because I just didn't find anyone in the same situation." (Claire)

Kyle identified that his mother also felt alone in the struggle as his sister's suicide attempt was not something his mother could share with other parents due to her perceptions of being unfairly judged as a parent. Kyle reported his belief that suicide

and mental health issues are still heavily stigmatised and that this stigma blocks people from admitting they are struggling and also from accessing support:

“But yeah there is a stigma, people never want to admit that they’re suffering from mental health issues. Because in my opinion the word mental health is the biggest problem. When you hear the word mental it’s never ever used in any other ways other than describing someone who is unstable. You would never use the word in any other environment.” (Kyle)

For Kyle, the use of the term “mental” causes stigma. His interpretation of this term has negative connotations. He reported that people associate the term with people losing their tempers easily and being unable to regulate their emotions. Consequently, Kyle stated that no one would want to be associated with this term and that stigma therefore would prevent people from seeking help or support.

Similarly, Claire experienced the stigma around mental health and attributed it to people’s lack of understanding around mental health. She recalled her friends and family members describing her partner as “a bit of a nut job” or “a bit of a psycho” which isolated her further.

Interestingly, Callum felt comfortable sharing his concerns about his partner and information about his suicide attempt with some of his friends. However, he only shared this information with friends who had their own personal experience of mental illness. Callum explained that he also has to be careful not to ‘drag his friends’ down when discussing his concerns about his partner’s wellbeing:

“All of us are mentally ill so we’ve all had to kind of factor in our own like anxieties. And like we have to kind of be careful not to drag each other down too much because it will sort of have more consequence than it would have

with like a work friend or someone who doesn't have depression or anxiety or something else." (Callum)

This presented a further challenge for Callum as he needed to weigh up his need to speak about his concerns and the potential negative impact this may have had on his friends' anxieties and mental health. So although Callum was comfortable disclosing details of the situation to his friends, he acknowledged that he still held back to some extent in order to protect his friends mental wellbeing rather than protecting himself from stigma.

It was clear that participants felt isolated when living with a suicidal loved one. They felt that no one else could understand the challenges and struggles they were facing. Stigma was cited as a reason why suicidal loved ones did not want to be diagnosed or seek support for a mental health issue. Participants' awareness of the stigma of suicide and mental health issues prevented them from sharing their concerns with family members or friends unless they had a strong awareness of mental health issues or personal experience of it.

4.2.3 Coping

A range of coping strategies were adopted by the participants. Adaptive coping strategies included participants increasing their awareness of suicidal behaviour and mental health issues. Maladaptive coping strategies included engaging in a state of hypervigilance, avoidant behaviours and social withdrawal.

Increasing Awareness

Three participants (Claire, Tim, Kyle) engaged in online research about depression and suicidal behaviour to increase their understanding of these concepts and how they should respond to and best support their loved ones. This resulted in a major

shift in attitude for Tim who initially believed his sister was being selfish and dramatic. Through online research about clinical depression, Tim's increased understanding led him to develop strong feelings of empathy and understanding of his sister's behaviour:

“And then obviously when it happened I started looking into it and looking into the causes of it and, and how people react when they're depressed and then I realised that she was obviously seriously depressed and there was nothing selfish about it, there was nothing (pauses) it wasn't, it wasn't done for her benefit it was just a reaction to the depression really.” (Tim)

It is evident that information was pivotal in changing Tim's understandings of his sister's suicide attempt and his resulting empathy that he developed for her. Although increasing his awareness was helpful to a certain extent he also stated that he could not rely on the accuracy or reliability of this information. Tim's account therefore, highlights increasing awareness as a positive coping strategy but also emphasises further aspects of not knowing and the sense of isolation. Loved ones were left searching in the dark for answers and explanations to their loved one's concerning behaviours.

Hypervigilance

Hypervigilance was a further coping mechanism that participants employed to decrease their anxiety, worry and fears for their loved one. Although some participants were able to identify potential causes or triggers to their loved ones' suicide attempt in the aftermath of the attempt, participants struggled greatly with identifying causes and warning signs prior to their loved ones' making attempt(s). As we saw earlier, participants, felt that their loved one's suicide attempt(s) “came out of

the blue” which caused them to live “constantly on edge”. The unpredictability of their situation and the resulting difficulty in identifying triggers or signs was described powerfully by Tom:

“She was the world’s best actress. Em she could be (pauses) absolutely fine laughing and joking one minute and then take an overdose the next.” (Tom)

This highlights the extreme unpredictability of Tom’s mother’s multiple attempts. It emphasises the resulting difficulty that loved ones experienced in terms of recognising signs and preventing future attempts and coping with the pervasive unpredictability of their situation. This caused the majority of participants to engage in a state of hypervigilance as a method of coping with the persistent unpredictability and lack of control that they had over the situation.

Participants engaged in hypervigilance as a coping mechanism in different ways. Consequently, they are presented in a case by case format.

Tim acknowledged that he experienced “tremendous” worry and anxiety if his sister was not in close proximity to him. He therefore “shut down” his sister’s life when he initially found out about her attempted suicide. This resulted in his sister being on “lock down” and not being allowed to leave the house on her own in the weeks following her attempt. It is evident that being hypervigilant to his sister’s whereabouts at all times was an attempt to cope with this highly unpredictable situation and to her going “off the fucking deep end again”. However, this attempt to regain control over the situation was short lived as Tim identified that his family could not “shut down” her life for the long term.

Likewise, Kyle admitted to wanting to be close by in case he was needed. As previously stated this desire to be close by and Kyle’s sense of responsibility caused

Kyle to change his future plans to work abroad. Kyle, like Tim felt more in control of the situation and better able to cope with the unpredictability of his sister's behaviour if he was close by. He developed a coping mechanism whereby he became hypervigilant to any potential triggers of a subsequent attempt:

“And I was like parked outside her house, honestly like I was just waiting for something to happen..[]..And especially the more pregnant she became, the more I thought if this goes wrong she's not going to be able to cope with this.

(Kyle)

Therefore, identifying potential triggers of subsequent attempts and being on constant alert helped Kyle to cope with the unpredictability of the situation, the lack of control he had over it and his guilt around not seeing his sister's initial attempt coming.

Meanwhile, Callum was also hypervigilant and living on edge. In an attempt to cope with his constant worry for his loved one, he ensured that he was in constant communication with him through texts or social media. However, the sense of relief that Callum experienced when he receives a reply from his partner was short lived:

“But like anytime there's like a gap, I'll be like oh God something's happened.

And it's kind of, it's my first impulse or my first thought.” (Callum)

It is evident from this extract that although contact from his loved one alleviated Callum's anxiety initially, his sense of relief was temporary. Any gap in communication resumed the cycle of worry, panic and a total sense of powerlessness and helplessness which caused Callum to develop catastrophic thought patterns, assuming that the worst had happened. Callum also explained that

he was hypervigilant to how his partner was reacting or interpreting certain comments from friends:

“So it was almost like a how I’m interpreting everything and then there was a is John interpreting this in a bad way?” (Callum)

This demonstrates Callum’s experience of feeling constantly on edge and his ongoing need to be hypervigilant to how his loved one was interpreting comments or other potential environmental triggers and subsequent changes in his loved one’s behaviour. This coping strategy was therefore driven by an attempt to regain control of the situation and to identify signs and prevent any future attempts with the aim of addressing or preventing loved ones’ sense of guilt.

Avoidance and Risk Taking

Avoidant behaviours were utilised by participants as a coping method. For participants, avoidant coping strategies were the result of the pervasive negative impact that their loved ones’ multiple suicide attempts had on their wellbeing. Participants therefore engaged in avoiding certain situations which may have exacerbated their high stress levels and already depleted wellbeing.

For example, avoidance was used extensively by Tom as a method of coping with his mother’s multiple suicide attempts and the impact that this had on him. Tom avoided going home after school and frequently went into the woods near his home to be by himself where “[he] was free”. Tom explained that in one way his mother’s suicide attempt was one of the best things that happened him as it led him to move abroad for ten years. Feeling free was therefore central to Tom’s experience:

“The only thing in this life that actually matters to me is being free.” (Tom)

This suggests that he felt trapped within his experience of living with a suicidal mother as a teenager. This sense of feeling trapped was also evident in Claire's account when she described being unable to leave their home after her relationship with her partner was over. As a result of feeling trapped, Tom withdrew socially which maintained his sense of social isolation. Although Tom was extremely isolated as a teenager by circumstances, he later chose to isolate himself in his early adulthood avoiding close or intimate relationships. He explained how ten years after his mother's suicide attempts, he still had very few friends and described how he actively avoided developing intimate relationships with women as a coping mechanism:

"I was quite a ladies' man. I am not proud of that either. Em yeah (pauses) its (pauses) yeah. I would quite happily go from one woman to another to another to another. And (pauses) aye just move on easy, simple as that. And there's also, you can probably count the amount of friends I have on one hand. And they are spread few and far between (pauses) em aye. I just never, I never actually let folk in at all." (Tom)

This inability to settle in one place or form meaningful relationships is likely to have become a habit for Tom and a result of his desire to be free. For Tom, being free meant avoiding becoming attached to anyone or having anyone who became dependant on him. He compared his parent's relationship to "a prisoner and a keeper". He strived to avoid ending up in this situation by avoiding others and remaining guarded. This is likely to have given him some sense of relief as a teenager when he admitted to not wanting to get "to get noticed". This avoidance of relationships and being free then became his preferred response later in life.

Meanwhile, social withdrawal and maintaining isolation were adopted as a coping mechanism by Claire also. She explained how she could not face friends and family as she did not want them to see the seriously negative impact that her loved one's behaviour had on her:

“Em, and I remember at one stage going into the hair dressers and looking in the mirror and just crying and (long pause). Yeah, because I just didn't even recognise myself” (Claire)

By looking in the mirror at her reflection, the toll that living with her suicidal partner has had on her and on her life was reinforced. In that moment, she was forced to reflect back on how much things had changed and how these changes negatively impacted her wellbeing. Claire avoided social gatherings as a means of protecting her family from the gravity of the situation. It seems that this was due to the shame of staying with her partner despite the negative impact it was having on her physical and emotional wellbeing. Consequently, Claire's social withdrawal reinforced her social isolation.

Therefore, these coping strategies seem to be an attempt to avoid situations, relationships and potential conflicts which may have exacerbated participants' wellbeing further. For Claire, she did not want to see her family and friends as she believed it would result in them telling her to leave her partner. For Tom, he did not want to develop any attachments or responsibilities to people as he felt that this would compromise his sense of freedom and that he may have repeated his parents' relationship of “a prisoner and a keeper”.

Furthermore, one participant (Tom), engaged in risk taking behaviours, described as taking a lot of “daft chances”. For example, driving tractors along motorways as a

teenager without a driving license and becoming a bull rider in Canada for ten years. Tom admitted that when he engaged in risk taking behaviours he was “maybe looking for a way out”. No other participants reported engaging in risk taking behaviours or developing suicidal intent. However, no other participants were exposed to their loved one’s suicide attempts at age fifteen, as Tom was.

It is clear that participants utilised a range of coping mechanisms to deal with the negative impact that their loved one’s suicidal behaviour had on their emotional wellbeing and on their life world. Some of these strategies were positive while others were maladaptive and put participants at further risk of isolation which exacerbated their negative emotions and feelings of helplessness.

4.2.4 Support

It was evident across all participant’s accounts that they felt alone in their struggle while living with their suicidal loved ones. This theme, therefore, outlines the support or a lack of support offered to participants, barriers to seeking support and attempts to access support for themselves and their loved ones. Subsequently, participants’ recommendations on what support would be helpful for others in their situation are outlined and further considerations for practitioners and support services are provided.

Feeling Unsupported

Participants attempts to access support for themselves and for their loved one’s varied greatly. Despite this variation, participants felt unsupported and alone in dealing with this extremely distressing experience.

Some participants (Callum, Kyle) were offered no support from healthcare or support services when they presented at A&E with their loved one. Others (Tim, Tom) were

offered support from their GPs and did not accept it. Meanwhile, one participant (Claire) was offered no support due to her loved one's refusal to access any support for himself.

Some participants felt unsupported and isolated as a result of being offered no support from healthcare or support services before, during or after their loved one was admitted at A&E. This is emphasised by Callum's account:

"I wasn't really included in any conversation about John's wellbeing. It was all focused on, it was people talking to him so I wasn't really spoken to..[]. Em but I kind of expected there, like it sounds weird but even on TV you have the if you were affected call this number type thing. So I kind of expected like a, kind of like if you're not feeling okay call these people or this is the number of the crisis line or a pamphlet or something..[]. Just not kind of not really acknowledging so it was a bit strange. But like after it I was like what do I do, there's nothing really, I don't know if that's quite entitled, but like there's nothing for me here." (Callum)

After finding his partner overdosed in a public park, Callum was surprised and saddened to find that no one offered him any sort of emotional support when he was recently exposed to such a traumatic and distressing situation. Feeling unacknowledged and overlooked at A&E did not fit with his expectations.

Various barriers to engaging with support services were observed throughout participant's accounts. In some cases, participants (Tom and Tim) were offered support from their GP. However, they were offered this in the presence of another family member or through another family member who declined this support on their behalf. This was eloquently described in Tom's extract:

“And I can remember the doctor saying Tom are you alright?.[]..The doctor said “Are you alright?” and that’s when my old man jumped in and said “Aye he’s fine, he’s fine, dinnae worry about him” so that was it kind of left” (Tom)

This resulted in Tim and Tom receiving no support while they were living with their suicidal loved ones. Tom eventually accessed support for his PTSD. However, this was several years after his mother’s attempts took place and inpatient support was accessed in crisis as a result of Tom’s own suicide attempt. Consequently, the way in which Tom’s father “kind of left” the offer of support for his son had a severe and enduring impact on Tom’s mental health. Potentially this impact could have been prevented or minimised if he sought treatment at an earlier age.

Similarly, Tim explained that if the GP “had actually said it to me and kind of laid it out” he would have been more likely to “have gone down that path” than he was when the offer of support was made through his mother who refused it. It is clear from Tim and Tom’s accounts that participants were not isolated solely because support was not offered to them. The manner in which this support was offered to them was very important and this seems to have had a major impact on the likelihood of loved ones engaging in support.

A running theme across participants’ accounts was that although they identified that their loved one needed support, they struggled greatly with encouraging or communicating these feelings to their suicidal loved ones. In most cases, their loved one’s either did not recognise that they needed help (Claire) or were unwilling to access it (Tim, Kyle, Tom). The strength of will in refusing support was highlighted in Claire’s extract:

“Em, it so it was really, you know I knew it was something just wasn’t right at all and kept asking him to get help to (breathes) you know but he was determined not to get help em. Under no circumstances would he let me ring (breathes) the doctor or (pauses) was completely against anything like that, any form of help.” (Claire)

This resulted in suicidal individuals and their loved ones slipping through the cracks and not being offered support as they were not on the radar of any support services. As Claire’s partner refused to get help and threatened her not to tell anyone, she felt her “hands were tied”. In desperation she sought support from Samaritans and other phone lines. Claire also accessed support by attending a counsellor, attending support groups and checking into a therapy centre. However, as the source of her stress, her partner’s refusal to seek help endured, she continued to feel isolated and helpless despite accessing a range of supports for herself.

In contrast to the rest of the participants, Callum believed his loved one recognised that he needed support and was willing to access it. However, Callum explained that despite multiple attempts over a period of months, both he and his partner were unable to book a GP appointment for his partner who had run out of his medication for his depression:

“You can’t book in advance. So whenever he tried to book an appointment it would be fully booked for the day so we would have to try to book the next day. And it happened over months so he just wasn’t able to get an appointment. Previously he was on medication for depression and then the medication ran out and he couldn’t get an appointment so he has been un-medicated for however many, for six months now.” (Callum)

For Callum, the inability to get a GP appointment for his loved one was a major barrier to his loved one accessing support. It left him feeling unsupported, helpless and “very hopeless” as he felt he was doing all he could to care for this partner and that there was “just this like wall that we can’t get through”. The description of the wall **is** an interesting analogy. It suggests that Callum felt the appointment system at his partner’s GP practise was impermeable and he therefore perceived it to be a barrier not only to support for his partner but also to potential recovery for his loved one.

In summary, participants varied in terms of the lengths they went to access and avail of services. Barriers such as family members rejecting support on participants’ behalves, social norms of help-seeking behaviours, appointment booking procedures and suicidal loved one’s refusal to get help made it difficult for participants to access support for them and in turn left participants feeling isolated. Overall there was a sense that participants felt unsupported and being left to deal with the situation on their own across their accounts.

Recommendations for Support

Participants provided useful insights into what supports would have been beneficial to them and may be helpful to others in this situation. These recommendations were based on their own support needs, which in most cases were unmet. Five main recommendations of appropriate supports were made by participants which included: emotional support, practical advice form medical professionals, inclusion of family members or significant others in treatment planning, campaigns targeting loved ones and providing support from community services to engage with harder to reach groups. Each recommendation is discussed in turn, below.

Participants explained that emotional support would have been beneficial to them. Callum however, stated that this support would not necessarily need to be provided face to face:

“But em, I think I would have benefitted from someone being like are you doing okay, do you need the number of like someone to talk to or something like that.” (Callum)

It was evident across participants’ accounts that a major support need (which in most cases was not met), was the need for practical advice and guidance from medical or mental health professionals. Therefore, participants recommended that “medical professionals or counsellors, people who know and who are trained in dealing with this” could provide advice or training on “next steps” after their loved one was discharged. The great need for this was outlined by Kyle:

“I think in terms of knowing how to, some support in terms of next steps. So someone with a bit of experience to say these are the likely emotions that your daughter is going to go through over the next few days. This is the general feeling of things not to do, don’t badger her, don’t get angry with her. Like I would imagine that there’s groups out there or people with expertise that would give good advice..[]..You know just, just how to deal with it. It’s something a parent probably never plans for is taking a kid home who’s tried to take their own life and then how do you deal with that.” (Kyle)

Kyle’s extract highlights that this situation is something that no parent is likely to have prepared for. Therefore, families were in desperate need of advice, training and guidance from medical professionals with expertise in this area. Therefore, participants reported a strong need for advice or expertise on how to respond to their

loved one, how to identify triggers and where to go for support, were strongly desired. It was suggested that a pamphlet or leaflet with this advice and the number of a helpline may be sufficient for family members and loved ones to feel more supported and confident in caring for their loved one post-discharge. This support would be likely to decrease loved ones' anxieties to some extent and increase their confidence and ability to care for and cope with their loved one's suicidal behaviour.

Participants felt that as their loved ones were discharged into their care at home, they should have been included more in their treatment and care planning. Claire who works in a mental health role believed that often GPs are

“just being told what that person might want them to hear.”

Therefore, Claire felt that medical staff often did not get the full picture of the situation. Recognising that people with depression are often socially isolated and may not have the most accurate perspective on their behaviour, Claire suggested that GPs could “examine the support” network a patient has or reach out to family members or loved ones to gain a more comprehensive picture of the situation as they are likely to be effected by their loved one's behaviour. She suggested this based on her understanding of the negative impact that a loved one's suicidal behaviour or mental health issues has on loved ones:

“So you know family members or partners aren't involved at all in it but it very much affects their lives..[].. so there's this whole impact that it has on other people's lives as well where they end up needing support for their own mental health you know so.”

This extract emphasised the profound impact that a loved one's suicidal behaviour had on their family members' and partners' lives and their emotional and mental

wellbeing. Furthermore, this extract implies that if loved ones were consulted more, they may not have felt as isolated in this situation and consequently, the negative impact on their own mental health may have been lessened.

Although participants acknowledged that a lot of work has been done to reduce the stigma of depression and accessing support for it, they believed that more needs to be done. Therefore, participants recommended more campaigns to increase people's awareness of mental health issues and to promote open conversations about mental health. Furthermore, participants suggested that mental health campaigns which targets family members to encourage them to access support, may be helpful:

“I think there should be more of an awareness when talking about mental health problems and depression and things. Just more awareness and more (pauses). You know the way there's campaigns about people with depression or mental health problems you know to talk about it. I think there should be a campaign as well that like if you are affected by a family members or partner's mental health you need support as well. And just more of an awareness of that.” (Claire)

This suggests that current campaigns which encourage people with mental health problems to seek support are not encouraging loved ones to seek support for themselves. It was highlighted by participants that they focus primarily on the suicidal individual or the person with mental illness. Consequently, participants suggested that campaigns should cast a wider net. They suggested that if more targeted campaigns were developed which highlight the need for loved ones to get support, this may result in an increase in the uptake of support.

As previously mentioned, Kyle explained that his family who were from an area of low economic status were less likely to access support due to their social norms and attitudes seeking help from support services. Consequently, he suggested that some sort of support running from local agencies or community centres which are already established in these communities may help to engage this harder to reach group.

“So I don’t know is there a way of providing more support in the community potentially. Like my mum visited the same community centre for most of her life like for mother and toddler groups and different things. And even, I’m not sure what the answer is like I’m no sure, I don’t know what the answer is. But maybe like some sort of support where with an understanding that not everyone is going to go home and read up on stuff.” (Kyle)

This extract suggests that while Kyle’s mother was unlikely to have accepted support from an agency or service outside of her community, she may have been more likely to engage with support if it was delivered from a service she already engaged with and was comfortable attending.

Finally, two further considerations for support services were put forward by participants. Firstly, the timing of the offer of support was highlighted as being crucial in terms of the likelihood of family members accepting it. It was clear that when participants were in A&E, they were solely focused on their loved ones’ physical recovery. Therefore, they felt they would not have accepted support if it was offered to them in A&E at that point in time as they were unable to think about or prioritise their own support needs. However, participants felt that if they had been offered any support from services either in the events leading up to their loved one’s suicide attempt or when their loved one was discharged from hospital into the family home,

they would have greatly welcomed emotional support and practical guidance on how to care for and manage their loved one.

Subsequently, participants also cautioned that support services should not assume that partners or family members are mentally healthy or able to fully adopt the carer and protector role:

“So I think a lot of the basic supports that they say to do like the practical ones especially kind of rely on the supporter not being mentally ill. Because it’ll be like do this for the person like do the practical stuff for them and that’s not always something people are capable of doing.” (Callum)

This extract highlights the assumption that when a suicidal loved one is discharged from hospital, their loved one is mentally or physically capable of taking on the carer’s role. Callum felt that healthcare staff should be aware that often “birds of a feather flock together”, meaning that if a person has attempted suicide, it is likely that one of their family members or partner also struggles with their mental health also.

Participants provided a great deal of insight into how services can better support loved ones of suicidal individuals. As loved ones seemed to have varying needs at different times throughout their journey, suggesting a uniform support which would effectively meet loved ones’ needs is challenging. However, as Kyle poignantly stated, often the offer of support is enough to make someone feel less alone in their struggle:

“Sometimes I think the option of support is just as powerful as the having full on support because knowing that there is someone there to speak to is sometimes enough. You don’t need to actually speak to them but know that you know if I am actually in trouble I can go and get help. I think for me

personally that is as powerful as having someone there because I'm not a big sharer of things but if I know that I've got a mechanisms of support that I could use I'm much more comfortable." (Kyle)

4.3 Summary of Results

This chapter has outlined the five master themes which emerged through analysis of the participants' interview data. It has summarised the emotional turmoil participants experienced while living with a suicidal loved one, their varied understandings of suicidal behaviour, the range of challenges they faced as lay carers, their coping strategies and their experiences of support and recommendations on supports for loved ones of suicidal individuals. The implications of these key findings and how they relate to existing theory and research are discussed in Chapter 5.

Chapter 5 – Discussion

5.1 Introduction

In this chapter, the findings are discussed in relation to theory and the extant research. Implications for further study and practice are outlined and the advantages and limitations of the study are examined.

5.2 Discussion of Results

5.2.1 Discussion of Results in Relation to Extant Research

While existing research on this topic has focused primarily on parental perspectives or bereaved samples, the present study offers a range of novel insights into loved ones' experiences of living with a suicidal individual and also extends findings from extant research.

Firstly, by including adult children, siblings and partners of suicidal individuals in the sample, the present study found that ongoing worry, persistent anxiety and intense fear of future attempts is experienced by loved ones irrespective of their relationship to the suicidal individual. This extends the findings of extant research which focused primarily on parental perspectives (e.g. Buus *et al.*, 2014; Daly, 2005; and Byrne *et al.* 2008).

In incorporating a mixed sample, the present study highlighted that loved ones' perspectives vary according to their relationship with the suicidal individual. Although participants' accounts were similar in many ways, subtle differences in their lived experiences were observed according to their relationship with the suicidal individual. Consequently, the challenges they faced and their support needs varied. For example, partners struggled with fears of overstepping

boundaries if they pushed their loved one to access support. Siblings appeared to be shut out from conversations about their suicidal siblings and were often drip fed information from parents. The child of a suicidal mother felt overlooked and pushed to the side due to his mother's suicide attempts being prioritised over his wellbeing.

As with the challenges they faced, loved ones' support needs were subtly different, again depending on their relationship with the suicidal loved one and also on the time elapsed since their loved ones' attempt(s). Some participants reported a need for emotional support, while others required family support or practical information. Furthermore, unlike Owen's *et al.*'s (2011) study which employed a bereaved sample or Sun *et al.* (2009) and Sun *et al.* (2008) who interviewed family members at a specific point in early in their journey, this study highlighted how loved ones' support needs varied over time. To the best of the author's knowledge this is the first study to explore how loved one's support needs evolve and change over time. Consequently, further research is required on different supports offered to loved ones of suicidal individuals.

This study has emphasised the guilt that loved ones' experience when living with a suicidal family member or partner. It supports Daly (2005), Byrne *et al.* (2008), and Buus *et al.*'s (2014) findings that family members feel extremely guilty about missing warning signs or indicators of their loved one's suicide attempts. However, it also extends these findings, demonstrating that loved ones feel intense guilt whether they are a parent, sibling, child or partner of a suicidal loved one. Furthermore, this study explored guilt in a different context. It emphasises that an enduring sense of guilt is central to loved ones' experience. Loved ones in the present study felt guilty about positive events or successes in

their own lives such as planning to move abroad for their career, having a lively social life or moving out of the home they shared with their suicidal loved one. This guilt was experienced for years after their loved one attempted suicide resulting in biographic disruption and an inability to move on.

The finding that participants entered a state of hypervigilance in response to the unpredictability of loved one's attempts is consistent with McLaughlin *et al.* (2014), Buus *et al.* (2014), Nosek (2008) and Champlin's (2009) findings. However, the present study found that hypervigilance served two functions. Firstly, it helped loved ones to cope on a day to day basis with their lack of control and the uncertainty of their situation. Additionally, hypervigilance was also engaged in, to prevent participants from re-experiencing the level of guilt they experienced in response to their loved one's initial attempt. As this guilt was caused by perceptions that they had missed signs and indicators of distress, engaging in hypervigilance allowed loved one's to prevent a similar experience of guilt. Being hyper-alert to any potential triggers of subsequent attempts, allowed loved ones to feel less responsible for future attempts as they felt they were doing all that they possibly could to recognise and prevent a future attempt. This finding has not been reported in the literature to date.

Although trauma relating to a loved one's suicide attempt has been explored in the extant research, the present study did not focus primarily on the trauma experienced in the immediate aftermath of the suicide attempt. Instead, it emphasises the ongoing and persistent trauma that loved ones' experience over a period of years while they wait for their loved one to make subsequent attempts. The unpredictability of loved ones' previous attempt(s) exacerbates trauma and leads loved ones to believe that subsequent attempts are imminent.

In many cases trauma and anticipation of future attempts was experienced for years after initial attempts were made. In one participant's case, this ongoing trauma resulted in him attempting suicide years later as a direct result of exposure to his mother's suicidal behaviour. This finding supports Buus *et al.*'s (2014) results which identified that two parents sometimes ideate about suicide in response to the unbearable pressure they are under to keep their children safe. This has serious implications for clinical practice and highlights the need for services to make every effort to offer support to loved ones of suicidal individuals.

Isolation was cited as being central to loved one's experiences. This finding extends research by Sun *et al.* (2008) and McLaughlin *et al.* (2014) who found that loved ones are isolated within their communities due to the stigma around disclosing that a member of their family is suicidal. Participants were acutely aware of the stigma surrounding their loved ones' suicidal behaviour. Consequently, they were unwilling to share their situation with others. This was highlighted by Callum who would only tell his friends with personal experience of mental health about his partner's suicide attempt. Extending this previous research, the present study found that while participants were isolated from people who did not share their experience, they often felt isolated from their family members and loved ones within their own homes. Therefore, stigma was not just restricted to the community. In some cases, it was experienced within the four walls of the family home where people should feel safe, secure and able to express themselves freely. Siblings of suicidal individuals were often actively excluded or shut out from conversations about their loved one. Similarly, partners were unable to share their concerns with their own family members or partners' families due to strained family relationships and hurtful

comments from others. Isolation experienced within the family has not been referred to in the extant literature.

In terms of support needs, this study found that support groups could exacerbate feelings of isolation if a new member of the groups experience is very different to other members of the group. This is also a novel finding. In general, it is expected that social support would buffer the experience of a traumatic event. However, this study found that sometimes this has the opposite effect. It is likely that this finding has not been reported in existing research, due to previous studies primarily recruiting participants directly from support groups.

This study supports previous findings that loved ones of suicidal individuals are extremely vulnerable due to the cacophony of emotions and the intense pressure they experience. It also reinforces arguments put forward by McLaughlin *et al.* (2014), Daly (2005) and Nosek (2008) that loved ones of suicidal individuals desperately require mental health support for themselves but rarely receive any support. However, the key message from the present study which is not reported in the extant literature, is that no two suicide attempts are the same and no two dyads between a suicidal individual and a loved one are the same. Each loved individual's story and experience is different depending on the nature of the dyad between the loved one and the suicidal individual. This finding is highly significant in terms of implications for clinical practise as it highlights that support needs vary greatly over time and across different groups of people. Suggestions on how this could be addressed are discussed in terms of implications for practise below.

5.3.2 Discussion of Results in Relation to Theory

Although the present study did not aim to develop a theory or model of caring for a suicidal loved one, it is pertinent to discuss how its results correspond to existing theory.

The results of the present study reinforce aspects of Noesk's (2008) "maintaining vigilance through managing" theory. In identifying that participants felt their loved ones' suicide attempts came out of the blue, this finding strongly supports Nosek's (2008) initial phases of "not knowing". This stage states that family members did not recognise that their loved one was in distress prior to their attempts. Similarly, participants' descriptions of being hyper-vigilant to potential triggers to further attempts echo Nosek's (2008) "watching and waiting" phase.

However, a number of stages in Nosek's (2008) theory were not identified in the present study. For example, the present study's results showed that participants did not know how to respond to signs of distress contrasting with Nosek's (2008) "knowing and understanding" phase. Participants in the present study did not get to a point where they understood how to respond to and manage their loved one's suicidal behaviour. Subsequently, Nosek's (2008) "not wanting to know" phase was not identified in the present study. Instead, loved ones were found to be desperately trying to find out how their loved one was feeling, to identify if they were at risk of future attempts and how they could support them.

Certain components of Sun and Long's (2009) theory to guide families and carers of people at risk of suicide were supported in the present study. For example, the lack of psychoeducation and support available to loved ones was

highlighted. Subsequently, Sun and Long's (2008) theory suggests that family members' ability to care for their suicidal loved one depends on their support systems and coping strategies. Given the maladaptive coping strategies and the strong sense of isolation identified in the present study this component of Sun and Long's (2008) theory has serious implications for the safety of suicidal loved ones' safety and family members emotional wellbeing.

Lastly, contextual factors of family environment and Chinese culture referred to in Sun and Long's (2008) theory were supported in the present study. Both studies identified that loved ones struggled with monitoring the suicidal individuals' whereabouts and keeping them safe as they could not prevent their loved one from leaving the house. Similarly, the present study found that family dynamics impacted loved ones' ability to care for their suicidal loved one. Interestingly, prior to the present study being conducted, Sun and Long's (2009) appear to be the only researchers who explored the impact that relationship dynamics have on family members' ability to care for their suicidal loved one. Surprisingly, despite major differences between Chinese and British culture, intense stigma around loved one's suicide attempts was experienced by participants in the present study. Sun and Long (2009) argue that these factors contribute to caregivers' impending burnout.

To some extent, the results of the present study support Grant, Ballard and Olsen-Madden's (2015) claim that the COPE model could be applied to caregivers of suicidal loved ones. The model calls for greater collaboration between loved ones and healthcare professionals. This is consistent with the present study's recommendation that loved ones should be more involved in treatment planning and should be given training or psychoeducation around

triggers and prevention strategies. Additionally, this study has highlighted how family dynamics vary from family to family and how the support needs within families vary from person to person. As the COPE model can be tailored to suit the individual needs of loved ones, this model addresses this challenge in terms of offering support.

According to Grant, Ballard and Olsen-Madden (2015), the COPE model can be combined with suicide prevention education such as Mental Health First Aid courses. They propose that this could increase caregiver efficacy, competence, satisfaction and decrease caregiver burden (Grant *et al.* 2015). However, it is imperative that further research is carried out on the efficacy of applying this model to loved ones of suicidal individuals and on how it can be infused with Mental Health First Aid courses. To date there appears to be very little published research which assess the applicability of this model to loved ones of suicidal individuals.

5.3 Implications

5.3.1 Implications for Further Study

Given the extreme vulnerability of loved ones of suicidal individuals, their increased risk of suicide and their limited ability to care for and safeguard their suicidal loved one, it is felt that further investigation into this phenomenon is greatly needed. Further research exploring who needs support, how support needs vary over time, when support is most needed and what this support should look like, is crucial. Without further investigation into this, it is unlikely that service provision will be improved for loved ones of suicidal individuals.

As there appears to be no other IPA studies which have explored this topic, it is felt that further research into this phenomenon using an IPA methodology could increase understandings of this phenomenon. In order to address loved ones' varying support needs over time, the present study recommends that a longitudinal IPA study is conducted with a sample of loved ones of recent attempters. Follow up interviews should be conducted at regular intervals to identify how loved one's support needs and the challenges that they face evolve over time.

It is pertinent to point out that when researching this subject, no quantitative studies investigating this phenomenon were found. Although the present study did not aim to produce generalizable results, its results could inform a larger scale quantitative study. A larger scale quantitative study would possess increased empirical generalisability and may therefore carry more weight in terms of improving service provision. It is suggested that a questionnaire could be sent to family members of suicide attempters following their admission to A&E to identify their evolving support needs, challenges and their views on living with a suicidal loved one. Responses could be collated to identify trends which could then inform best practise. Therefore, despite the small sample used in the present study, it is hoped that the results may be used tentatively to inform future research and service provision by establishing the necessary supports for loved ones which are tailored to their support needs at various points in time.

Furthermore, the limited research focusing on loved ones' experiences of suicidal behaviour has mainly been conducted in North America (Daly, 2005; Nosek, 2008; Champlin, 2009) and China (Sun & Long, 2008; Sun *et al.*, 2008; Sun *et al.*, 2009). To the best of the researcher's knowledge, only Owens *et al.*

(2009) and McLaughlin *et al.* (2014) have explored this subject matter in Britain and both included bereaved participants. While suicide was reported as a highly stigmatised concept in China by Sun and Long (2009), the present study, conducted in Britain, also found that suicide was highly stigmatised. Furthermore, this study suggests that stigma is one of the main reasons why loved ones choose not to access support for themselves. Considering this finding, the increasing suicide rate in Britain and the differences in terms of healthcare systems in different countries, further exploration into this topic in Britain is greatly needed.

Further research should also be conducted on the application and efficacy of the COPE model to family carers of suicidal loved ones. In theory, this model could be very applicable to loved ones of suicidal individuals as it addresses a number of challenges that they face and can be tailored to loved ones' individual needs. However, further research is required to assess the applicability and efficacy of applying this model to loved ones of a suicidal individual.

5.3.2 Implications for Clinical Practice

Given the extreme pressure that loved ones are under, it is imperative that emotional support is offered to them in order to prevent them from developing mental health issues themselves. This is particularly needed for those who find their loved one in the aftermath of their attempt. As support needs vary greatly from person to person and over time, the present study recommends that loved ones are immediately provided with written information on support services when they encounter health professionals. Loved ones can then choose to access support when they feel it would be most helpful to them. This written

information could be in the form of a pamphlet which signposts loved ones to existing help lines such as Samaritans of Breathing Space. Supplying a pamphlet signposting loved ones to these services would benefit family members as they would be able to access support whenever they felt they needed and would provide the opportunity for catharsis if they wished to take up this support.

A further recommendation for addressing loved ones' evolving support needs is that support services could monitor loved ones' support needs on an ongoing basis through regular and ongoing consultations with the entire family. This would allow practitioners to identify who requires practical support, emotional support, respite from their caring role or any other appropriate support, in line with loved ones' evolving needs. By monitoring their needs over time, support could then be offered at the point when it is most needed and therefore most beneficial to family members.

Subsequently, this study recommends that loved ones are provided with psychoeducation training from mental health professionals in how to care for and safeguard their loved one at home. As further research is required to assess the applicability of the COPE model to family members of suicidal loved ones, this study recommends that a series of dialectical behaviour therapy (DBT) skills training workshops are offered to family members. Research by Rajalin, Wickholm-Pethrus and Jokinen (2009) has shown that this training is effective in increasing the wellbeing of family members of suicidal individuals and in reducing caregiver burden and anxiety. In line with this research, it is recommended that psychoeducation training for family members should include:

- information on risk factors of attempted and completed suicide and practical advice on how to reduce risk at home,
- emotional regulation for family members in response to their loved one,
- a focus on improving communication and problem solving strategies
- enhancing family carers' wellbeing through mindfulness, validation and acceptance,
- encouragement to develop a support network for others

It is hoped that this training would increase loved ones' confidence in caring for their loved one and would reduce the sense of helplessness and self-blame which negatively impact loved ones' health.

The complexity of professional confidentiality when caring specifically for suicidal individuals was highlighted in this study. While the researcher recognises the importance of confidentiality which all healthcare professionals are bound by, this study has revealed that family members often fear that their suicidal loved one has not disclosed the "full story" regarding their suicide attempts to healthcare professionals. As suicidal individuals are frequently discharged into the care of family members at home, this presents challenges for family members. Findings showed that despite family members being expected to adopt a caring and preventative role following a loved one's suicide attempt, they are rarely included in discussions about their loved one's care or support needs. Therefore, this study echoes Nosek's (2008), recommendation that loved ones should be included in discharge meetings and subsequent care planning meetings where the consent of the suicidal individual is obtained. This is likely to improve loved ones' confidence in managing their loved one at home without breaking patient confidentiality. It also offers loved ones a space

to raise concerns and seek advice from health professionals and may allow health professionals to get a more comprehensive picture of the patient's situation.

Given that one participant in the present study found that attending a support group exacerbated her sense of isolation, it is recommended that an online forum for loved ones of suicidal individuals is developed. By providing social support online, loved ones could seek out individuals with very similar experiences. It is hoped that this would benefit loved ones by making them feel more supported and less isolated in their situation. Furthermore, this may be a more realistic option for loved ones who are unable or fearful of leaving their loved one unattended at home.

Based on participant's recommendations, this study suggests that campaigns which target loved ones are developed to encourage them to seek support for themselves. It is hoped that this may address loved ones' tendency to put the suicidal individual's needs first and may result in loved ones recognising that they need support also. It may be helpful for these campaigns to reflect that loved ones can be pressured by their suicidal family member or partner to keep their suicide attempts secret. Therefore, campaigns could focus on the need to widen the net of support for the suicidal person as well as the need for loved ones to access support for themselves.

In conclusion, it is evident that loved ones in this situation do not have the capacity, the time or the desire to actively seek out support for themselves. Therefore, every effort should be made by services to make loved ones aware of the supports available to them. This study has made six strong

recommendations for how services can more effectively and appropriately meet the evolving needs of loved ones living with a suicidal individual. Some of these supports could be readily put into practise such as providing loved ones with pamphlets for existing supports. Other recommendations require resources and funding to be delivered and a shift in culture around the boundaries of confidentiality when caring for suicidal patients.

5.4 Advantages and Limitations

5.4.1 Advantages

This study adds significantly to the limited research base exploring loved ones' experiences of living with a suicidal individual. It has shed new light and uncovered novel aspects of this experience, extending previous research. Furthermore, it has made some important recommendations for future research and how clinical practise could be readily improved. Additional advantages to the present study are listed below.

Advantages of the IPA Methodology

Previous studies exploring this topic have focused heavily on thematic analysis and grounded theory methods. As far as the researcher is aware, no previous studies exploring this topic have adopted an IPA methodology. The advantages of using IPA to explore this topic are as follows:

- A rich 'insider's perspective' of what it actually means to be a familial carer to a suicidal loved one, from the carer's own perspective, was uncovered.

- It explored how participants make sense of their own experiences of living with a suicidal loved one and what meaning this experience held for participants over time.
- It acknowledged the researchers own biases and values which are likely to have impacted the interpretation of participants' accounts.
- The idiographic characteristics of each participant were emphasised while also patterns which emerge across participant's accounts were also highlighted.

Consequently, in comparison to the descriptive analysis methods used employed in existing research, the IPA methodology, provided a richer insight into the idiographic experiences of loved ones living with a suicidal individual.

Addressing Methodological Limitations to Extant Research

This study addressed a number of methodological limitations observed in previous research. First, the present study aimed to explore the experiences of loved ones who did not engage with support services. Unlike Buus *et al.* (2014) and Daly (2005), who recruited participants exclusively from support groups, used on an online recruitment advert also. Consequently, this study's sample consisted of participants who did not engage in support groups. This is an important advantage as it has provided new insights into loved ones' views on support services, barriers to engagement and suggestions on improving support services which may increase uptake of support.

Additionally, like Buus *et al.* (2014), the present study defined suicidal behaviour as an attempt to end one's life which caused serious injury to the person. Consequently, loved ones of individuals who engaged in low level deliberate self-harm or expressed

ideated about suicide without an attempt were not included in the sample. This is an important advantage to this study as it increases the homogeneity of the sample.

Furthermore, the present study employed a sample of non-bereaved family members of a suicidal loved one only. Bereaved participants were excluded from the study as it was felt that their knowledge of the outcome of their loved one's suicidal behaviour would impact their retrospective accounts of living with their suicidal loved one as shown in Owens *et al.*'s (2011) study. Therefore, it was felt that their experiences would not be directly comparable to non-bereaved loved ones' experiences of living with a suicidal individual.

Credibility

This research has been conducted in line with Elliot, Fischer, and Rennie's (1999) guidelines for qualitative research and therefore demonstrates a strong level of rigour, trustworthiness and credibility.

Firstly, the researcher's personal understanding of this subject matter and how her values may have influenced her interpretation of the data was outlined in Chapter 3. In terms of situating the sample, descriptive data for participants and information on was provided to contextualise participants' lived experiences. This study has

The analytical process used in this study is grounded in examples. Extracts and quotes are provided throughout Chapter 4 to demonstrate the fit between the data and the researcher's understanding of it. As previously mentioned in Chapter 3, credibility checks using multiple qualitative coders were used to ensure credibility of the primary researcher's themes. Additionally, the understanding of the experience of living with a suicidal love one is illustrated in a framework providing coherence and integration. Figure 1 in Chapter 4 provides an overview of a clear framework,

highlighting the temporal dimension of participant's experience. The integration of master themes and their inter-related subthemes is emphasised throughout Chapter 4. For example, the emotional turmoil experienced throughout participants' journeys was shown to impact their coping strategies, to add to the challenges they face and to influence participant's recommendations for further support.

This framework also preserved the nuances in the data. It highlighted how some participants' experiences varied within the master themes and suggested reasons that account for these differences.

A suitable number of participants were used to accomplish the task of achieving a general understanding of the experience of living with a suicidal loved one. A justification for using a sample of five participants was outlined in Chapter 3 and the resulting, limited, generalizability of this study's results has been outlined.

Finally, the researcher aimed to present the results of this study in a manner which resonates with readers. It is hoped that this research was presented in a manner which allows readers to judge it as an accurate depiction of the experience of living with a suicidal loved one. Furthermore, it is hoped that this accurate depiction has increased readers' understanding of loved ones' experiences and provided them with an 'insider's perspective' of this experience.

5.4.2 Limitations

Participant Recruitment

From the outset of this research project, it was acknowledged that participant recruitment would be challenging. Although twenty-five potential participants contacted the researcher initially, this materialised into just six interviews, one of which could not be included as the participant was not living with the suicidal

individual. Similarly, although seven charities agreed to advertise the study through their websites and mailing lists, this did not recruit any participants. This may account for the limited research base investigating this topic and why so many previous studies recruited participants from one support group.

Sampling

The challenges of participant recruitment resulted in the sample not being as homogenous as was preferred. Although all participants had a shared experience of living with a suicidal loved one, the varied relationships with suicidal individuals resulted in variations within their experiences. Therefore, it is suggested that further research targets a specific a category of loved one (e.g. children, parents, siblings or partners), to increase homogeneity, particularly if employing an IPA methodology. However, in employing a varied sample with varied relationships to suicidal loved ones, this study has explored different loved ones' perspectives. This has been advantageous particularly in terms of recommendations for service provision as it highlights that loved ones support needs vary depending on their relationship to the suicidal individual.

Additionally, the length of time since participants' loved one's most recent suicide attempt varied greatly from 2 weeks to 10 years. This is likely to have influenced participants' accounts of their experiences and the accuracy of their recall. For example, it was felt that Callum, whose partner had overdosed two weeks prior to his interview was still in shock to some extent. It was observed that he had not fully processed this event or had time to digest it. This contrasted greatly with the rest of the participants who had five to ten years to 'replay' and make sense of their loved ones' attempts. However, the variance in terms of the time elapsed allowed for

exploration into the long term and short term impact that the individuals' suicide attempts had on loved ones. This is important given that results showed that participants' needs varied over time. Consequently, while Sun *et al.*'s (2008) focused on a specific point in the family carer's experience and therefore has the advantage of increased homogeneity, they were unable to examine the long term impact of this experience. Therefore, it is recommended that a longitudinal IPA study is conducted with a more homogenous sample in terms of time elapsed since the loved one's suicide attempt. It is felt that this would could examine loved one's experiences over time while have a more homogenous sample in line with IPA. However, given the difficulties this study faced in terms of participant recruitment, this may prove to be challenging.

The purposive sampling strategy used in this study is also subject to limitations. This sampling strategy led to a smaller sample size which cannot be considered as representative of all loved ones living with a suicidal individual. Although this study does not attempt to empirically generalise its findings, it acknowledges that a sample of this size allows for very little empirical generalizability. Therefore, as previously stated, further research focusing on the experiences of loved ones living with a suicidal individual is necessary.

Data Collection

When using semi-structured interviews, the positive rapport developed with each participant and the resulting likelihood of them sharing their private experiences relies on two factors. First, it relies upon the researcher's communication and interpersonal skills. Second, semi-structured interviews assume that language plays a fundamental role in communication, interpretation and understanding (Smith,

2008). Therefore, participants' ability to communicate their experiences, perceptions and understandings to the researcher during the interview relied on the level of their articulacy (Smith, 2008). In the present study, levels of articulacy varied across participants which consequently limited the richness of the data in certain interviews. For example, some participants struggled when attempting to describe how they coped with their experience. Kyle stated that he "just powered through" while Tim explained that he coped with it "day to day". A lack of emotional literacy or articulacy, may account for these limited descriptions and insights. It is also possible that participants may not have considered how they coped with this experience prior to the interview or that they found this question too difficult to expand their answers. Strength of recall may also be a factor given that both participants were recalling events from six and four years ago, respectively. Consequently, the dependence on participants' articulacy to communicate their experiences could be considered a limitation to this study.

Finally, the researcher's own biases, values and beliefs influence the collection and analysis of the data. As the findings consist of the researcher's interpretation of the data they cannot be considered to be fully objective. This may be viewed as a limitation to the present study by quantitative researchers. However, this is consistent with the constructivist research paradigm and IPA methodology; the researcher outlined her personal beliefs and biases in Chapter 4 and acknowledged how these were likely to impact the interpretation of the data.

Caregiver Research

Prior to conducting participant interviews, the researcher was aware that keeping participants focused on their own experience can be a challenge when conducting

caregiver research. Although an interview schedule was therefore developed which aimed to guide participant interviews and keep participants on track. Despite this, the researcher struggled with keeping participants focused on their own perspective and encouraging them to talk about their own beliefs, feelings and the impact that the experience had on their identities, wellbeing and lives. It was observed that participants often reverted back to their suicidal loved ones' perspective often. Consequently, this is considered to be a further limitation to the present study as it directly impacted on the richness of the data.

Scope of Present Study

Finally, this was a small scale research study completed in partial fulfilment of a Masters by Research degree. Therefore, it was conducted within time, size and funding constraints which limit the study's scope. The time restraints for this study meant that the researcher could not apply to NHS Research Scotland Ethics Committee. It is recommended that future research on this topic should obtain ethical approval from the NHS as it may result in a more fruitful method of participant recruitment.

5.5 Conclusion

This study has added to the limited research base investigating loved ones' experiences of living with a suicidal individual at home. It has produced new findings and insights into this under-researched and poorly understood phenomenon. These are summarised below:

- The impact of an individual's suicide attempt is unique, complex and varies from person to person.

- Loved one's experiences, support needs and challenges, all differ according to their relationship with the suicidal individual and vary over time.
- Ongoing and persistent trauma is experienced for years following their loved ones' attempt, not just in the immediate aftermath of attempts.
- An enduring sense of guilt which is experienced by loved ones, years after suicide attempts are made, often results in biographical disruption and an inability for loved ones to move on with their lives.
- Hypervigilance
- It has examined the dual function of hypervigilance, as a coping mechanism for the unpredictability of the situation and also as a coping strategy to limit guilt.
- Loved ones not only experience isolation from those without this shared experience, they can also be isolated within their own families.

Subsequently, this study has extended findings of existing research and has suggested potential reasons for discrepancies in its results in relation to the extant research. Most importantly, it has highlighted the vulnerability of loved ones living with a suicidal individual, the lack of support available to them and the reasons some loved ones do not engage with support services. This has allowed for a number of tentative recommendations for service provision to be made, in terms of meeting the varied and ongoing support needs of loved ones living with suicidal individuals.

Finally, this study argues that, in order for supports to be developed which are tailored to this specific population's needs, further research into loved one's perspectives and experiences is crucial. Loved ones' accounts are therefore

essential to fuelling and establishing more appropriate, relevant and useful supports. Service provision can only be improved via a better understanding of the perspectives and experiences of these individuals themselves.

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Appendix 1: Participant Recruitment Advert

Do you have a family member who is/ has been suicidal? We want to hear your views. Participants needed for a study exploring family members' experiences of living with a suicidal loved one.

A researcher at Edinburgh Napier University is seeking adults (18 years or older) to participate in a research study. The study will explore the impact that living with a suicidal loved one has on family members and partners.

It is hoped that the result of this study will shed light on family members support needs and how these can be more effectively met by healthcare and support services.

Eligible participants must:

- Have an immediate family member/ partner/ spouse who has thought about or has attempted suicide.

Participation involves taking part in a confidential interview with the primary researcher, Rachel Hanson. The entire procedure should take up to 60 minutes. All identifying information will be anonymised and it will not be possible for you to be identified in any reporting of the data gathered.

If you are interested in taking part in this study or if you want to learn more about it, please contact Rachel Hanson at 40221029@live.napier.ac.uk. Please leave your name and email address or contact telephone number.

Appendix 2: Participant Information Sheet

Exploring the lived experience of suicidality: An interpretative phenomenological analysis of the loved one's perspective.

My name is Rachel Hanson and I am a postgraduate research student from the School of School of Life, Sport & Social Sciences at Edinburgh Napier University. The title of my project is: Exploring the lived experience of suicidality: An interpretative phenomenological analysis of the loved one's perspective.

This study will explore the impact that caring for a suicidal loved one has on family members and partners. The findings of the project will be useful because research shows that currently, there is little support available to carers of a suicidal loved one despite the caring and preventative role they often adopt. It is hoped that this research can inform healthcare professionals about family members' experiences of caring for a suicidal loved one, their support needs during this time and inform service development for family members of suicidal loved ones.

I am looking for volunteers to participate in the project. In order for participants to be included, they must be 18 year of age or older and have an immediate family member/ partner/ spouse who has thought about or attempted suicide.

If you agree to participate in this study, you will be asked to take part in an interview with the researcher. You will be free to withdraw from the study at any stage without reason and you will be free to pause the interview at any point. You will be free to decline to answer any questions that you do not wish to answer. The whole procedure should take no longer than 60 minutes.

Your interview will be audio recorded and transcribed by the researcher. All data will be completely anonymous and confidential. Confidentiality will only be broken if a participant discloses to the researcher that they are at risk of harming themselves or harming others. In this case the researcher is legally obliged to pass this information on to the participant's GP or the police if they are at risk of harm to themselves or to others. Your name will be replaced with a pseudonym and it will not be possible for you to be identified in any reporting of the data gathered. All data collected will be kept in a locked cabinet and stored on a PC that is password protected to which only I have access.

The results may be published in a journal or presented at a conference.

The researcher is aware of the sensitive nature of the issues covered by this project and, should you require more information about any aspect of the research, please contact:

Primary Researcher:

Rachel Hanson
Edinburgh Napier University,
Room 2.B.48,
Sighthill Campus,
Edinburgh,
EH11 4BN.

40221029@live.napier.ac.uk

Supervisor:

Dr Adele Dickson
Edinburgh Napier University,
3.B.39,
Sighthill Campus,
Edinburgh,
EH11 4BN.

a.dickson@napier.ac.uk

Independent Advisor: (knows about the project, but not involved in it)

Geraldine Jones
3.B.35,
Sighthill Campus,
Edinburgh,
EH11 4BN.

g.jones@napier.ac.uk

If you have read and understood this information sheet, any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.



Appendix 3: Participant Consent Form

Exploring the lived experience of suicidality: An interpretative phenomenological analysis of the loved one's perspective.

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I understand that I am under no obligation to take part in this study.

I understand that the information I disclose in this interview is confidential and that confidentiality will be broken only if I disclose that I am at risk of harm to myself or to others.

I agree to participate in this study.

I agree to my interview being audio recorded and transcribed.

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of researcher:

Primary Researcher: Rachel Hanson

Address: Edinburgh Napier University
Room 2.B.48,
Sighthill Campus,
Edinburgh, EH11 4BN

Email: 40221029@live.napier.ac.uk

Ph: 07449859458

Appendix 4: De-briefing Sheet

Exploring the lived experience of suicidality: An interpretative phenomenological analysis of the loved one's perspective.

Thank you for taking the time to take part in this research project.

The aim of this project is to explore the experiences of family members caring for a suicidal loved one. It is hoped that the findings from the project can be used to inform healthcare professionals and support workers on the support needs of these family members, the challenges they face, their support needs and how services can more effectively meet their needs. Any further questions about this study can be directed to the primary researcher, the project supervisor, or the independent advisor:

Primary Researcher:	Project Supervisor:	Independent Advisor:
Rachel Hanson Edinburgh Napier University, Room 2.B.48, Sighthill Campus, Edinburgh, EH11 4BN. 40221029@live.napier.ac.uk	Dr Adele Dickson Edinburgh Napier University, 3.B.39, Sighthill Campus, Edinburgh, EH11 4BN. a.dickson@napier.ac.uk	Geraldine Jones Edinburgh Napier University, 3.B.35, Sighthill Campus, Edinburgh, EH11 4BN. g.jones@napier.ac.uk

All results will be handled only by the primary researcher and the project supervisor. Results will be held on a password protected computer and in a locked filing cabinet. The findings may be published or discussed at a conference but, due to the anonymous nature of the interview no individuals will be personally identifiable. If you have been affected by the content of the interview, please do not hesitate to contact the following helplines:

NHS 24 Helpline

- Ph: 111
- Website: <http://www.nhs24.com/>

Breathing Space Helpline

- Ph: 0800 83 85 87
- Website: <http://breathingspace.scot/>

Samaritans

- Ph: 08457 90 90 90
- Website: <http://www.samaritans.org/>

If you wish, the primary researcher, Rachel Hanson, is happy to contact you by phone one week after your interview to check in with you and refer you to further support services if required. Please provide your contact details if you would like this to be arranged.

Also, please contact Rachel Hanson within one week following your interview if you wish to withdraw from this study for any reason.

Appendix 4: Participant Demographics Sheet

Participant Details

Recruited through: Gumtree Advert Charity

Age: _____

Gender: Male Female

Ethnicity: _____

Marital Status: _____

Religion: _____

Occupation: _____

Educational background: _____

Relationship to suicidal individual: _____

Name and contact details of your GP: _____

Are you accessing any support services at the moment? Yes No

Loved One's Details

Age: _____

Gender: Male Female

Ethnicity: _____

Marital Status: _____

Religion: _____

Occupation: _____

Educational background: _____

No. of suicide attempts made by suicidal individual:

Estimate of when last attempt was made: _____

Were they accessing any support services at any point? Yes No

Appendix 6: Interview Schedule

1. Tell me about your relationship with your loved one who attempted/ thought about suicide.
2. When did your loved one first attempt or think about suicide?
3. Can you talk me through the events leading up to your loved one's suicide attempt? What was going through your mind at that point?
4. When did you first become aware that your loved one attempted/thought about suicide? How did you feel? What were your thoughts/concerns? How did these change over time?
5. When you became aware about their attempts/thoughts of suicide, in what ways did this impact on you most? How did you try to manage it?
6. Talk me through your experience of living with your loved one when they were suicidal. How did this impact you on a day to day basis (e.g. working life/ social life/studies/job searching/raising a family?)
7. What was life like at home during this time? How did it impact the rest of the household?
8. What impact (if any) did your loved one's suicide attempt/ideation have on your relationships with others? What impact did it have on your relationship with your loved one?
9. In what ways (if at all), did it impact your physical and mental wellbeing? Your sense of self? Self-confidence? Your identity as a parent/ sibling/ partner/spouse? Your anticipated/ future/plans for the future?
10. Did you tell anyone about your loved one's suicide attempt? If yes, who were you comfortable telling? In what ways was it helpful? Not helpful? If not, why were you not comfortable speaking to others about it?
11. Talk me through the main challenges that you faced while your loved one was suicidal. What kinds of things did you do to help you get through those challenging times?
12. What were your support needs during this time? E.g. Practical support or advice, educational support around suicide, listening ear, emotional support from others.
13. Did you receive support during this time? If yes, where from? (e.g. healthcare professional, voluntary organisation, family member, friend, helpline.) If no, why did you not access support during this period?
14. Did your loved one get any support from health professionals or the voluntary sector? If so did you have any interaction with them? If yes, how did you feel about the support they were given. Did they offer you any support? If no, what do you think stopped them from seeking support?
15. How do you feel about your loved one's suicide attempts now?
16. Has anything positive come out of your experience caring for your loved one during this difficult time?
17. Is there anything that we've not covered today that you think is important or relevant to your experience of caring for your loved one who is/was suicidal?

Appendix 7: Ethical Approval

WM Winterton, Mandy <M.Winterton@napier.ac.uk>

To: Hanson, Rachel;

Cc: MacLean, Rory; Dickson, Adele; FHLSS, Ethics;

Wed 09/12/2015 15:54

Hi Rachel

This is a really professional proposal and I am very happy to inform you that you have met all of the requirements for such a sensitive topic. Congratulations and I wish you every success with your study. In fact, I hope I might get to read it in the not too distant future.

Please submit a final signed copy to Jill Napier for her records.

Best wishes

Mandy

Dr Mandy Winterton

Reader: Sociology and Social Inclusion

Programme Leader, BA (Hons) Social Sciences

Edinburgh Napier University

Sighthill Campus

Edinburgh, UK

EH11 4BN

Room: 3B16

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E: m.winterton@napier.ac.uk

Appendix 8: Search Strategy

Literature Search Strategy for Family Caring Experience Suicide Research

Exploring the lived experience of suicidality: An interpretative phenomenological analysis of the loved one's perspective.

Family Member Search Term	Suicide Attempt Search Term	Experience Search term
Family member Parent Sibling Spouse Partner Carer Caregiver Mother Dather Brother Sister Husband Wife Loved One Significant Other	Suicid* Behaviour Suicid* Attempt Attempted Suicide Parasuicide Self-harm Suicide surviv* Self injur*	Experience Lived Experience Impact Managing Response Effect Burden Burnout Stress Phenomenolog*
Combined these using OR search (A)	Combined these using OR search (B)	Combined these using OR search (C)

Combined A and B using **AND** search
(D)

Combined B and C using **AND** search
(E)

Combined A and C using **AND** search
(F)

Appendix 9: Annotated Transcript

P4: Claire

Date of Interview: 22/03/16

Interview Duration: 1 hr 2 mins

I: Em, so if I can start off could you just tell me in your own words about your relationship, em, with your ex who has attempted suicide?

P: Yeah, (exhales), em, I suppose when, when we first met, **had no knowledge of any of it he... you know that he was experiencing any problems, other than you know, I knew that his family was quite (sighs) just seems quite em, disjointed.** And (breathes) em he wasn't, you know, **he hadn't spoken to his mum in a number of years, which em, yeah, that seemed to be, well, you know an issue, really and, (breathes), and I suppose it was only you know, living together em when we were living together sometime really before I kind of realised like that things weren't quite right, you know**

Challenges
Family Reln
Warning signs

I: Okay

P: But Ag...again, I'd suppose, I kind of put it down that it was work stresses or something, and then em, it was quite sudden I think, just the way he seemed to deteriorate, where he was under lots of stress before he started a new job, em, I find the... it seemed to me, to me he seemed to have the symptoms of depression but refused all help, wouldn't do you know just wouldn't go and seek any kind of help. Em, em, em things were just, just kind of happened very, very suddenly and then eh, spoke to the (breathes) to the, the effecting kind of... deteriorated very rapidly you know, he was trapped trying to complete a masters part time whilst working full time (breathes) went away on a course, em, for his masters like, went to the dentists' course and back and em, the only way I can describe it is he was like a robot, you know, em, then, just started breaking down in tears and (breathes), just very difficult really (sigh)

Warning signs
Challenge
not willing to get help
sudden deterioration
Warning Signs / Understand stress of work & study

I: Okay, so initially when you, when you first started to see signs that things weren't quite right, what kind of em, what kind of things did you notice?

P: Em, (breathes), I'm, I'm trying to think now, you know, I suppose em, things like with sleeping habits em, (breathes) irritability, just trying to think now because it was so long ago, em, just em, probably the emotional side of things as well, you know, where, yeah, he was very irritable, he seemed to, seemed to keep having lots of rows with people in work and, you know just very stressed all the time, very irritable, em, it's hard to explain, you know, because it just, em, it was kind of out of character for him as well.

Warning signs
irritability
sleeping
rows with colleagues

I: Yeah

P: I think the main thing was really, the irritability to, I suppose the lack of as well, he kept, withdrawing socially more and more, you know, that became more quite prevalent and you know em. And what I noticed as well and I felt it wasn't an issue but maybe more and more I noticed there were things like em, em, constantly trying to (pauses) change, you know, circumstances as in I mean remove certain at certain times. Because we'd move to somewhere and he just wasn't happy there, wasn't happy in the job em. It, it sounds ridiculous but kept, kept wanting to, you know, go on holiday constantly. Em it was like, just escapism, all the time you know em, and, (pauses), sort of trying to do things like em, yeah, kind of quiet extravagant and buying a lot of extravagant stuff and (pauses) and again just a lot of it seemed to me just, again, you know, that escapism em, no, nothing at all like substance misuse or nothing like that. But em, (pauses), just more and more the isolation and escapism I think is the, is, is, as I said because it had happened, gradually at first, you know, em, it, it didn't become apparent to me until things were quite (breathes) they were, you know, just getting very stressed, very emotional. Em, (pauses) em, then I think when things got really bad, em,

Warning signs
social withdraw
Coping / Warning

Appendix 10: Coding Matrix – Emotional Turmoil

Master Themes	P1 Tom	P2 Tim	P3 Callum	P4 Claire	P5 Kyle
Emotional Impact Subtheme Range of emotions Subtheme Exacerbates: unpredictability,	<u>Guilt</u> <u>Blame/Guilt</u> “It (sighs) was bizarre em, (pauses) for em (exhales and pauses) well she was my mum so obviously, I loved her. For a long time I actually blamed myself for her being ill, for her illnesses which I suppose tarnished it in a way, if that’s the right word. [] Em and instead of admitting to folk that she had multiple sclerosis she said em that the reason that she was ill was the fact that an epidural went wrong when I was born. And she said this in front of me once when I was about eight or nine and I picked up on it. But when you’re that age an epidural could be something you ate right. Em so for (sighs) seven years I carried that around	<u>Helplessness</u> <u>Shock, Disbelief & anger</u> “I was just really like overwhelmed and really worried you know. (Pauses) it’s a funny thing like (pauses). You can’t really describe your reaction its like (pauses) it was just shock like. And you never really think that something like that is will to happen so close to home it’s like, you know what I mean like (pauses). And then (pauses) yeah it ah, it’s just, to be honest I probably went through a bit of almost disbelief as well like.” “I think its like, it’s em, it’s like something you just never think it going to happen in you like, it’ll happen to someone else like do you know what I mean like? You just never really consider it until you’ve gone through it kind of thing.” “But it was shock really to be honest, more than anything else but I eh eh I think I just, I	<u>Anxiety</u> – overstepping/ walking on eggshells, “I didn’t want to push too much in case he then was like no it’s my life, leave me alone. [] So while I would suggest it I was wary of pushing it too much in case I made it seem like I know what’s best or I’m telling you what to do. It was difficult to get the balance. Because I had to, like made it very clear that that’s what I think you should do but whatever you do I’ll still be here, I’m not going to be like I told you so or whatever.” “Because I would be so worried about overstepping. Because he has a job I would be of the opinion that he should go privately to therapy like because the NHS way took so long. And I brought it up a couple of times and he was like no I don’t feel	<u>Stress & Anxiety & Panic</u> “And then I suppose the stress of it as well and, you know, feeling like I had to walk on eggshells, em, and just you know, the worry and the concern as well, you know. And then em, when, when things got very, very bad, em, you know where he was saying he was going to just crash the car into a wall and, or crash it into the back of a truck. Em, you know he would just say this an then take off in the car and just the sheer panic I suppose, was you know what do I do” “I just kept thinking I don’t know how I haven’t lost everything, that I didn’t end up in a psychiatric ward myself due to the emotional turmoil and the stress	<u>Shock</u> “I got a phone call from (long pause) I got a phone call I think from my mum. And on the phone call she’s like I think she said I think Emma’s dead, I think she’s died, she’s took her own life... []...And I was just like, cos I was half asleep on the couch and I got this call.” <u>Shows range of initial emotions</u> “I was angry because I couldn’t get there as quickly as I wanted to. And like I dinnae think I ever heard my mum cry before so you knew it was really bad. And agitated because I couldn’t get a hold of anyone to find out what was going on. But probably the most overwhelming feeling was just absolute helplessness and panic because I knew my sister was in trouble I didn’t know what had happened

	<p>with me that I caused her illness.</p> <p>Shock - physical</p> <p><u>Anger (turned in – PTSD)</u> “I thought well okay but a lot of it was anger diverted in a way because I couldn’t speak to anyone about it and I couldn’t vocalise it out of the way so I turned a lot of anger in towards myself if that makes sense?” “Em nightmares, flashbacks, em (pauses) for a while, a really, really bad temper and that was not healthy for anyone that yeah. I used to be the quite fat kid in the corner that naebody really noticed apart from bullies and that was fine. Em except after that day, the two things happened. I grew about a foot and a half over the summer holidays and two, I learned how to hit straight and that was the best and worst thing that ever happened to me for want</p>	<p>think my body actually went into shock. I just didn’t know. And anger as well. I was angry, really, really angry like. ever happen so</p> <p><u>Stress/Worry/Panic</u> “Em (pauses) a lot of it as well, the not knowing thing, just not knowing what to do, where to go, if she was going to do it again. Em it’s just really fear of the unknown like because you just didn’t know what to think, what to do really like other than take her to the doctor to talk to. But like other than that, as I said I don’t know anything about depression, I’m not a doctor, I don’t know. So its fear of the unknown more than anything else it was just really terrifying. It was really scary like because obviously I love my sister and you wouldn’t want her to do something stupid you know.” “Well yeah maybe a little bit because I wasn’t sleeping at all. And I know it definitely did my mam’s as well because stress affects her in a way where she just doesn’t sleep at</p>	<p>comfortable with that or no, I don’t think I can afford it or whatever excuse there was. So I just immediately dropped it. And now I’m like, I should have been more, I should have spoken up more or whatever. So it was more at my own reluctance but I didn’t want to push too much in case that meant he stopped talking to me or got mad or something like that.”</p> <p><u>Anxiety – next steps</u> “But em it was the kind of what comes after that. Because I wasn’t really aware of what they could do besides, like once you were discharged it’s like what do they do then because you’re not in the hospital with the people so what can they do besides telling you to go to your doctor (laughs) which was already an issue. So it was very kind of, well we’re here, now what? That kind of feeling.”</p>	<p>that I was in.”</p> <p><u>Anger – being blamed on relationship, no one taking it seriously</u> “but had done similar in the past to ex-girlfriends and, as in, just, you know the behaviour, (breathes). Em, so yeah I just felt, you know, this isn’t about me, this whole history of it before we even met, you know, so, em.” “I think worse in that again, people were just dismissing things and nobody seemed to be listening. You know, em, so, yeah it just became very isolating then and oh do they think I’m just this, you know that I’m just, I don’t know what they maybe thought but just I felt they’re maybe not believing me or they’re not taking it seriously, you know.”</p> <p><u>Fear</u></p>	<p>and I didn’t know if she was okay. And that would probably be the main thing really is just not really knowing.”</p> <p><u>Helplessness – exacerbated by not knowing</u></p> <p><u>Disbelief</u> “I think you’re just kind of like, it’s hard to fathom why like.”</p> <p><u>Relief</u> “But yeah, when I seen her it was just kind of relief that she was okay em and that she was talking.”</p> <p><u>Anxiety quickly follows relief like P3</u> “And then obviously the main question you start to asking is what’s wrong, what’s lead to this, why has she done this.” “You’re just like constantly on edge all of the time in terms of worrying about it (pauses).” “Cos even now like I’m on eggshells around my sister.</p>
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	<p>of a better word.” “My mind-set at that time was (pause) because I still blamed myself, by the age of fifteen, despite the fact that I had figured out that it was two entirely different things, the epidural and the MS, em I still couldn’t shake myself, that it was your fault.” “There is a friend of mine, I have absolutely no memory of this at all, who is absolutely terrified of me. I said “ have I done anything to offend you?” “No, no but I’ve seen what happens when you loose your temper.” “What the hell are you on about?” I have genuinely got no memory of this whatsoever but apparently I went, he was at college with me. And apparently into the college bar one night and (sighs) just punched my way from one end of it to the other. And I have no memory of that whatsoever. And that is one of a hundred things</p>	<p>all. I don’t think she was eating really properly and eh eh. But me? I wasn’t, at least for a few weeks anyway I wasn’t sleeping well at all, I was getting very little sleep at all and I suppose it did affect me physically yeah.” “. And yeah when she wasn’t very close to me I worried like fucking mad like you know. Em I was like, even two or three months later after when she was kind of getting back to normal and she wanted to go out again to parties and stuff. The thoughts running through my head were you know yourself, girls can be so bitchy what if she gets in a fight with someone or in an argument with one of her friends or something like that and you know goes off the fucking deep end again? So yeah I was still worrying about that like.” “well I can only speak for myself, I can’t speak for my mam or my brother but yeah I was under a tremendous amount of stress. I was thinking about it all the time because I just didn’t know</p>	<p><u>Worry</u> “But then obviously I do have that constant worry which isn’t great to have to deal with all the time.” “I would be in contact all the time like a mother hen (laughs) just being like is everything okay or how are you doing? We talk a lot anyway so it didn’t seem unusual but if we hadn’t been in contact in too long or if like aside from when he’s be in work then I’d be like is everything okay, what are you up to? How’s it going? Like and trying not to be overbearing but also being like it’s for my peace of mind, I don’t know what’s going on.” “it was very just kind of a (pauses) there was always a sort of low key worry just sort of in the back of my mind, there was always a “but how’s John doing?”. Or “is John doing okay now? or “how is John reacting to this?”. “Em so it’s a very kind of</p>	<p>“I suppose, I suppose I was kind of concerned that if I did that, I think I was just concerned if I did get a GP out, I wasn’t sure about the level of help he would get. And I thought that (pauses) what if he just takes off somewhere and just you know, does try to make an attempt and is successful.” “Em, and yeah, I mean he would just take off sometimes for weekends and I just wouldn’t know where he’d be and we were living in a house down the country and yeah, I would just spend the time there just worrying myself sick, em.” <u>Guilt</u> “I had said to him you know, because the whole thing that he said that, the relationship was over that he didn’t love me anymore but yet pleaded and begged</p>	<p>I’m panicked. I’m concerned like because she is, she is an unstable girl. You know when she got pregnant my first personal thoughts were oh jesus I don’t know if she’s emotionally stable enough to deal with that..[.. Even like maybe four or five months ago she’d said that she didn’t want to be here anymore.” <u>Blame</u> “My mum obviously at the time as well, blamed herself a lot” because she was the only parent there. <u>Guilt</u> “Em I think yeah I felt guilty as hell because as a twenty-one year old, I’m just away partying and enjoying myself and living the dream if you like. I’m out of the council estate that I grew up in, I’ve got my own flat em, I’m working a job that I love, I’m coaching, I’m at college doing sport. So I’m having the absolute time of my life and I’m completely kind if sheltered to maybe what my</p>
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	<p>like that that has happened that I have no clue about. [] They continued all through my twenties until I was about twenty eight I think.”</p> <p>“It was almost as if I’d been in a bad mood for twenty year and I was looking for someone, for some outlay for it.”</p> <p>“The thing I needed the most at that time was somebody either my mum or dad to say this wasn’t your fault. That is the one thing that would have meant more to me than anything else. Em (pauses) yeah.”</p> <p><u>Self-loathing</u></p> <p>“...at one point I took an overdose myself. I just I’d had, I’d absolutely had enough and that was a, that was a dent in the road. But since then there has been improvement time on time. Yeah that was, I just didn’t like who I had became more or less sorry. And em I didn’t like what</p>	<p>what to do, I felt a bit helpless like do you know what I mean?”</p>	<p>(pauses) anxious feeling because I don’t know what’s going on. And if we weren’t in contact for a while then I would be like what’s happening, I don’t know what’s going on and it’s very sort of paralysed kind of feeling.”</p> <p>“Em so it’s a very kind of (pauses) anxious feeling because I don’t know what’s going on. And if we weren’t in contact for a while then I would be like what’s happening, I don’t know what’s going on and it’s very sort of paralysed kind of feeling.”</p> <p><u>Worry</u></p> <p>“Em and it was just sort of constant. If ever we weren’t in contact for more than maybe two or three hours I’d be like okay, that’s it he’s done it, he’s done it.”</p> <p>“so I’m kind of like every time he’s not in contact for a little while which isn’t often recently because like he knows that I’m worried</p>	<p>with me not to move out. He still wanted me to be in the house and to be very much in my life and... yeah (pauses) at the same time telling me he didn’t want a relationship and he didn’t love me anymore and em, that makes no sense and you know, we had to move on, this isn’t right and (pauses). You know, any time I made an attempt to move out or anything again it was the whole emotional side of things, I just felt I couldn’t move out because if I move out, who’s going to look after him.”</p> <p><u>Self Confidence</u></p> <p>“And so I suppose all of that, yeah, really knocked my confidence [].I knew that I was suffering at that stage extreme stress myself and I just, I just really need help now myself</p>	<p>sister’s going through while I’m having an absolute ball.”</p> <p>“Especially cos I worked with females so much, I’ve worked with female teams for years. And I’ve been able to help so many people but I didn’t feel like I could help my own sister and that was kind of not idea. [] I just felt guilty really and a bit helpless was probably the main thing.”</p> <p><u>Fear of future attempts and how to respond</u></p> <p>“She threatened to take her own life again on the phone to me on another occasion like later on. And like that’s just heart-breaking do you know what I mean. She was just like I’ve had enough I’m going to kill myself. And you’re like I mean how do you respond to that.”</p> <p>“Yeah everyone was just petrified it was going to happen again. Like I was kind of phoning my mum like you need to watch her, you need to watch her. And she was like I am, I am.”</p>
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	<p>had became of me. I thought I was going, I thought I had just had enough. No anything like that (sighs) anything like that, anything like that a kid for want of a better word, goes through is obviously will affect them for a long time”</p> <p>“Twenty, to a certain extent wasted years. Because I should be a lot further ahead than where I am right now but a lot of those years I wasn’t worth a damn.”</p> <p><u>Empathy for mum – death would be kinder</u></p> <p>“I often said this is going to sound heard hearted again but if she was a beast I would have and her shot just for being like that because that wasn’t life, Christ that wasn’t life at all.”</p> <p>“I suppose in a way, disappointed for her. Because I knew how much she hated being, because obviously to go and to that</p>		<p>so he does try. But like anytime there’s like a gap, I’ll be like oh god something’s happened. And it’s kind of, It’s my first impulse or my first thought.”</p> <p>Frustration at GP appts</p> <p><u>Disbelief</u></p> <p>“So it was (pauses), there was still a, in the back of my mind the all the time until the second suicide attempt there was still a but he wouldn’t actually do it or he wouldn’t go that far. It’s not that I didn’t believe him but just that its, it’s not a like it’s not something I had experienced first-hand of anybody. I just hadn’t been in that situation so in the back of my head I was like well it’s probably not going to happen hopefully you know”</p> <p><u>Fear/Panic</u></p> <p>“And then he didn’t get back to me for about three</p>	<p>at this stage. Em, and I remember at one stage going into the hair dressers and looking in the mirror and just crying and (long pause). Yeah, because I just didn’t even recognise myself”</p> <p>Desperation</p> <p>Aware people are fearful that they will be shut out or upset the person, advises against this need to prioritise keeping loved one safe over upsetting them</p> <p>Disbelief – goes from job, house, bf, going to get married and have kids to begging for social welfare in less than a year</p> <p>LT impact of stress, lower tolerance for stress even now</p> <p>Phsyical wellbeing</p>	<p>“But with that in the back of my head, even though I don’t know like she got pregnant before and lost it. And I was like parked outside her house, honestly like I was just waiting for something to happen. And then she obviously she got pregnant again with Harry and the whole time you’re thinking like please, like please don’t let anything go wrong. ..[]... So I was just thinking oh God please don’t let this happen again. And especially the more pregnant she became, the more I thought if this goes wrong she’s not going to be able to cope with this. ”</p> <p><u>Emotional Wreck</u></p> <p>“So I was kind of like, I mean personally I was an emotional wreck because I was kind of having to put on this incredibly kind of like happy personality and the second they finished I was broken because it just took so much out of me to put on that kind of show if you like.</p>
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	<p>they hate the way they are so aye (exhales).”</p> <p><u>PTSD</u> “It left me with (pauses and clears voice) it was only diagnosed with a few of years ago, with post-traumatic stress relating back to that one particular episode as well as just the build up to it. [] But the more you look into it the more obvious it is, especially with how I became following that, em it all fits. It was only about 2010 or 2011 that I was actually diagnosed with it”</p> <p><u>Helplessness</u> – no one to talk to as felt it was his fault</p>		<p>or four hours and I was very worried because I was thought if you’ve been drinking you may have drank more or whatever and it’s like ah. It’s because we live in [refers to place name], some of his work mates live like quite close to us but there’s like a gap and we live a bit further out so there would have been a distance where he would have been walking home alone at 1am. So I was like this is not a good plan (laughs) and he hadn’t gotten back to me in ages and he wasn’t answering his phone so I was like this is it.”</p> <p>“Em, mostly I suppose a lot of fear. Because it’s very just like that someone could do that is very kind of frightening. And also the what if they hadn’t text me or what if I had gone to sleep by that point and hadn’t arrived. Or what if they had taken more pills than they actually did. Or what if even though we’ve</p>	<p>impacted – stopped periods, weight loss, immune system affected</p>	<p>”</p> <p>Searching for answers, what caused this, Walking on eggshells</p> <p>Guilty didn’t give mum more support</p> <p>An “emotional wreck in work” – “putting on a show”</p> <p>LT panic and concern for her wellbeing and ability to cope years later</p> <p>LT anxiety – walking on eggshells, fearful of how he responds doesn’t know how she will react, fear of future attempts</p> <p>LT effect of guilt, wasn’t there when she needed him, will do anything for her now, money, lifts etc</p> <p>Hopeful yet wary about the future</p>
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gotten here, what if something goes wrong or something happens. So really just a delay, a delayed fright really was kind of the big thing. And then it was also a what happens now type thing? So it was very, just kind of like waiting and just the not knowing what was going to happen. Because for the immediate future they're going to be in hospital for a while, they'll be on a drip or whatever em and the psychologist will come around at some point probably. But beyond that I didn't know what was going to happen. I didn't know if I'd be allowed stay or would I have to leave. Because obviously at 4am it's not visiting hours so I didn't know what was going to be allowed."

Helplessness
Hopelessness (Jon) as trying to take unsuccessful steps to get GP apt
Hopeful for the future,

			now has GP apt, hopeful there will be recovery, hopeful won't need to be carer moving forward Worried about the LT plans for John post-discharge		
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