From Pain to Purpose: A psychodynamically and psychosocially informed narrative inquiry into suicide bereavement

Sue Egan

May 2022

Word count: 38,807

Department of Health and Social Sciences, Faculty of Health and Applied Sciences

University of the West of England (UWE), Bristol

(Thesis submitted in partial fulfilment of the requirements for the award of Professional Doctorate in Counselling Psychology)

Abstract

A reported 5,691 people died by suicide in England and Wales in 2019 (Office for National Statistics, 2021), leaving behind an unclear number of suicide-loss survivors living with grief. The British Psychological Society's (BPS) (BPS, 2016) position statement on understanding and *preventing* suicide acknowledged the need for further research into how suicide loss can impact others and how professionals can support them. Scholars have argued that when suicide-loss survivors attempt to access support and share their story, they can experience shame, stigma and feelings of responsibility for the discomfort of others (Peters et al., 2016). It is therefore likely that suicide-loss survivors may be affected by social discourses and personal constructs of suicide.

The aim of this research was to explore a) the psychologically defensive deployment of narratives used by those affected by suicide loss and b) how dominant constructs of suicide may impact these narratives and the support suicide-loss survivors receive from health professionals. To conduct this qualitative study, I used an adapted Free Association Narrative Inquiry (FANI) to explore the defensive use of narrative and to identify key themes across the group. Four suicide-loss survivors from England and Wales each took part in two interviews, the first based on the *life story method* (Atkinson, 1998) and the second on the psychodynamic principle of free association (Freud, 1915). Additionally, I maintained a research journal, conducted a data panel and used psychodynamic theories and techniques, such as *transference* and *containment*, to interpret each case. The whole data set has been extrapolated to present a themed interpretative account.

The suicide loss caused cognitive destabilisation (Clark & Goldney, 2000), rupturing the mental containment (Bion, 1962) needed to mourn and integrate the traumatic experience into the participant's subjectivity of self. Different levels of formal (e.g. counselling and support groups) and informal (e.g. fundraising and being with other suicide-loss survivors) support was needed to process the heavy, complicated story of suicide. Surrounded by the suicide *prevention* construct, which led to a significant felt responsibility and identification with the suicide construct itself, participants invested in the heavy and complex internal narratives of purpose and healing to feel safe enough to integrate the experience into their life story. The themed interpretative account highlighted the narratives they used to protect themselves, and others, from the pain of their loss. The main overarching theme was transforming pain into purpose. The three subthemes were: (a) who am I? (b) the suicide construct: ours to own, and (c) the healer narrative, *holding* and *containment*.

These findings offer great insight into the experience of suicide grief and how suicide-loss survivors are likely to be driven to find purpose in their loss. Health professionals need to provide multi-level support specifically for suicide loss, away from the rhetoric of suicide prevention. Additionally, they must be aware of the social and personal constructs contained within the psyche, which may impact the health professional and client within the therapeutic relationship and therefore efficacy of support, demanding specialist supervision and supervision training.

Acknowledgements

Firstly, I would like to thank Stella Maile, Zoe Thomas and Sydney Gautreau for their academic and emotional support throughout this project. You have all challenged and motivated me when I was struggling with my academic writing and putting my thoughts into words.

Next, I would like to very warmly thank the participants who gave themselves willingly to help others through telling their personal, emotional story.

I would also like to acknowledge my family and anyone who was affected by my brother's suicide. From the man who found him to my brother's children, his partners in life, my forever-loving siblings Helen and Robert and my dearly loved, supportive Father. I am so sorry you have been affected as you have. Thank you to those who have supported this research in so many ways: offering me a space to talk about my own loss, encouraging me and offering me guidance when I needed it. Your continual strength and love shine through when grief takes over.

My continual thanks go to my husband, Paul and children, Patricia, Carrick, Niall and Coran, who gave me support, space, encouragement and love whilst my research took me away from my role as mother and partner.

Finally, I would like to *hold* a space for my mother, who passed away from a condition and couldn't be here to witness this project, and Andrew, my brother, who had to make the decision one day that he couldn't live anymore.

Without Andrew, this research would not be what it is. His legacy will live on in his children and this research supporting others.

Table of Contents

Glossary

These are short descriptions of subjective terms that feature in this thesis. Some terms rely on a basic understanding of psychodynamic theories from Winnicott (e.g., 1960, 1965, 1969), Klein (e.g., 1946, 1988a, 1988b), Freud (e.g., 1915), and Bion (e.g., 1962, 1967). Full elaboration can be found in dictionaries that are available such as: Rycroft, C. (1995) *A Critical Dictionary of Psychoanalysis* (2nd Ed) and Hinshelwood, R. D. (1989) *A Dictionary of Kleinian Thought.*

Term	**Definition**
Abnormal	A value laden term assuming that there is a normal expected way of conforming which is deviated from in a negative way.
Contained/Container/Containment	A complex psychodynamic theory outlined in full in Subsection 1.12.2. In this research, the concept of containment considers **how** defended lived experiences are processed (Ogden, 2004). Containment has been traditionally referred to as that within dyadic relations – that is, either mother (container)–baby (contained); health professional (container)–client (contained), or that within internal psycho-analytic processes – that is, the capacity to do the psychological work (container)-unconscious thoughts denied from the living emotional experience (contained). Holding and containment work dynamically together within complex relationships of container and contained. Put simply, in this research containment refers to the complex multi-layered process of reconstructing a loss, which was attained

	through different forms of container-contained (Bion, 1962).
Countertransference	A psychodynamic theory, originally depicted as the therapist's own unconscious emotional attitude towards the client's behaviour based on their own transference (Freud, 1910) which, when made conscious can be used to better understand the client (Freud, 1912).
Defence mechanism	Unconscious processes which happen in order to defend against anxiety (e.g. projection and denial).
Denial	An unconscious defence mechanism where a person will not accept reality – blocking external events or an aspect of the self from awareness (Freud, 1937). Klein (1946) suggested that denial is followed by splitting and projection of the denied aspect.
Depressive position	Within object-relations theory, the depressive position of the mind is able to come to terms with the reality of the world and their place within it. Mourning an absence is experienced as sadness and grief rather than an attack of the self. The 'good' and 'bad' become closer in comparison and brings an integration of the ego (Klein, 1946).
Direct costs	Direct costs related to a suicide. Including (but not limited to) service costs (e.g., emergency services, insurance claims and psychological services prior to the suicide and care for the bereaved) (Bonin & McDaid, 2011).
Disorder	A value-laden term that has arisen through the scientific movement to denote there is a problem with the norm. i.e. bipolar disorder defines that living with bipolar is a problem that needs to be fixed.
Dynamic psyche	The process of the non-unitary conscious and unconscious layers of the mind which are fluid, situational and multidimensional.

Ego	One of the three parts (or systems) of the human psyche. The part people are usually aware of when they think about themselves – the self - the realistic part that constantly mediates between the id and superego (Freud, 1923).
Gestalt	The theory that the whole is greater than the sum of its parts (Murphy & Kovach, 1972). Defined in Subsection 4.1.6.
Holding/(to be) Held/ (to) Hold	Derived from object-relations theory (Klein, e.g., 1960, 1965, 1969; Winnicot, e.g., 1988a, 1988b) holding is a dynamic, alive, fluid, relational concept of a mother selflessly attuning to her child, allowing the child's ego to establish and instincts to be fulfilled (Winnicot, 1960). Holding and containment work dynamically together within complex relationships of container and contained. In this research, holding refers to the psychological space offered in order for someone to discuss their story discussed further in Subsection 1.12.2.
Human costs	When suicide has a cost to humans, such as loss of years without psychological difficulty and the impact on the bereaved (Seena & Bo, 2020).
Id	One of the three parts (or systems) of the human psyche. From the drives of Euros and death, including unconscious instinctual human drives, instincts and desires (Freud, 1923).
Identification/Identified/Identifying	A psychodynamic theory with several different levels. For a full definition refer to Ryroft (1995). Within object-relations theory, the ego relates to the world through part-objects (Hinshelwood & Fortuna, 2018) splitting the psyche between the polarised positions of 'good' and 'bad'. From this position parts of others that are 'good' are internalised and identified with as

	part of who we believe we are. Aspects that are felt as 'bad' are not perceived as realistic within our sense of self and may be projected out and believed to be within another object (known as projective identification) (Klein, 1946). For simplicity within this research, identification is when the psyche identifies (recognise, distinguish, designate a person or thing) and bases one's own behaviour, feelings, words and thinking on a model provided by another person (Florence, 2021). In mourning, identification has two main aspects: 1) where a 'good' aspect of the self that has been internalised from a strong relationship is in danger of being lost with the deceased and the whole sense of self is shaken up (Klein, 1940) and 2) when an aspect of the lost person is internalised inside the depressed person in order to continue bonds with the deceased (Freud, 1917).
Indirect costs	The costs of suicide on society (e.g., the cost of leaving employment or absence from work) (Bonin & McDaid, 2011).
Introjection	Both a defence and normal developmental process. As a defence, it is a mild form of identification and the opposite of projection (Freud, 1917; Klein, 1946). Where the mental representation (the imagined object 'inside') takes over the functions of the external object (Rycroft, 1995). For example, in order to reduce the anxiety of separation the views of a spouse may be internalised as our own. There are unconscious adoption of the thoughts and feelings of others without changing who we are (Hinshelwood & Fortuna, 2018). In normal development, it increases autonomy because the super-ego introjects parental figures as if their views are their own. Introjection can be followed by identification.

Life story method	An interview technique which involves an interviewer asking one question and allowing the participant to talk freely for the duration of the interview (Rosenthal, 1993). This is consistent with the biographical-interpretative understanding that the less structure a life story interview has, the more effective it will be at uncovering the participant's account in the style, form and way they want to tell it (Atkinson, 1998).
Live out loud/Living out loud	A construct found within suicide bereavement outlined in full in Subsection 3.4 and throughout the findings of this research in Parts 5 and 6. Put simply, due to the felt responsibility of the suicide construct, some people who carry the burden of suicide loss speak publicly about their loss.
Manic defence	From within the depressive position, a manic defence denies difficult aspects of psychic reality - using manoeuvres (such as rationalisation or justification) to bypass the guilt of needing an object who also makes you angry (Klein, 1940).
Melancholia	A complex psychodynamic theory used in different contexts and explored further in Subsection 1.9. Within this research, melancholia refers to parts of the grieving process that may be particularly difficult and long-term – when unconscious mechanisms are at play and require conscious awareness to heal.
Mental containment	Mental containment (or cognitive stabilisation) is attained in infancy when a child is able to integrate a healthy psyche and has a clear sense of themselves (Bion, 1962). This allows them to contain strong emotions, learn from experiences and grow from awareness and reflexivity. Described in detail in Subsection 1.12.2.
Mourning/(to) Mourn	A theory of the process following loss where we gradually become used to not having the person in

	our lives (Freud, 1917). Klein believed that mourning work happens within the depressive position, where there is an acceptance of reality without any burden of responsibility. Mourning is explored further in Subsection 1.9.
Normal	A value laden term that assumes there is a societal norm which is typical, usual or expected that people conform to.
Object-relations theory	A psychoanalytic theory describing how the psyche develops in complex ways in relationship to others – where others are objects that are internalised (e.g. Winnicot, 1960; Klein, 1946; Bion, 1962).
Paranoid-schizoid position	Within object-relations theory, the paranoid-schizoid position of the mind is when the ego relates to the world through part-objects (Klein, 1946) splitting the psyche between the polarised positions of 'good' and 'bad'. From this position parts of self that are felt as 'bad' are not perceived as realistic within their sense of self and may be projected out into someone else (known as projective identification).
Personality	A complex process consisting of characteristics and qualities that form an individual's character and complex human behaviours.
Post-traumatic growth (PTG)	Positive growth that comes from a stressful, traumatic event (Tedeschi & Calhoun, 2004).
Postvention	An intervention of support for those bereaved by suicide - to reduce the risk of suicide in the bereaved.
Prevention/Preventative/Prevent	A value laden term which is explored throughout this thesis in terms of the suicide prevention movement and the effect it may have on the bereaved.
Projection/Projecting/Project/Projected	An unconscious defence mechanism whereby the ego will split off an undesirable part of itself, project it out

	and attribute it to someone else (Freud, 1910). Outlined further in Subsection 1.12.1.
Projective Identification (PI)	From within the paranoid-schizoid position, PI is an unconscious defence mechanism whereby the ego will split off an undesirable part of itself (e.g. feelings of guilt for something they have done), project it into another object (e.g. a wife blames her husband for the act), believe it belongs to the external object and the receiving object introjects it as if it is their own (e.g. the husband feels guilty) (Klein, 1946).
Psychic equilibrium	A psychoanalytic term where all 3 systems of the mind (the id, ego and superego) work together to create a coherent healthy psyche (Freud, 1910).
Reality principle	A healthy psyche that subjectively processes perceptual information according to information from the outside world (social realities and norms) and sensory perceptions of the internal world (bodily needs, drives and instincts) which governs realistic ways to feel and behave (Freud, 1910).
Repression/Repressing/Repressed	An unconscious defence whereby someone's ego keeps disturbing thoughts or feelings from consciousness (Freud, 1910).
Resilient/Resilience	When someone is able to recover quickly from a difficult situation.
Splitting/Split/Split off	Within object-relations theory, splitting is when the ego relates to the world through part-objects splitting the psyche between the polarised positions of 'good' and 'bad'. When aspects of the self are rejected as 'bad' they are too uncomfortable to be directly owned and are projected out (Klein, 1946).
Suicide contagion	The contagious effect suicide can have on the people exposed. For example, there appeared to be an

	increase in suicides following the suicide of Robin Williams, a famous Hollywood actor in 2014 (Carmichael & Whitley, 2019).
Suicide-loss survivor	A value-laden term. Within this research, the term suicide-loss survivor is used to differentiate between someone bereaved through suicide and those who may have attempted suicide. The definition includes anyone "who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person (Jordan & McIntosh, 2014a, p. 7)." This term is discussed throughout this thesis in terms of how the term 'survivor' may have developed and may imply there has been a tragedy that needs to be 'survived.'
Superego	One of the three parts (or systems) of the human psyche. The part that identifies with the ideals and morales of society and how to behave within it (Freud, 1923).
Therapeutic alliance	The dynamic relationship held between a therapist and a client.
Transference/Transferring/Transferential	Transference is traditionally understood as the re-experiencing of early or transformative intra (and inter) psychic conflicts within the therapeutic relationship (Cabaniss et al., 2016). Explained in full in Subsection 1.12.1.
Wounded Healer	From a Jungian perspective, it is thought that the wounded healer archetype is a driving force within all of us that is triggered when traumatic wounds are a burden and become a driving force to help others (Jung, 1951). Explored further in Subsection 1.11.

Part 1: Overview

This thesis reports on a reflexive qualitative study conducted within England and Wales from January 2020 to September 2021. In Part 1 of this thesis, I present: (a) the epidemiological data on suicide bereavement; (b) a review of how suicide bereavement is supported by practitioners; (c) an overview of this study, the scientific and reflective principles of counselling psychologists, psychosocial research, and narrative inquiry; (d) a definition of the terms subjectivity of self, mourning and melancholia, the wounded healer and defended subjects; and (e) how I used reflexivity with psychodynamic techniques to investigate the hidden nuances beneath the surface of the stories told. Please refer to the glossary in the previous section for clarification of any terms particularly subjective and requiring definition.

1.1 Epidemiological Data on Suicide Bereavement

A reported 5,691 people died by suicide in England and Wales in 2019 (Office for National Statistics, 2021). Worldwide, more than 700,000 people die by suicide every year (World Health Organization, 2021). How many people are impacted by each of these deaths is difficult to discern. As a rough estimate, at least six people are significantly affected by each suicide (Begley & Quayle, 2007). More recent estimates report that this number is too low (Cerel et al., 2013) and that a more likely number is 135 (Cerel et al., 2019). Of particular concern is the finding from a study in the United Kingdom (UK) that showed family and friends bereaved by suicide are more likely to attempt suicide than those bereaved by sudden natural causes (Pitman et al., 2014).

The development of the term ‘suicide survivor’ in the 21st century demonstrates an attempt by society to define and understand this particular group of bereaved people. This choice of language illustrates the existing clumsiness around

the subject, largely stemming from the fact that the term is also commonly associated with those who have unsuccessfully attempted suicide. The criteria for who is included in this cohort have been variously defined as direct family members of the person who has died as well as “someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person” (Jordan & McIntosh, 2014a, p. 7). In this research, I use the term suicide-loss survivor to differentiate between someone bereaved through and those who may have attempted suicide and use the aforementioned definition by Jordan and McIntosh (2014a) as the criterion for participation in the study. However, I am aware that the term ‘survivor’ implies there has been a tragedy that needs to be overcome and this research may add to the discourse that suicide loss is something that needs to be ‘survived.’ More importantly, this language demonstrates the need for a thorough investigation into how these discourses have developed and how professionals can best support those who are affected.

1.2 Practitioners Working with Suicide Bereavement

Research has consistently found a lack of support felt by those bereaved by suicide through professional health services. For example, in a study by Wilson and Marshall in 2010, it was found that only 44% of 166 people closely related to those who died by suicide received help and only 40% of those who received professional support felt satisfied with it. In particular, they identified judgemental and insensitive attitudes as part of the reason for their dissatisfaction with the support workers. Part 2 discusses the religious and historical stigma that has been accumulating for centuries around suicide (Peters et al., 2016). Highlighting that all of society, including the bereaved and qualified professionals, may have internalised this stigma

in their own belief systems and defensive narratives that make up their subjectivity of self (Van der Pol & Pehrsson, 2015), which may impact the therapeutic alliance. Researchers have continued to investigate the effectiveness of various interventions (e.g., Andriessen et al., 2019; McDonnell et al., 2020a; Zisook et al., 2018). A recent survey of 7,150 suicide-loss survivors in the UK found that, of the 4,621 who answered, 62% of respondents felt the services they received were inadequate and 31% did not know: leaving only 7% feeling satisfied with the support they had received (McDonnell et al., 2020a).

There have been developments in postvention services since 2016. For example, the National Institute for Mental and Care Excellence (NICE) recently published the *Suicide Prevention Quality Standard*, which outlined measures on the structure of service provision, the process of delivering support and the effectiveness of the outcome (NICE, 2019) – a standard for supporting people bereaved or affected by a suspected suicide. The recognition for personalised suicide bereavement support is growing and specific suicide-loss support services are being implemented throughout the UK, as confirmed by the Department of Health and Social Care's (DHSC) allocation of £1,082,000.00 funding across the UK in 2019 (DHSC, 2019). This funding comes as a part of the National Health Service's (NHS) Long Term Plan to transform mental health care services and the DHSC's long-term suicide prevention plan. It is vital that whilst services are being formed specifically to support suicide-loss survivors, health professionals and the public health care system are aware of how to do so effectively.

1.3 Overview of this Study

The British Psychological Society's (BPS) *Position Statement on Understanding and Preventing Suicide* (2016) acknowledged the need for further research into the

effects of suicide on vulnerable others and how professionals can support them. This qualitative reflexive study, with the BPS aims firmly in mind, uses an adapted version of psychoanalytically informed FANI (Hollway & Jefferson, 2001, 2013) to explore the psychologically defensive use of narratives after suicide loss and to identify key themes across the group. Additional tools and theories utilised from psychoanalysis helped me think about the defensive nature of narratives that constitute the subjectivity of self. These included a consideration of transferential material, my countertransference responses and the potential meaning of these. Sometimes my responses felt physically overwhelming and the use of projective identification (PI), which I explored in supervision, was useful. I will introduce these key terms within Part 1.

The findings of this study will offer professionals working in this area an opportunity to reflect upon the relative balance between the defensive and creative uses of narrative in the work of sense-making, deconstructing and reconstructing the self in the face of deep emotional pain. The findings presented in this study can inform professionals working with suicide-loss survivors and enable them to provide a space where clients to feel less isolated and ashamed, and more able to make sense of the death. This will help to meet the aims of the BPS's suicide prevention paper in the area of postvention, especially as these aims acknowledge an increased risk of suicidal thoughts and behaviour by the relatives and friends of the deceased (BPS, 2016).

As a suicide-loss survivor myself, it is important to establish my positionality as a researcher. I was (a) a researcher taking an outsider position to the unique experiences the participants have had, (b) a counselling psychologist in training taking an insider position of a health profession seeking to understand how to

support others and (c) after losing my brother to suicide in 2015, an insider to the experience of suicide loss. Consequently, I use both third-person and first-person language throughout this thesis, which informs my analysis as it highlights the relational aspect of working therapeutically with others as well as the integral part a researcher plays in qualitative research.

As meaning interrelates through interactions with others (Buber, 1965), my position as a researcher is highly relevant. By describing my experiences and the part I have played in the participants' stories, I wish to acknowledge my position as an insider defended subject (Yardley, 2000) explored further in Section 1.10 and Section 4.3. As Groos and Shakespeare-Finch (2013) argued, suicide-loss survivors feel more secure around those that have experienced suicide themselves. My positioning allowed a thorough investigation of why this security may be felt and also allowed me to hear stories with emotional and intimate depth whilst reducing the hierarchical power that can exist in the dynamic between interviewer and participant (Ellis, 2004). Doing so makes power negotiable rather than an inevitable effect of status differences and therefore data suitable to be analysed (Hollway & Jefferson, 2000).

The most popular methods of data collection within qualitative inquiry are semi-structured interviews and case studies (Braun & Clark, 2013). Researchers often use these methods to capture the experience of certain cohorts, which relies on the assumption that the participants are fully capable of communicating their story. Traditional research into suicide bereavement uses these methods alongside narrative analysis. However, as discussed further on in Section 1.7, these narrative inquiries ignore the unconscious psychosocial aspects of the experience of suicide

grief. This study addresses this void by recognising the interaction between the layers of the psyche which will be explored further in Part 1, specifically:

- the use of narratives within our psyche and subjectivity of self and how this may affect grieving after suicide,
- the non-unitary defended subject,
- the relational aspect of human nature in which humans constantly engage in defensive processes of identification, projection and introjection,
- the personal and social interaction of the experience – the why not the how,
- that stories exist in a social world and have a significant relational experience,
- the biographical uniqueness of each experience, and
- the reflective and scientific positions of counselling psychologists.

1.4 Counselling Psychology as a Scientific and Reflective Practice

Counselling psychology has its own conscious and unconscious constructs that define practitioners in their ethical practice. The stories contained within practitioners' own narratives encompass theory, client-work, supervision, lectures, conferences, and peer experiences (amongst others). These stories blend with practitioners' personal and social stories, all merging into a fluid, situational, and contextual standard for their work as a professional. One important aspect relevant to this study and the counselling psychology profession is the balance between the two dialectical positions of scientific practitioner and reflective practitioner (Woolfe, 2016).

The British counselling psychology identity evolved within the scientific practitioner movement and developed the profession during the medicalisation of the mental health industry (Woolfe, 2016) in the 20th century. However, because counselling psychology also developed within the humanistic movement (Woolfe,

2016), scientific practitioners are well placed to consider themselves as reflective practitioners. The success of the profession is partly due to practitioners' ability to identify how both positions shape themselves and the work they do (Woolfe, 2012). This dedication to reflective practice is now represented in BPS ethics, which historically contained explicit rules to minimise inappropriate behaviour, but have since been worded carefully to become guidelines that inspire us to own ethical maturity (Shaw & Carroll, 2016). This ethical maturity comes from considering scientific and reflective positions and how to balance these dialectics (Woolfe, 2016), whilst remaining aware of the need to remain critical of any social agendas (BPS, 2005).

1.4.1 Scientific Practitioner

The classic definition of the scientific practitioner is "someone who produces (does), consumes (uses) and evaluates (criticises) research" (Donati, 2016, p. 67). In other words a scientific practitioner will use research tools in various ways to understand and dictate the work they do. Counselling psychologists are positioned to practice scientific work within their domains of work, such as within the NHS, where evidence-based practice is endorsed. An example of evidence-based practice is Cognitive Behavioural Therapy, which is a therapeutic model that can be measured and replicated in order to show results. The concept of evidence-based practice comes from the medical-scientific movement, in which professionals reify subjects (simplify human behaviour) in order to objectively intervene (medicalise and treat) and make the abnormal more normal (solve the problem that has been shown to be abnormal in society). However, viewing humans from this objective position leaves little understanding of individual differences and requires more scrutiny, which can be obtained through reflective practice.

1.4.2 Reflective Practitioner

The reflective practitioner has a longstanding history within the counselling psychology profession (Woolfe & Strawbridge, 2009). To focus on the practitioner's impact within the therapeutic relationship, there must be an awareness of how their feelings, needs and unresolved issues may be evoked. The combination of both scientific and reflective practitioner within the nuances of suicide bereavement allows practitioners to recognise discourses of suicide and suicide bereavement whilst reflecting on their own constructs which may affect how they work with those bereaved. Highly relevant within the BPS practice guidelines, which encourage "responsibilities and obligations to self and society" (BPS, 2005, p 7). This research gives explanations of what conscious and unconscious processes might be evident in working with those bereaved through suicide, so practitioners can be aware and alert to working more effectively with this presentation as discussed in Section 1.2.

1.5 Counselling Psychology and Social Justice

In 2007, the BPS, in partnership with the DHSC, published a document entitled *New Ways of Working for Applied Psychologists* (Onyett, 2007). This paper was aimed at encouraging psychological leadership in NHS mental health services. One identified aspect of effective psychological leadership was the ability to offer authoritative alternatives to the medical model (Onyett, 2007). Counselling psychology's leadership qualities are therefore able to challenge social constructs due to their inclination to add a voice to the insider perspective and change the social agenda for marginalised groups (Strawbridge, 2002). The professional practice guidelines of the profession encourage its members to "consider at all times their responsibilities to the wider world" (BPS, 2005, p. 7) whilst not assuming "the automatic superiority of any one way of experiencing, feeling, valuing and knowing"

(p. 2), and to “recognise social contexts and discrimination and to work always in ways that empower rather than control and also demonstrate the high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today” (BPS, 2005, p. 2). This will ultimately allow counselling psychologists to pursue a wider social justice agenda position, which can function as a potential bridge between critical approaches and applied psychology. Within research, psychosocial principles can act as this bridge.

1.6 Psychosocial Research

Psychosocial studies, emerging over the last 15 years, have attempted to avoid the polarised positions of society and the individual when understanding the subjective human experience (Clarke & Hoggett, 2009). In the psychosocial framework, there are two key premises concerning how people experience the world: first, we are all influenced by constructs that exist in the social world; second, we have our own internal ways of deploying these narratives based on personalities and life histories. According to the principles of counselling psychology as outlined, reflective and scientific practitioners must consider social constructs and personal responses in relation to the experiences in the life of the client, in their own lives, and within the therapeutic relationship.

Additionally, there are two key premises to the psychosocial framework. First, that the whole dynamic psyche is fundamental in constructing reality and our perception of others. Second, the whole psyche is involved in the research environment and generation of data. Furthermore, psychosocial methodology assumes that the inner world cannot be understood without knowledge of experiences in the world. Yet, experiences of the world cannot be understood without knowledge of the way inner worlds allow experiences of the outer world

(Henriques et al., 1984). Psychosocial assumptions enable researchers and practitioners to explore beyond the simply narrative (Clarke & Hoggett, 2009). In doing so, we can access the voices of marginalised groups who are often shamed and stigmatised in society and may defend some of their feelings against consciousness (Midgley, 2006), such as in the fear of crime (Hollway & Jefferson, 2000), the experience of Black and Asian students in the British education system (Clark, 2002), and the effect of prison culture on Black women employees (Morgan, 2018). Demonstrating the appropriateness of applying psychosocial principles when researching the possibly guarded cohort of suicide-loss survivors who have been found to feel shame and stigmatised (Scocco et al., 2017).

The positivist scientific movement in psychology during the 20th century has led us to believe we can research an accurate understanding of the psychological world. However, counselling psychology (as opposed to applied psychology) values facilitating people's experiences, standing alongside them, rather than being an expert in their psychological health as discussed in Section 1.4. These resonate with the goals of qualitative study, whereby researchers aim to capture some meaning or aspect of the social or psychological world, whilst acknowledging there is no replicable, accurate truth (Braun & Clarke, 2013). I chose to combine these principles within an adapted narrative inquiry to deeply analyse the stories told.

1.7 An Introduction to Narrative Inquiry

Scholars who subscribe to the narrative school of thought have suggested that the desire and ability to tell stories is an innate part of being human (Atkinson, 1998): "We think in story form, speak in story form, and bring meaning to our lives through a story" (Clandinin, 2008, p. 224). As humans, we do not only tell stories to others – we also tell them to ourselves. Narrative inquiry suggests that coherence

(Crossley, 2000a), unity (Carr, 1986), and order of meaning lead to a coherent life story (Crossley, 2000a). As individuals understand themselves through language, they constantly recreate themselves (Crossley, 2000a). Atkinson (1998) classified 'narrative' as an ontological condition of social life and a tool for understanding ourselves. With an ongoing narrative of our self, we can predict and understand our lives; with an ongoing narrative of society, we can know how to behave within it. In terms of narrative psychology, language is the medium through which humans do this. Through shared understanding of language, tellers and listeners give and receive stories throughout life. This process commences at a very young age, when carers share stories with children, and often concludes in a eulogy where the speaker tells the story of a person's life.

Scholars have critiqued the use of narrative inquiry as reifying the experiences of people through the investigation of language with discourse analysis and interpretive phenomenological analysis (Crossley, 2000a). This reification reduces the self to an effect of linguistic practices and ignores resources available that can enable people to make sense of and engage with issues around suicide bereavement (Marsh, 2016). As such, it is essential to consider narrative inquiry from a psychosocial position as described above, to overcome both social reductionism (reducing psychology to the social) and biological reductionism (reducing psychology to a physical level) (popular in discourses about mental illness – namely that the mentally ill should be medicated) (Longhofer et al., 2013). This positioning leaves the self available for a deep analysis that is based on the power of language and acknowledges the significance of psychic realties that may be hidden from the obvious story told (Day Sclater, 2003).

1.8 Defining Subjectivity of self

Narrative psychology and psychoanalysis have an interest in unconscious phantasies and beliefs that are not available to the conscious mind, which impact the subjective conceptualisation of self and how narratives impact this self. In psychodynamic terms, Freud's personality theory (Freud, 1923) saw the human psyche being composed of three parts (or systems) that interact to form a whole psyche that governs personality: namely the id (euros and death – drives, instincts and desires), superego (the ideals of society and how to behave within it) and ego (the part people are usually aware of when they think about themselves - the realistic part that constantly mediates between the id and ego). The ego operates according to the reality principle (Freud, 1911) to maintain psychic equilibrium. That is, a healthy psyche that subjectively processes perceptual information according to information from the outside world (social realities and norms) and sensory perceptions of the internal world (bodily needs, drives and instincts) which governs realistic ways to feel and behave.

The reflexivity and self-interpretation demanded by a healthy psyche is inextricably linked with the sociocultural constructs that have evolved throughout contemporary Western society. Considering the ways in which constructs and discourses of and surrounding suicide is of particular interest as these are linked to the reality principle and how the superego views the events in terms of ideals and social morals and how these may be introjected into a person's ego and sense of self after a suicide loss.

Taylor (1989) suggested that, prior to the 20th century, humans in Western civilisation lived in unchangeable frameworks. Religion nonnegotiably taught God's rules. These rules were immoveable and static, which helped individuals in society assess themselves in relation to those rules – humans could not change what God

had decreed. Consider the act of suicide in 17th century London. If a woman's husband died by suicide, the law – based on God's law – regarded this act as a mortal sin and a crime. The wife's fate would have been dictated. She would lose the family's estate and her husband would be humiliated in the public eye to deter further crimes of a suicidal nature. The woman's fear would probably be eternal damnation for her husband and herself. Most in society would agree that she must pay the price for his deed. In 21st century London, however, the act of suicide – its motivation, the consequences – is open to interpretation. With the decline of religion, community, and social institutions, no one single construct of suicide is shared by everyone which the psyche can use to measure reality. Depending on whom one asks, suicide could be deemed a person's prerogative or the selfish act of removing oneself from the collective. Mostly, people say nothing and do not offer their opinion. This decentralisation – the ability to choose the narratives (or reality) one lives by – can be liberating and terrifying at the same time. Is suicide morally wrong? Is it good or bad? How the superego interprets reality depends on the social framework and how easily the loss is assimilated into a healthy psyche.

According to Taylor (1989), a person constructs their subjective sense of self in relation to things from which they derive meaning or in which they imbue meaning: If suicide happens to someone we love, we will conceptualise a self in relation to that experience. The relational nature of the self also extends to how a person interprets meaning – their interpretations can only be assessed in relation to other objects. As such, experiences of self can take on meaning through specific linguistic, historical, and social constructs. It is assumed that the ego, or self as we know it in Western civilisation, has an objective status and establishes a certain degree of constancy and unity over time (Crossley, 2000b). Hence, to maintain our subjectivity of self we

look to constructs that support our sense of unity whilst integrating all systems within the dynamic psyche which includes drives, needs and desires.

This research defines subjectivity of self as the person (or ego, or sense of self) who, within their dynamic psyche, defensively adopts narratives in order to re-establish coherence and unity after a devastating loss to suicide.

1.9 Defining Mourning and Melancholia

In *Mourning and Melancholia,* Freud (1917) explored the idea that the non-unitary psyche has different internalised love objects (or parts) that relate to each other in different ways, and the qualities of the relationships that are held between each part is what defines our moods, emotions and character. Furthermore, Klein theorised that an infant will identify with a good object (such as another important person in their life) and safely establish it in the infant's ego - giving a sense of coherence (Roth, 2001). Hence, when object loss happens (when something catastrophic has happened to the external connection with an object, either through death or by any other means), there is a danger to our sense of self because its coherence depends on an ongoing attachment to the lost object.

According to Freud (1917), during the process of mourning the lost person is installed as a separate internal figure into the psyche (i.e. talking to them as if they were in the room) – the lost one lives on as a separate individual (Freud, 2005). If there is a deviation from this, then melancholia can occur – when feelings of depression and sadness are consolidated internally in a more permanent state. The scientific study of grief designated the term 'complicated grief' to the theory of melancholia and more recently, 'Persistent Complex Bereavement Disorder' is labelled within The Diagnostic and Statistical Manual of Mental Disorder (5th Ed.; DSM-5; American Psychiatric Association, 2013). Whilst acknowledging this

categorisation, within this research melancholia is defined as a term far more nuanced than that of the diagnostic manual, outlined here.

Freud (1917) believed that there are different processes for mourning and melancholia. In mourning we gradually become used to not having the person in our lives and relinquish interest in them. In melancholia we go through unconscious processes as if the loved one has not been lost at all. Freud initially believed that some people hold feelings of ambivalence towards their loved one (both love and hate) and when these conflictual feelings cannot reconcile, the anger is directed inward on the person themselves during the process of melancholia. Put simply, the lost person is kept alive by being internalised inside the depressed person and the person **becomes** the lost person by process of identification. Later, Freud (1923) revised his theory and redefined the identification process as an integral component of any form of grieving, suggesting that there would be fluctuations between melancholia and mourning throughout the endless grieving process.

Klein (1940) believed that the crucial aspects of mourning are within the depressive position, where there is an acceptance of reality without any burden of responsibility. When the loss of the other is externally felt whilst the internal pain of losing the internalised object is felt, the internal flux between love and aggression is reconciled for the loved person. Within this position, guilt is characteristic because we have to accept the guilt of losing the loved object as part of our own character. If this guilt is too overwhelming then manic defences (Klein, 1940) can be deployed, whereby the importance of the loved object is denied and no guilt or dependence on them is felt.

Klein (1940) suggested that to overcome manic defences, reflection and awareness of unconscious processes can soften the effect they have on internal

beliefs. In particular, any responsibility or guilt felt, or any identification with the lost person, needs to be recognised in order to soften the anger towards themselves. For example, in this research Macy spent years combatting depressive episodes whilst trying to prove she was “enough” (Interview 1, 99) because she hadn’t been ‘enough’ for her Dad to stay alive for when he had suicided. Macy spent five months in a meditation retreat and recognised how much her self-worth was impacted by her father’s suicide and the depressive episodes dramatically improved.

This research defines mourning as the process of grieving within the depressive position outlined above and melancholia, rather than the violent version depicted by Freud (1917), refers to parts of the grieving process that may be particularly difficult and long-term – when unconscious mechanisms are at play and require conscious awareness to heal. Unconscious mechanisms that include the narratives we tell ourselves about the kind of person we are and strive to be (Crossley, 2000a), which must be acknowledged to deeply analyse the subjectivity of self in the stories of suicide loss.

1.10 Defining Defended Subjects

In the last sections, key assumptions of narrative inquiry, psychosocial research and psychodynamic theory highlighted the necessity of understanding the dynamic inner psychic world which impact our subjectivities (views and beliefs) and intersubjectivities (views and beliefs that are shared between more than one person) when grieving. Psychoanalytic and psychosocial principles posit that all human beings are defended subjects. That is, humans have a dynamic unconscious world that has a significant influence on their sense of self. When research assumes people ‘tell it like it is’ in full consciousness, we ignore the complexity of different levels of meaning within psychosocial dynamics of the human experience, which can

cause a problem for practitioners who wish to use the research to inform their practice.

Hollway and Jefferson (2000, 2013) emphasised the role of anxiety in the research relationship. They suggested that both the researcher and participant may have uncomfortable feelings during the process, which makes for both a defended participant and defended researcher. For example, during the research I have encountered difficulty with my academic writing which is demonstrative of the anxiety from my own experience of suicide loss destabilising my cognitive capacity to think. It is therefore essential when conducting narrative inquiry with psychosocial principles to consider subjects as defended. Researchers must use analytical and interpretative skills to consider what investments motivate different accounts, which includes identifying any latent and manifest communications important to the subject's story that are hidden under the surface including avoidance, contradictions, and incongruities (Hollway & Jefferson, 2000). Doing so enables the researcher to study a participant's defensive narratives that they may have developed from their personal or social past, which can be understood through the use of the researcher and the research relationship, interpreted using techniques and theory from psychoanalysis, such as the wounded healer archetype.

1.11 Defining the Wounded Healer

Jung (1951) thought that the wounded healer is a driving force within all of us that is triggered when traumatic wounds are a burden and become a driving force to help others. From a Jungian perspective, within the wounded healer there is both the 'healer' (helping others) and the 'patient' (wounded needing help). The ego cannot cope with such ambiguities, and it can split these poles to gain clarity (Guggenbühl-Craig, 1998). One way of doing this is by repressing the wounds into the

unconscious, at which point the ‘patient’ can be projected externally. This can make a person feel stronger, more able to cope, and more invulnerable to the grief, which leaves them unable to identify with their own wounds and unable to activate the wounded healer archetype in the other person. This dynamic can be seen in the relationship between the powerful health professional and the patient who is sick and unable to help themselves.

Once the health professional has split the patient healer archetype, the grief continues to belong to the ‘healer’ whilst they continue to help others (Guggenbühl-Craig, 1998). However, this makes ‘others to help’ become objects to fix – they project their own grief onto the patient and his weakness becomes more distant and more powerful through his failure to integrate his grief with his sense of self. When the healer can experience his own wounded self, he is united with his ‘patient’ self, creating more empathy and a dyadic relationship where both are healing themselves with less defences and power differential.

1.12 Using Myself within the Research Process with Techniques and Theory from Psychoanalysis

I draw on psychodynamic techniques to interpret the defended subject whilst recognising my own position as a defended subject. For example, by recognising the phenomenological sensations I experienced during the research process, I can understand the hidden nuances of the stories told when using psychodynamic techniques and theories of defensive mechanisms such as splitting, transference, projection, holding and containment. This study draws on theories from Winnicott (e.g., 1960, 1965, 1969), Klein (e.g., 1988a, 1988b), Freud (e.g., 1915), and Bion (e.g., 1962, 1967) and the fundamental propositions of these theories are as follows:

1. Unconscious processes are hidden from our awareness and inaccessible by normal communication.
2. Psychic causality – our thoughts, behaviours, and emotions are indicative of our underlying mental life and include unconscious processes.
3. The participant and researcher's relationship are central to the use of psychodynamic techniques, enabled by the reflexivity and self-scrutiny of the researcher.
4. Psychoanalytic concepts are used as a tool to inform psychosocial methods.
5. Anxiety and defence mechanisms are inevitable. Anxiety is manifested in different ways and are handled defensively, through mechanisms described further in this section, such as projection and transference.
6. Transference and countertransference are an inevitable part of relationships and can include fantasies and behaviour based on previous relationships.

1.12.1 Transference, Projection and Introjection

Transference is traditionally understood as the re-experiencing of early or transformative intra (and inter) psychic conflicts within the therapeutic relationship (Cabaniss et al., 2016) and is a helpful part of the meaning-making process when applied therapeutically to make sense of interpersonal events (Grant & Crawley, 2002). Feelings and behaviours that come from interactions from earlier relationships are repeated and experienced as a process between both therapist and client, which we can use to examine how the past is alive in the present (Grant & Crawley, 2002). Conscious and unconscious processes of both parties co-construct the intersubjective reality. Hence by using myself in the research encounter, I can investigate feelings that may not be apparent from the stories told. For example, by applying transference to the interview process I was able to highlight how we shared

solidarity around the subject of suicide because of the warmth I felt from participants during the research process.

Transference can be communicated in numerous ways: from direct communication of conscious feelings and behaviours to re-enactments of previous relationships (Grant & Crawley, 2002). This study is interested in the symbolism of what is transferred – that is the metaphors, stories or descriptions of events – within the research relationship. It is important to recognise the research relationship is different to a therapeutic relationship. However, transference is thought to occur in all relationships, hence when someone starts a new relationship they will use representations of older relationships in order to compare and judge. For example, by noticing the somatic experience of painful headaches during the research I was able to use transference and projection to interpret the heaviness of the subject of suicide.

This interpretation is possible because of the understanding that transference, projection and introjection provide a reflection of the internal subjectivity of self. Projection is caused by transference (Grant & Crawley, 2002). That is, projection is the disowned aspects of the self that are split off or (more forcefully in the case of PI), put into (transferred) onto another person, who introjects the aspects of self as if they were their own. In the clinical setting, there is an unconscious hope that the therapist will be able to bear, understand and give meaning to these otherwise unbearable feelings. My role as a researcher is different but nevertheless requires similar capacities to hear, feel, bear and understand what is, especially in the case of suicide bereavement, usually so unbearably painful. For example, during the research process I was able to hold the heaviness of the painful emotions of suicide loss so that several participants were able to use the research encounter as a

container to process more of the emotions of their loss, which will be explored further during the interpretative themed account in Section 5.3.

1.12.2 Holding and Containment

Winnicot's concepts of holding (Winnicot, 1960) and Bion's theory of container/contained (Bion,1962) have often been used interchangeably in psychoanalytic literature (Ogden, 2004) and are therefore essential to define.

Derived from object-relations theory (Klein, e.g., 1960, 1965, 1969; Winnicot, e.g., 1988a, 1988b) holding is a dynamic, alive, fluid, relational concept of a mother selflessly attuning to her child, allowing the child's ego to establish and instincts to be fulfilled (Winnicot, 1960). Before the baby becomes a 'being' (or has a fully integrated ego) the mother's attunement knows what the child needs at any given moment and allows the child to recognise and 'own' how it feels – it's identification with self. Winnicot referred to this early child state as 'going on being' (Winnicot 1956, p. 303) which becomes object-related ways of being alive once the ego has been established. That is, living with the subjectivity of self with external objects it experiences throughout life. When this sense of self finds it difficult to integrate an experience, holding then becomes when another person offers a psychological space (Ogden, 2004) to someone else and attunes to what they need in any given moment. However, containment is when the holding becomes a place to process more of the experience and move towards a more coherent sense of self.

The concept of container/contained considers **how** defended lived experiences are processed (Ogden, 2004). Hence, containment has been traditionally referred to as that within dyadic relations – that is, either mother (container)–baby (contained); health professional (container)–client (contained), or that within internal psycho-analytic processes – that is, the capacity to do the

psychological work (container)-unconscious thoughts denied from the living emotional experience (contained). All involving a complex process crossing the cognitive/emotional, verbal/nonverbal, and unconscious/conscious divisions (Finlay, 2015). The metaphor of container was used by Bion (1962) to signify the caregiver's role in containing the overwhelming feeling states and bodily sensations of children that were too painful to directly experience. The caregiver will receive the emotions via projection of behaviour from the child by way of an unconscious process of communication (e.g., crying) and respond with care and love, rather than hostility (Finlay, 2015). These feelings are then projected back to the child in a modified, more manageable form so that the child can accept them within themselves (Finlay, 2015). This then creates mental containment that becomes internal for the child and leant on throughout life to contain strong emotions.

The containment principle has been applied to all areas of function (or dysfunction) of the mind, acknowledging movement between levels of functioning including the individual psyche or the dynamics of a social group. Containment is a complex process, determined by various relations between container and contained. Containment is most readily recognised when achieved between two individuals (Casement, 1985). In a therapeutic relationship this refers to the reflective nature of the therapeutic alliance – i.e. where the client shares his fragmented story and the therapist holds the clients fragmented self and allows projection to occur, explore what that projection may be and reflect it back to the client, allowing the client to integrate an adjusted sense of self through the container-contained relationship that is offering containment.

Clearly, holding and containment work dynamically together within complex relationships of container and contained, including those that do not consist of an

actual relationship between two people. In this research, containment refers to the ability to process a loss further which was attained through different forms of container-contained whereas holding refers to the psychological space offered in order for someone to discuss their story. For example, for each participant (the contained) the first interview used the life story method, where they were asked to share their story without any interruption (offering them a psychological holding space) and my research journal was used to reflect on themes and possible unconscious communication. Offering this back at the second interview (providing a container for participants) provided containment for the suicide loss survivor to process their loss further and integrate the experience further into their subjectivity of self. The period between the first and second interview was also a time of refection for all participants, highlighting how the research process itself offered a form of container for some.

Bion (1962) suggested that trauma ruptures the mental container (or psyche) established at infancy, leading to cognitive destabilisation, and unless there is an external way to hold the trauma, it is impossible to think. This has more recently been related to trauma and the difficulty in linking thoughts to somatic, traumatic events (Szykierski, 2017). For example, brain imaging of those reliving traumatic events show that, although everyone's brains react differently, it is very common for areas of the rational brain (that mainly deal with the outside world and deciding on the best course of action) to be negatively impacted (Van Der Kolk, 2015). This thesis does not have the capacity to consider neuroscientific research in depth, however it is important we investigate where suicide grief may impact our capacity for rational thinking and the ability to process traumatic grief. My own reflective account (Section 5.2) illustrates how I found academic writing difficult during the

research process and how my mental containment was broken, which required holding and containing by family members and during supervision to allow me to process my loss further.

This study refers to holding and containment relative to suicide loss, including: (a) where the holding environment can be provided (such as the relationships with other suicide-loss survivors) and (b) where containment can be achieved (such as the research itself where I processed more of my loss) and (c) where the mental container necessary for processing the loss has been affected and may be achieved (via many different forms of containment). The following section will show how mental containment may be affected by the strong historical context of suicide (a culturally specific construct held within the language, social discourses, and behaviours of those around us) that will affect the type of holding environment and containers needed to process and integrate a loss by suicide into our subjectivity of self.

Part 2: The Development of Suicide Constructs

As discussed in Part 1, dominant social constructs may influence how someone is able to integrate a suicide loss into their subjectivity of self and may affect practitioners supporting them. In this section, I outline the evolution of three significant developments in the history of the suicide construct: (a) from a crime to an event, (b) suicidology, and (c) suicide and mental health: a media spotlight.

2.1 Suicide: From a Crime to an Event

In the Middle Ages, the general view of suicide was very different. Society had rules to follow during the rise of the Christian church. Suicide was seen as self-slaughter and a crime. The murderer (the dead body) was reported as being tried in court within criminal proceedings (Cvinar, 2005). Relatives of the dead body would be called as witnesses in court. If deemed guilty, punishment would follow. Punishment included confiscation of the family's estate and the body being treated with deliberate, savage brutality: dragged through the town on the back of a cart and hung upside down on gibbets to deter others from the crime (Alexander, 1991).

Literature started showing fissures in this view of suicide during the mid-16th century (Barbagli, 2015). Thirteen characters in Shakespeare's plays explicitly took their own lives (e.g., Juliet, Romeo, Hamlet, and Macbeth), with other deaths being unclear (e.g., Othello and Portia). Even so, Shakespeare based these characters in foreign countries to protect London from the view it was acceptable in England (Barbagli, 2015). Outspoken challenges to the belief that voluntary death was a crime continued throughout the 18th and 19th centuries. Intellectuals began using characters in romantic plays to challenge laws and reassess the customs they knew with a critical eye. For example, in *Persian Letters* (1721) by Montesquieu, a leading European intellectual, the character Usbek states, "When I am crushed by physical

pain, by poverty, by scorn, why should anyone wish to prevent me from ending my suffering, and cruelly deny me of a remedy which lies in my own hands" (Montesquieu, 1721, as cited in Barbagli, 2015, p. 76). This quote openly offers the view that suicide is "cruelly" condemned yet could be the answer to a life full of pain: a very different view to the historical one of suicide not being an acceptable option for anyone.

The word suicide evolved from literature and its use is relatively new in Western culture. Prior to its conception in the 17th century, the objective terms 'self-homicide' or 'self-slaughter' were used in England to depict the act of murdering oneself. The slow adoption of the word suicide in the following centuries within dictionaries and literary works demonstrated the cultural shift from viewing suicide as committing a crime to being seen as a voluntary death (Barbagli, 2015). Even so, it wasn't until 1961 that the Suicide Act decriminalised suicide in the UK and it is evident that, culturally, the criminal legacy remains. To this day, the word suicide remains a noun and therefore needs an active verb to clarify it. Hence to commit suicide is commonly used as the object of the subject. Commit is defined as "to perpetrate or carry out (a mistake, crime or immoral act)" (Cambridge Dictionary, 2018, para. 1). The word 'commit' in relation to suicide has only recently been challenged in the suicide prevention movement of the 21st century. Beaton et al. (2013) suggested general use of the term 'died by suicide' to avoid stigmatism and shame and this neatly illustrates the cultural shift from the subjectivity of suicide from a crime to a less shameful act. Although some research still uses the word 'commit' in relation to suicide, most psychological literature now tends to use 'suiciding' (e.g., Wubbolding, 1998) and 'to suicide'. Doing so negates the need for the active verb (to

commit) and makes it into a verb itself, demonstrating it is more helpfully viewed as an ‘event’ rather than a subject in and of itself.

Outside of literature, the first theory about suicide was put forward by French academic, Emile Durkheim, in 1897. For Durkheim, suicide rates were related to social trends and reflected the shifting structures and values of society. Durkheim’s work has been heavily debated in terms of ecological fallacy (e.g. Selvin, 1958: van Poppel & Day, 1996); that is, how can we analyse the micro events (the personal behaviour that drove someone to suicide) in macro terms (suicide is related to social trends). However, Durkheim’s work was vital in driving attention to suicide and demonstrated how the act could be viewed through different lenses; subsequently informing the development of suicidology by psychologists, sociologists and psychiatrists in the 19th century (Marsh, 2016).

2.2 Suicidology

Suicidology is the scientific study of suicidal behaviour (American Association of Suicidology, 2020a) and typically focuses on four questions:

- Why would someone want to end their life?
- What are the psychological and biological factors that may impact their decision?
- What can mental health professionals do to prevent it?
- How can we help those left behind?

In a rather similar way to certain aspects of the movement of the medical model, with its emphasis on evidence gathering, sociological studies have predominantly used positivist tools to investigate these questions. Research has tried to identify the genetic, biological, psychological, physiological, personality characteristics, or social

factors that influence suicidal behaviour (Marsh, 2016). Specifically, researchers have identified predisposing factors (psychiatric disorders such as depression and bipolar disorder) and precipitating factors (life events such as divorce and cancer diagnosis). However, unlike mainstream medicine, practitioners cannot objectively observe suicidal behaviour and interventions as we can cancer symptoms and treatments, which has led to complex theorised models that are difficult to interpret (Hjelmeland, 2016).

The discourses around the causes and complexity of suicide may significantly impact how suicide is considered as a public and policy issue. For example, a social research project published by the DHSC and supported by the Institute of Psychiatry investigated the economic case of mental health (Knapp et al., 2011). Based on their findings, the DHSC claimed that, based on the economy in 2009, each suicide cost the UK £1,450,000.00 (Bonin & McDaid, 2011) through indirect, direct, and human costs. This cost of suicide is quoted regularly throughout government policies around suicide and literature on suicidology. Although reducing a suicide loss to an economic value feels insensitive, it is also reflective of contemporary understandings of suicide: “Suicide is a complex, public health problem of global importance.” (Turecki & Brent, 2016, p. 1227). Discourses such as these can reduce suicide prevention to screening for risk, managing that risk and providing the right intervention to minimise the global suicide rate (Marsh, 2016). Within the past decade, medical professionals have challenged these discourses, as they may impact practitioners’ unconscious worlds, which will shape how they assess suicidal clients, the services they provide, and the way they work with clients in the therapy room. Moreover, recent research has encouraged practitioners to support people without assuming their suicidality is a symptom of mental illness (e.g. Kral & Idlout,

2009; White, 2012; Marsh, 2016). They suggest we do this by using the unique insider perspective (Epston, 1999) to reframe suicide and suicide prevention towards a more “contextualised, poetic, subjective, historical, ecological, social-justice-orientated, and political perspective” (White et al., 2016, p. 2).

This nuanced approach has been taking place over the last decade as researchers within the suicide prevention field are recognising the complexity of suicide and the interplay between societal influences and individual differences. For example, Rory O’Connor (2021), professor of Health Psychology at the University of Glasgow and an international expert in suicide prevention, brought together decades of research about suicide prevention in a book aimed at the general population. The book attempts to dispel myths and misunderstandings around suicide and suggests an integrated model that illustrates the complex processes and factors that may lead people to take their own life. This accessible book allows a window into the world of suicidology and highlights how researchers in the suicide prevention field have changed their outlook more in-line with the psychological movement of the 21st Century. Attempting to develop tailored psychological treatments whilst looking beyond mental illness, undoubtedly adding to the proliferation of perspectives on mental health and suicide, which has been largely aided by the media in the last few decades.

2.3 Suicide and Mental Health: A Media Spotlight

Since the 1980s, technology has enabled people to share their experiences of mental health on social media and in the mainstream news, which has led to the creation of charities and groups designed to support those struggling with their mental health and address the lingering cultural stigma. This cultural shift is also evidenced by the regularity of popular figures in music and film discussing their

mental health stories, including Carrie Fisher (Fisher, 1987), Dolph Ludgren (Spitznagel, 2012), Dwayne “The Rock” Johnson (O’Connor, 2018), Lady Gaga (Young, 2019), J. K. Rowling (Caruso, n.d.), Miley Cyrus (Proudfoot, 2019), Beyoncé (Gottesman, 2016), Brad Pitt (Proudfoot, 2019), Sinéad O’Connor (Lees, 2017), and Kendrick Lamar (MTV, 2015).

On October 10, 1992, the World Federation for Mental Health, including representatives from over 150 countries, created Mental Health Awareness Day (World Federation for Mental Health, 2020a); Mental Health Awareness (MHA) day is now celebrated across the world (World Federation for Mental Health, 2020a). The theme of MHA day in 2019 was suicide prevention, which was intended to promote conversation “about a subject that tends to be taboo and about which many hold mistaken and prejudiced ideas” (World Federation for Mental Health, 2020b, para. 10). Mental Health Awareness Day has given mental health charities across the UK a platform to share new narratives of suicide. For example, in 2018 the Campaign Against Living Miserably (CALM) charity launched a campaign called Project 84. The objective was to combat the silence around suicide and bring attention to the number of men who die by suicide each week in the UK by constructing 84 life-sized figures on top of ITV’s headquarters in London. The charity purposefully involved the bereaved family members in the construction of the models – each one representing a real life lost – and used ITV’s This Morning programme to highlight the stories behind the men who died (Hickman, 2019).

Stories of celebrities who have died by suicide have also been prevalent in the media. Following the death of Caroline Flack on February 15, 2020, her family members and celebrity friends made an abundance of tributes online as well as in social media. Many press reports continued for months after Caroline’s death, with

varying foci. Some media outlets focussed on the proliferation of “be kind” tattoos done in honour of “Caroline and the rest of the human race” (Farmer, 2020, para. 1.). Others used her family members’ and friends’ experiences as headliners: “I keep waiting for it to become easier” (Dean, 2020); “It’s really hard to take” (Wheeler, 2020). Many tabloid newspapers celebrated her life with stories and headlines, such as, “You will shine on forever” (Green, 2020). The Times newspaper chose a narrative based around the construct of suicide: “It’s devastating because suicide is the saddest of stories. It is devastating because many of us watched this trajectory unfurl – a spectator sport of abject pity” (Vernon, 2020, para. 3). The UK audience read and watched the story of someone who was variously a beloved star, a mental health tragedy, a criminal, a domestic abuser, a suicide victim, and a media victim. The varying nature of the media coverage following Caroline Flack’s death represents the changing and somewhat inconsistent social views of suicide in the mainstream. Nowadays there is very little mention of ‘committing’ suicide in the mainstream media of Western society. The discourse has changed due to mental health awareness and charitable guidelines to reduce stigma and suicide contagion.

2.4 Conclusion

The story of suicide not only has a narrative of being a crime and forbidden – it also has a social impact on the economy and has been reduced wherever possible to a diagnosable state: controlled and prevented. Although the reification of suicide as a medical risk is being challenged, this summary has shown that suicidology constructs and medical discourse will no doubt affect the social constructs of suicide bereavement. When someone loses someone to suicide for the first time, it is unlikely they have consciously considered the construct of suicide, and these narratives (or constructs) of suicide will affect their ability to integrate the experience

with their subjectivity of self. Demonstrating the importance of this research where the psycho-social nuances of suicide loss are examined in order to increase the understanding of suicide grief, which is in its infancy in comparison to research on suicide itself.

Part 3: The Development of Suicide Bereavement Research

Suicide bereavement occurs within a cultural context and no suicidal act is "conducted without reference to the prevailing normative standard and attitudes of a cultural community" (Hjelmeland, 2010, p. 34). Within the past decade, suicide bereavement research has largely been conducted in the United States (US) and the UK and has been practitioner-driven, focussing on understanding the nuances of suicide grief and providing appropriate postvention support. Most academic books on the topic of suicide bereavement have come from North America. In the 1970s and 1980s, several books were published in the US aimed at medical professionals. In 1972, Albert Cain's *Survivors of Suicide* attempted to identify suicide bereavement as the "important historical omission on suicidology" (Schneidman, 1972, p. xi). The first edited book, *Suicide and its Aftermath*, again from the US, was edited by suicide-loss survivors themselves. These survivors formed a professional group and noticed that Cain's book had only been checked out of the library twice in 10 years (Dunne et al., 1987). They felt this was a "symbolic" representation of the interest in suicide-loss survivorship (Dunne & Dunne-Maxim, 1987, p. xi).

In this section, I outline significant research conducted on suicide bereavement and focus on six themes: (a) suicide prevention and suicide grief are linked, (b) suicide involves stigma/guilt/responsibility/shame, (c) suicide bereavement is different from other kinds of grief, (d) suicide makes us want to 'live out loud', (e) suicide grief requires healing and can be transformative and restorative, and (f) meaning-making is a crucial part of suicide grief.

3.1 Suicide Prevention and Suicide Grief is Linked

Suicide bereavement and suicide prevention are often discursively linked. For example, the Support After Suicide Partnership (SASP) was conceived in 2013 and

their mission was (and is) to improve the care for those bereaved through suicide across the UK; they hold an alliance with the National Suicide 'Prevention' Alliance (SASP, n.d.). In 2018, their work resulted in the inclusion of specific wording on the provision of suicide bereavement support in the NICE guidelines (NICE, 2019). However, this was placed in the suicide prevention section, rather than it being something in and of itself.

Additionally, the UK's National Suicide Prevention Alliance (NSPA) includes public, private and voluntary organisations who "care about suicide prevention and are willing to take individual and collective action to reduce suicide and support those bereaved or affected by suicide" (NSPA, 2020a, para. 1). Their members include charities that specialise in suicide bereavement (e.g., Survivors of Bereavement through Suicide [SOBS]), other mental and physical health awareness (e.g., MIND and Bipolar UK), specialist communities (e.g., Farming Community Network), and public bodies (e.g., Dorset Police) (NSPA, 2020b). The NSPA's reason for engaging so many members is their belief that everyone "has a role to play in reducing the number of suicides and improving support for those affected by suicide." (NSPA, 2020b, para. 1) – further demonstrating the discursive link between the narratives of prevention and support.

Furthermore, the DHSC's cross-government prevention plan, published in January 2019, aims to ensure every health service across the UK has a 'zero suicide' ambition plan for inpatients. The NHS has begun to deliver. For example, the Avon and Wiltshire NHS have recently published their zero suicide ambition (NHS, 2020a). Interestingly, they state it is an "ambition and aim, not a performance target" (NHS, 2020a, para. 1). Interesting because they are clear the subject is not that simple. They have one helpful leaflet for survivors of suicide. It is entitled "Support

Following Suicide" (NHS, 2020b, para. 1) and is buried within the Suicidal Feelings webpage (NHS, 2020b). This page is for those who want support if they are thinking of suicide or worried about someone who may be at risk of suicide. This feels a confusing way to access support **after** suicide. On your journey through the website, there are headlines such as "Our suicide Prevention Strategy" and "Zero Suicide Ambition." When someone has already been bereaved by suicide and could not prevent their loved one's death, how they feel when accessing this support needs to be considered.

There has been a similar discursive link made in the US. For example, the American Association of Suicidology (AAS) aims "to promote the understanding and prevention of suicide and support those who have been affected by it" (AAS, 2020a, para, 2). The division held their first conference 22 years after the first suicidology conference. The 32nd *Healing Conference after Loss* (AAS, 2020b) was held in June 2020 and was co-sponsored by the American Foundation of Suicide Bereavement (AFSP) and the Tragedy Assistance Programme for Survivors (TAPS).

The development of support for suicide grief highlights the discursive link between suicide and suicide grief and the consequential links between suicide grief and the suicide prevention construct, which may be discursively odd and impractical from the perspective of those seeking support **after** a loss to suicide. This research will demonstrate how the suicide prevention construct may impact someone's ability to mourn and integrate the loss into their subjectivity of self - creating an unconscious need to defend against the ensuing stigma, guilt, responsibility and blame they may feel because they could not prevent their loved ones death.

3.2 Suicide Bereavement Involves Stigma/Guilt/Responsibility/Blame

> The judgement was every place I went. I'd go to the grocery store and see someone staring at me. Whether I knew the person or not, I could see the look on their face. I was damned.
>
> A Survivor
>
> (Barrett, 2013, p. 128)

Narratives like this occur regularly in individual stories as well as in findings of existing research on suicide bereavement. Social acceptance of death by suicide is less likely than other traumatic deaths (Cleiran, Grad, Zavasnik, & Diekstra, 1996; Pitman et al., 2016), as confirmed throughout qualitative research and literature investigating the lived stories of survivors (e.g. Barrett, 2013; Barton, 2016; Eisma et al., 2019; Evans & Abrahamson, 2020; Gavron, 2015; Lukas & Seiden, 2007; Peters et al., 2016). Stigma is composed of a set of negative, often unrealistic beliefs that a group of people hold about something or someone (Scocco et al., 2017). The word 'stigma' comes from an ancient Greek and Roman practice of burning marks into the skin to indicate a slave or criminal and their social status in the community (Scocco et al., 2017). Today, stigma is characterised by physical characteristics (e.g., tattoos) or mental diagnoses (e.g., psychosis) that offer objective, constructive positions from which people can behave accordingly (e.g., avoid and discriminate) (Barrett, 2013).

Within this context, internalised stigma refers to the blame, shame and withdrawal triggered by applying negative stereotypes to oneself (Corrigan, 2004) (relative to identification in psychodynamic terms) and perceived stigma refers to beliefs about the stigmatising attitudes of others (Scocco et al., 2012) (relative to introjection in psychodynamic terms). In an online study, Scocco et al. (2017) surveyed the views of 155 people bereaved by suicide and found that psychological distress was most related to perceived stigma, especially interpersonal sensitivity

and paranoid ideation. Internalised stigma can be seen in other studies which highlight self-blame. For example, the parents of a child who took their own life either question if they had caused it or somehow been able to prevent it – only after people kept asking them how the death had happened (Barrett, 2013). Blame, shame, taking responsibility for the death, and guilt have been noted throughout research and are integral to internalised stigma defences. Peters et al.'s (2016) qualitative study showed themes of 'feeling the burden of others discomfort,' whereby the survivor does not broach the subject with others to protect others from the discomfort they themselves feel. Research findings have often indicated that survivors feel they need to conceal the cause of death (Sveen & Walby, 2008) and do not always feel able to share their stories, which complicates their grieving process (Peters et al., 2016).

Suicide support group research has demonstrated that people feel supported when talking to others bereaved by suicide. One study found that people feel they gain perspective by being with others who understand the story through their own eyes and that they feel security and a sense of normality within these groups that enables them to express and tell their own story (Groos & Shakespeare-Finch, 2013). Accordingly, my own story and reflexivity is integral in my examination of the subject. Individual responses to the death of a loved one through suicide are complex and based on a person's beliefs regarding the self, others, and the world. Research to date has concentrated on experiences that commonly involve people noticing feelings of stigma, self-blame, and rejection – in other words, has focussed on the **how**. By using narrative inquiry and psychosocial principles, this study considers the **why**, essential in order to understand the differences between suicide bereavement and other types of bereavement.

3.3 Suicide Bereavement is Different

Scholars have debated whether there are any differences in grieving between suicide and other violent deaths (Clark & Goldney, 2000; Cleiran, 1993; Jordan, 2001; McIntosh, 1993; Sveen & Walby, 2008; Van Der Wal, 1989). Jordan and McIntosh (2014b) conducted a thorough review of research in their edited book on grief. They concluded that, due to small sample sizes and inconsistent methods of measuring issues specific to suicide, the body of research does not adequately "provide strong evidence of clear and consistent differences or unique features associated with suicide bereavement" (p. 29). However, they did find that studies using interview methods were more likely to find differences than those that used only objective self-report measures. As such, some scholars have recognised that qualitative research is more suited to investigate the intricacies of suicide-loss survivors' grieving process (Creswell, 2014).

Jordan and McIntosh (2014b) proposed a new way of looking at the differences between suicide deaths, violent deaths, unexpected deaths, and all other deaths. They suggested that all deaths can include universal and normative reactions such as sorrow and a yearning for the loved one to return. However, unexpected deaths – whether through suicide, accidental death, or violence – can be seen as non-normative (i.e., not universal). Non-normative deaths often do not prepare the bereaved for the death through what is often known as anticipatory grief or mourning (Rando, 2000). Jordan and McIntosh (2014b) highlighted the nature of grief responses depends on the trajectory and type of death and the responses may overlap depending on the individual situation.

Ellenbogen and Gratton (2001) objected to the comparison of different group variations. They argued that comparing one bereavement group to another ignores

individual differences, especially when comparing reactions depending on the type of death. Ellenbogen and Gratton (2001), Jordan and McIntosh (2014b), and Sveen and Walby (2008) concur that suicide-loss survivors are not a homogenous group and that reactions to the death can differ. For example, when someone is involved in caring for someone with mental health problems and has witnessed numerous suicide attempts prior to the final act, there can be a mitigation of the shock response (Clark & Goldney, 2000), whereas the reaction to a sudden death which was not anticipated can shake the assumptive world of the mourner, in what is known as the cognitive destabilisation component of violent loss, which makes the integration of the loss an important aspect of grief work.

3.4 Suicide Makes us Want to 'Live out Loud'

Since the 1980s, there have been numerous autobiographical books written by suicide-loss survivors, such as: *No Time to Say Goodbye* (Fine, 2002); *My Son…My Son* (Bolton, 1995); and *Life After Suicide: The Story is Never Over: It's Just Being Retold* (Travis, 2019). All these books were written in an autobiographical style with the aim of helping others whilst they shared their story.

These published stories give a glimpse into the experiences of loss. Many of these authors, after publication, were approached by people who wanted further help with their grief. This led the authors to continue sharing their experiences at conferences. For example, at the healing conference held by the AAS in 2020, Donna Barnes, a researcher of suicide bereavement amongst African Americans, gave a talk called *Paving the way to healing* (AAS, 2020b). She described losing her son to suicide in 1990 and explained how her son turned from the 'promising baseball player' to 'the one who committed suicide'. Her narratives about him changed, and suicide dominated her thoughts. She described the shame she felt and

the ignorance she experienced from others, which led to her being socially isolated and silent when she wanted to share her feelings. Donna now appears to 'live out loud' with her grief and her son's story. She found an avenue for this through research and helping others with their suicide grief through support groups. In 'living out loud', Barnes has 'healed' from the loss the best way she can.

3.5 Suicide Grief Requires Healing and Can Be Transformative and Reconstructive

There is a growing body of research into post-traumatic growth (PTG) in terms of suicide grief (e.g., Levi-Belz, 2015; Frank, 2013). Sands (2009) theorised a tripartite model of suicide bereavement after conducting research with a support group throughout their transformative grief process: a relational model of meaning-making with self, the deceased, and significant others. Although Sands suggested that meaning-making occurs through dialogue and discourse, transformative grief processes are led by emotional engagement with others. Sands used three metaphors to demonstrate the different types of meaning-making stages the group moved though: First, "trying on the shoes" signifies the investigation of the intentionality of choosing not to live, when the victim cannot explain why they chose to die. Survivors metaphorically try on the shoes of the deceased by developing an account of the state of mind, concerns, feelings, thoughts, and events leading up to the decision. Second, "walking in the shoes" captures the process of incorporating the survivor's own part in the death story – the 'now' of the death. Thirdly, "taking off the shoes" refers to the repositioning of relationships with oneself, the deceased, and others where any blocks have lifted, sense has been made and integrated into current life beliefs and behaviour (Sands & Tennant, 2010). This study illuminates what processes people may go through whist being supported within a support

group, however it does not explain why these processes were important and why emotional support by others in the group was helpful. Levi-Belz (2019) conducted an 18-month longitudinal study of 156 suicide-loss survivors to investigate the interpersonal factors relevant to growth after suicide. This study found that belongingness, self-disclosure and social support were significantly important factors in facilitating PTG (Levi-Belz, 2019), which illuminates why support groups are so helpful towards transformative growth. However, although it explains that a feeling of belonging to the group, where everyone is a suicide-loss survivor, is helpful, it does not explain why this is so important to growth.

Although there has been research supporting PTG after suicide (Gall et al., 2013; Levi-Belz, 2015; Moore et al., 2015), it is a complicated process and suicide loss has various paths it can take. A recent qualitative study (Dransart, 2017) found several areas which were involved in the mourning process after suicide loss. They looked at the reconstruction patterns of 50 suicide-loss survivors and identified four different patterns to the way they journeyed through the reconstruction: the vulnerability pattern (suicide had become a destructive element of their life, relying on others to support them), the commitment pattern (whereby the death marked the reorientation of their whole life, committing to a cause), the transformation pattern (growing by using the death as an opportunity to better understand themselves and live more firmly in the knowledge that it is important to do so), and the hard blow pattern (a great deal of suffering without a reorientation of their whole life). Overall, the study indicated that not everyone finds positive reconstruction easy, and it will depend on interpersonal factors as well as the support given. Researchers continue to search for what makes some individuals personally grow after grief whilst other do not, and what processes are involved.

3.6 Meaning-Making is a Crucial Part of Suicide Grief

Scholars have theoretically explored meaning reconstruction and its relationship to bereavement (e.g., Neimeyer, 2001). Specifically, they have examined meaning-making:

- as the prime motivator in understanding the lost relationship (Stroebe & Schut, 2001),
- and its interaction with the worthiness of the self (Stroebe & Schut, 2001),
- and sense-making and benefit-finding (Davis et al, 1998),
- and its importance in rebuilding shattered assumptive worldviews (Janoff-Bulman, 1992),
- as an appraisal of life significance (Hibberd, 2013),
- assisting positive appraisal (Janoff-Bulman, 1992), and
- being supported by spiritual beliefs (Murphy et al., 2003).

Gillies and Neimeyer (2006) critically reviewed empirical studies and concluded that study methods and designs have constrained this relatively new area of research and suggested an integrated model of meaning reconstruction for future research. Although this theory illustrates that meaning-making is a process, how it relates to suicide grief requires further research.

Although McIntosh and Jordan (2014) argued that the need to make meaning of the death of a suicide is no different than other traumatic deaths, the benefits of a narrative approach to integrate the violent death of a loved one (by accident, homicide, or suicide) is associated with a more favourable bereavement outcome (Groos & Shakespeare-Finch, 2013). Researchers have suggested this is because “traumatic events and losses can shatter a person’s assumptive world – the network

of cognitive schemas that bear on the benevolence and meaningfulness of the world and the worthiness of the self" (Janoff-Bulman, 1989 as cited by Gillies & Neimeyer, 2006, p. 34). Sands et al. (2014, p. 249) proposed that suicide appears to be "particularly potent in its ability to shatter the most fundamental of assumptions in life." Kelly (1991) explored people as meaning-makers who draw on social, personal and cultural resources to construct a system of beliefs that help them to anticipate and respond to the events and themes in their lives. This 'effort after meaning' integrates 'micro-narratives' of daily living into 'macro-narratives' of life's direction and purpose, which consolidate a subjectivity of self, whereby the complexity of living is accommodated by the construction and reconstruction of meaning (Sands et al., 2014). Loss challenges the assumptive world of meaning and the mourning process reaffirms or reconstructs this world where necessary (Neimeyer, 2006). The loss requires an integration of discrepancies of the experience in one's subjectivity of self and can trigger an existential reconstruction (Owens et al., 2008), or regain psychic equilibrium in psychodynamic terms.

3.7 Conclusion

Much of the research to date has been conducted assuming all survivors can adequately share all aspects of their experience. There remains a question of how people manage the more subliminal aspects of shame and guilt, which are harder to talk about, and why certain nuances of suicide grief have been found. Narrative inquiry, when situated in psychosocial principles, can attend to the stories that are in the cultural realm (as a way of understanding a subject) and the stories people tell about their own experiences (Andrews et al., 2000).

Part 4: This Study

4.1 Method

4.1.1 Design

To understand the dynamics of a defended subject with a dynamic psyche, a particular type of data collection and analysis is needed. In this section, I explain my adapted use of FANI and psychodynamic theories in this narrative inquiry, using the assumptions of narrative analysis and psychosocial research with an insider perspective on the subject under scrutiny.

4.1.2 Introduction to FANI

Hollway and Jefferson (2000, 2013) suggested that free associative narrative inquiry (FANI) was a way of addressing the inherent research assumption that humans are all transparent subjects who can communicate the whole of their experience. Rooted in the biographical-interpretative method (Rosental, 1993) and psychoanalytic case study methodology, they investigated the fear of crime with defended subjects (Hollway & Jefferson, 2000). This led to four fundamental principles:

1. Free association is a helpful tool for data collection: explored in Subsection 4.1.3 below.
2. Researcher reflexivity is a vital part of analysis: explored in Subsection 4.1.4 below.
3. The idea of Gestalt: explored in Subsection 4.1.6 below.
4. Both participant and researcher are defended subjects (explored in Section 1.10 above), psychoanalytic techniques allow researchers to explore the unconscious processes within the research process and the relationship itself.

4.1.3 Free Association

In this study, I collected data using free association. Free association is a common tool used by psychoanalysts that allows their client to access unconscious processes by freely saying what comes to mind without censorship (Freud, 1915). This can then be used by the analyst to identify latent processes which have been defending against anxiety, such as repression and projection as discussed in Subsection 1.12.1. FANI follows the same principles as free association in the way interviews are conducted: The researcher asks the participant to tell their story and the participant is in control of what they share (Hollway & Jefferson, 2000). Unlike a therapist using free association, however, FANI keeps interpretation outside of the encounter (Hollway & Jefferson, 2013). Hollway and Jefferson (2000) feared that narrative methodology alone may provoke a participant to produce a psychologically defensive story with the appearance of cohesion. Instead, by listening carefully and following up on themes using questions crafted with the respondent's own words and phrases, the researchers can retain an interviewee's account and access the spontaneous links and associations of unconscious emotions rather than a cognitively driven narrative (Hollway & Jefferson, 2000). This approach gives precedence to inherent meanings held in the links (or interstices) rather than the meanings attached to statements or language, which can allow an interviewer to identify the multi-layered subject of the individual as well as how social narratives may shape them. A crucial aspect of using FANI is a belief in researcher reflexivity, and as such the free association tool applies to both the defended subject of the participant and the defended subject of the researcher.

4.1.4 Researcher Reflexivity

As discussed in Part 1, the profession of counselling psychology involves working from a scientific and reflective position. This reflective position lends itself well to the techniques of psychodynamic theory – whereby the therapist uses themselves in the therapeutic alliance to illuminate defences that may be unconscious to the client. Additionally, the FANI approach assumes that both researcher and participant are simultaneously influencing each other. Data is a coproduct of the interview encounter, and it is important to be aware of subjective dynamics that are present during the process of interviewing and when analysing data. Reflexivity and self-scrutiny are central to consider the whole psyche present for both participant and researcher and the dynamic they create. I achieved this by regularly using a reflective journal (examples of entries can be found in Appendix H), supervision with two directors of studies (the first, a psychotherapist and member of the Psychoanalytic Council and the second, a qualified Counselling Psychologist), and recordings of the interviews and data panels.

4.1.5 Data Panels

Data panels were conducted to allow a dynamic, creative learning process (Hollway & Volmberg, 2010). Data panels consist of a group of professionals interested in psychosocial and psychodynamic principles who can provide different perspectives to uncover a researchers' unconscious blind spots or defences. These panels were undertaken using the Dubrovnik method (outlined in Appendix I) (Hollway & Volmerg, 2010). The process involves the researcher selecting extracts from the stories to share and a data panel being held. A data panel member reads the extract to the rest of the group and they free associate immediately. Within this research, the data panels offered a unique perspective into the effect suicide loss stories may have on a listener and how it felt sharing the stories with them. The data

panels are a very important aspect of working within the whole data set available when using FANI as a research tool.

4.1.6 The Gestalt

The Gestalt principle is that the whole is greater than the sum of its parts. Wertheimer, the founder of Gestalt psychology, believed that starting with the ingredient parts precludes one from achieving a picture of the total structure. Rather, he suggested that analysing the structure first will enable the ingredients to become known (Murphy & Kovach, 1972). Hollway and Jefferson (2000) suggested that this focus on the whole avoids the data fragmentation that can come from qualitative research based on the code and retrieve methods of data analysis. These considerations highlight the philosophical and operational significance of considering the whole when collecting data and analysing the detail.

In terms of understanding the Gestalt of someone's unique biography, it is important to recognise that someone cannot be known fully from two interviews, especially when focussing on one topic. In this study, a participant's 'whole' is their unique subjectivity of self in relation to the topic of suicide loss within their dynamic psyche. I did not ask questions relating to the participants' childhoods to gain a full life story; however, if a participant mentioned their childhood when telling their story or when answering a question, this was included in the analysis.

My use of Gestalt also relates to the data set I used to develop a full understanding of my research topic. The data set included my memories of the meetings, the reflective journal, the data panel's observations, notes from the interviews, audio recordings and transcriptions from two interviewees (totalling eight interviews). This enabled me to identify themes across the whole data set. Hollway and Jefferson (2013) suggested that the Gestalt principle is the internal capacity to

hold the entirety of the data set in the mind during analysis. From this position, I was able to consider participants' relationships to the topic of suicide and how these relationships may have changed throughout their experience of suicide loss and across the whole sample. However, my reflexive account in Section 5.2 demonstrates how hard this may be as an insider researcher to the subject under scrutiny.

4.1.7 Previous FANI Research

Many psychosocial inquiries have used FANI (e.g. Clark, 2002; Gadd, 2004) to explore social and cultural phenomena (Whitehouse-Hart, 2012). According to FANI research, there are many ways of collecting and analysing data. For example, a recent study of the resilience of ambulance workers used FANI to collect data and present themes (Clompus & Albarran, 2016). Similarly, a study of female therapists' experiences when working with male clients whom they are sexually attracted to, used FANI as a hybrid method for both the data collection and analysis stage with elements of a thematic structuring in the findings (Lukac-Greenwood, 2019).

Another study of gay men with suicidal ideation and suicidal behaviour (McAndrew & Warne, 2010) used data collection uniquely within the FANI model. Four participants were asked to go back in their minds to when they could recognise "a clear picture of themselves" (McAndrew & Warne, 2010, p. 94) and then tell their stories freely. The researchers then shared the transcript with the participants before the second interview, which allowed both the participants and researchers time to reflect. The analysis was typical for FANI: The researchers used psychodynamic theory to support their investigation of the accounts. Finally, the participants' narratives were developed into interpretative themed accounts, and thereafter shared across the sample.

Archard (2020) critiqued FANI by highlighting some of the issues associated with the approach. The first was the assumption that the researcher is the 'expert' whilst being used by researchers unskilled in psychoanalysis. This has challenged the authenticity of research in terms of the researcher not conducting interviews or analysing data effectively (Frosh & Baraitser, 2008). The second issue was the potential ethical challenge of bringing therapy into a research encounter. Some scholars have suggested participants may be exposed to insights that might be inappropriate in timing or hold too much emotional charge (Archard, 2020). Archard (2020) therefore suggested that FANI needs to be "approached cautiously" (p. 48) because there is no prescriptive method of data collection and analysis - only some suggested tools of inquiry (Elliott, 2001). This may be because psychosocial research is concerned with the research relationship of two defended subjects and as such there is no one particular way to proceed.

I wish to address these critiques in terms of this research. I am a trained counsellor conducting this research during my counselling psychology doctorate. I am therefore experienced in using psychodynamic techniques within the therapy room. However, I remain aware that this was a research encounter, not a therapy session, in which both parties are defended subjects.

4.2 Data Collection

I determined that an adapted FANI was the most appropriate way to collect data for this study. The first interview used the life story method to open the consciously constructed story upheld by conventions of storytelling (Hollway & Jefferson, 2000). This was necessary to hear what narratives people use to defend against anxiety and illustrated their subjectivity (Archard, 2020). This first interview also developed rapport and trust and a psychological holding space (Ogden, 2004)

as described in Subsection 1.11.2. I asked participants to tell me their story about losing their loved one to suicide and I did not interject. After this first interview, I hypothesised the participants' unconscious processes by paying close attention to my feelings and any: contradictions, avoidances, inconsistencies, and changes of emotional tone. By following up closely with the reflective journal, I was able to highlight any countertransference, projection or transference I may have felt during the interview. I then used this information to produce questions for and during the second interview, where I followed emergent themes from the first interview.

The second interview used the free association method, as described in Subsection 4.1.3, which allowed access to the unconscious. Because this method assumes that the participant and I are not always aware of or understand our own actions, feelings, and motivations, I was able to test my original hypotheses at the second interview. By questioning to clarify and gain further evidence, I checked on initial hunches and provisional hypotheses whilst giving the participants time to reflect (Hollway & Jefferson, 2000).

During the drafting of the questions and during the second interview itself, I considered four important FANI principles which Hollway & Jefferson (2000) based on the biographical-interpretative method of interviewing (Clark, 2002):

1. Open questions
    a. Open questions allow participants to share what they wish rather than what they feel is 'right'.
2. Questions that Promote the Narrative
    a. Asking questions that promote the narratives is important to narrative enquiry and psychosocial research. Consider:
        i. Why people tell certain parts of stories?

ii. Why are they telling them?

iii. What form of response are they trying to get? (Clarke & Hoggett, 2009).

3. Avoid Why Questions
    a. Why questions make people fit their answer to the criteria rather than following their own story (Hollway & Jefferson, 2000). For example, why did you think that? This question may make participants find answers to verify they did think that: rather than following their own course of narrative.
4. Ordering and Phrasing
    a. Using respondents' ordering and phrasing alongside careful listening enabled me to ask follow-up questions using the respondents own words and phrases, without offering my own interpretations.

I analysed out of the data after conducting the interviews, rather than offering in-depth analysis during the interviews themselves.

4.3 Positioning

Healthy qualitative research requires researchers to consider and discuss their position in relation to the participants and subject under scrutiny and how this may affect the research, especially when researching psychosocially using psychodynamic techniques. Recognising the similarities and differences between the researcher and their participants will help to situate the researcher within the research (Ely et al., 1991). This requires the researcher to be reflexive, aware, open, and honest about their own position in relation to the research they are undertaking (Dwyer & Buckle, 2009) and allows counselling psychologists to situate themselves

within research whilst maintaining their scientific-reflective position as discussed in Section 1.4 (Woolfe, 2016).

An insider researcher is considered to share the experience, characteristic or role of the researched (Dwyer & Buckle, 2009), whereas an outsider does not have commonality with those participating (Braun & Clarke, 2013). As such, because the participants and I share the experience of being bereaved by suicide, I am mainly positioned as an insider. Viewing myself from this polarised position has been very important. By recognising I am also an outsider to each participant in terms of personality, sex, age, or relationship to the lost one, enabled me to adopt a balanced approach. This balanced 'space between' allowed me to understand other's experiences whilst representing them (Dwyer & Buckle, 2009).

This 'space between' is similar to the one counselling psychologists hold in therapy sessions. In other words, being tuned in to the experiences and meaning systems of others and simultaneously being aware of how our biases and preconceptions may be influencing our understanding (Ogden, 1994). Because of my training, I was equipped to meet the demands of working creatively in the 'space between' being an insider and an outsider. However, I am aware that the researcher–participant relationship is not the same as the counselling psychologist and client relationship and as such was cognisant of both the weaknesses and benefits of this type of research.

The concept of researching from both the outside and inside has created ample scholarly debate (e.g., Kanuha, 2000; Serrant-Green, 2002), and reflections made by researchers about their own experiences have fuelled this discussion (e.g., Armstrong, 2001; Dwyer & Buckle, 2009). As an insider to my research, I needed to consider other researchers' experiences of being an insider whilst being aware that

the terms applied have come from psychological research which has evolved from the medical-scientific movement outlined in Subsection 1.4.1 (Fay, 1996).

4.3.1 Insider Position

When a researcher and their participants have a common experience, it can be initially helpful because it can "afford access, entry and a common ground" (Dwyer & Buckle, 2009, p. 58). However, as the researcher begins data collection and analysis, this commonality may thwart the research for several reasons. Asselin (2003) summarised the implications into three areas: (a) assumptions, (b) objectivity, and (c) participants' perceptions and expectations. In the subsections below, I consider these areas in relation to my own procedures.

4.3.1.1 Assumptions and Objectivity

Researchers sharing the same experience as the participants may assume that they know what the experiences are and cloud the perceptions of the researcher (Dwyer & Buckler, 2009). This may impact researchers' ability to probe for deeper meaning, or result in them overlooking important pieces of data (Asselin, 2003). By assuming a shared understanding, a researcher may not notice important subcultures, such as the type of relationship the participant had with the deceased. Dwyer & Buckle (2009) suggest researchers therefore need to 'bracket our assumptions' wherever possible. Similarly, according to Asselin (2003), "Researcher expectations, past experiences, beliefs, and emotions can prevent the researcher from achieving a detachment necessary for analysing the data objectively" (p. 100). Critiques with regard to scientific research are concerned that this may lead to a researcher projecting their own needs or emphasising shared experiences during analysis, which can, like assumptions, lead to overlooking important pieces of data (Field, 1991).

I argue that, from the position of conducting research through a psychosocial lens with defended subjects, it is impossible to completely bracket my assumptions as I am integral to the research process. Furthermore, true objectivity remains a value-laden term constructed from the scientific-practitioner movement, and to subscribe to this standard within research ignores the subjective experience and individual differences. Rather, in order to find the space-between whilst being situated within the principles of the scientific-reflective practitioner, I managed assumptions and objectivity by using psychodynamic tools and theories to analyse the data and remain reflexive throughout. For example, by using the psychodynamic concept of countertransference, I was able to reflect on my assumptions in order to shed light on unconscious defences which are highlighted through the research relationship.

Therefore, as has been discussed in this section: a reflective journal, data panels and supervision were vital parts of my research Gestalt. However, in order to be reflexive at the very beginning of the interview process, I identified my thoughts and beliefs about suicide, wrote them down, and put them aside before the interviews were held (Asselin, 2003), which helped me remain grounded in the data.

4.3.1.2 Participants' Perceptions and Expectations

Armstrong (2001) suggested that participants build up an impression of the researcher from their interactions and their positioning with the subject. This impression impacts how they perceive themselves in relation to the researcher and the story they share. By disclosing my position as a suicide-loss survivor, an impression would have been made straight away. As mentioned previously, this reduced the hierarchical relationship between researcher and participant and provided a holding space for the interviews (Acker, 2000). However, they may have

assumed I knew parts of their experience or wished to protect them from their own grief and omitted parts of their story as a result. By using only one open question in the first interview, I avoided influencing them with questions from my perspective. As a result, I needed to carefully choose the questions in the second interview. By ensuring that I only asked questions that arose from the first interview, I grounded findings in the data.

4.4 Recruitment, Sample and Participants

I used purposive sampling to recruit participants. I advertised in a UK suicide bereavement support group network called Survivors of Bereavement by Suicide (SOBS). There is no fixed sample size for healthy FANI research given that the focus is ideographic rather than nomothetic in terms of gaining greater understanding of the lived experience (Hollway & Freshwater, 2007). I therefore recruited four participants to allow a thorough, below the surface examination of each case (Hollway & Jefferson, 2000).

Table 1

Demographic Table

Participant	Age	Ethnicity	Location	Relationship to deceased	Time since death
Jim	63	White British	Wales	Father of Son	14 years
Chris	61	White British	Southeast England	Husband of Wife	2 years
Angela	43	White British	Southeast England	Daughter of Father	35 years
Macy	52	White British	Southwest England	Sister of Brother	8 years

It was difficult to gain a wide range of ages from different socioeconomic backgrounds with such a limited sample size, but I attempted to do so by approaching different support groups across the UK. I am aware by approaching

support groups I only gathered information from people already seeking support; however, this was an ethically sound way of ensuring the participants had access to support throughout the process, in case any difficult feelings arose.

4.5 Analysis

I conducted data analysis based on the Gestalt as discussed in Subsection 4.1.6. This allowed me to analyse how external social narratives and internal narratives may shape the subjective experience of losing someone to suicide and affect the healthy psyche.

Although the data production was based on free association, the data analysis was based on psychosocial interpretation. Additionally, the analysis of my reactions to the stories and the research relationship in which transference and projection occur relied on psychodynamic techniques, rather than the analysis being a complex psychodynamic formulation of each participant (Hollway & Jefferson, 2000). This process allowed me to access the context of the research relationship and the wider social narratives which may constitute subjectivity (Archard, 2020).

There are no clear guidelines for conducting analysis with the FANI method. However, acknowledging that analysis takes place from the position of a defended subject whilst analysing the story of another defended subject can enable a deep level of analysis. To do this, I broadly adhered to Hollway and Jefferson's guidelines (2000, 2013), which include developing interpretative themed accounts that were thereafter shared across the sample to present the research. However, my interpretation methods differed to those of Hollway and Jefferson (2000, 2013) because they have been critiqued as relying too heavily on Kleinian concepts, ignoring other possibilities (Archard, 2020). In my analysis, I was therefore open to interpretative accounts that emerged from the data based on a wide range of

psychodynamic theories (e.g., containment, object relations and defences against anxiety) alongside socially constructed narratives – especially how these narratives are constitutive of their subjectivity of self when faced with suicide.

The steps taken to ensure the analysis emerged from the data are shown in Appendix J, and in the next section I discuss the ethical considerations of conducting this type of research and the processes I undertook to ensure this study was ethically sound.

4.6 Ethical Considerations

The research project was approved by the Ethics Committee of the Graduate School of the University of the West of England (Appendix B) and adheres to the BPS Code of Practice. Ethical considerations included (a) reflexivity and my own wellbeing, (b) the participants and their wellbeing, and (c) data protection management.

4.6.1 Reflexivity and My Own Wellbeing

I have worked in mental health settings for four years, which has included work with people who are suicidal or have experienced the death of someone through suicide. Assessing risk was one of my key competencies as a trainee counselling psychologist within NHS teams, and my experience with counselling bereaved people was part of my placement with a bereavement charity. Therefore, I am skilled and trained in completing risk assessments and safeguarding referrals to appropriate services when necessary.

I am aware anonymity is lost by including my experience in the research process. This feels significant for me, as it will help dispel the shame around hearing suicide loss stories. I have had 3 years of personal therapy for my brother's death and feel I have processed my feelings and constructed a new narrative from the

meaning-making process of my own therapy. As a means to look after my own wellbeing, however, I kept the reflective journal to monitor my responses and used close supervision. I was also aware that my family may be recognisable using this method and therefore gained their permission (Appendix A) to conduct this study. Given that I ran the London Marathon after my brother's death and my campaign involved live radio talks and newspaper articles about his death, my family members have already experienced me sharing our story. Because I openly communicated with them while conducting this study, they were not emotionally harmed through this experience; in fact, they were proud I was challenging norms within society.

4.6.2 Participants and Their Wellbeing

Given that the sensitive nature of the topic and talking about past events could increase the potential for participants to experience psychological distress (Archard, 2020), I ensured they:

- had been affected by suicide loss over 2 years ago,
- self-defined as already having processed the death of the deceased,
- had a support network I deemed satisfactory,
- were aged 25 years old or above at the time of interview, and
- could speak English.

I screened participants during an initial telephone conversation in which I gathered a brief history of their mental health and built rapport. Rapport is essential due to the sensitive nature of the subject and the shameful feelings that can arise. This helped me to determine whether their participating posed any risk to their mental health using the risk screening tool (Appendix E). Furthermore, I obtained their general practitioners' details so I could disclose any identified risk as GP's hold clinical

responsibility for their patients. During this conversation, I was careful to monitor participants who self-defined as having already processed the death of their loved one and only accepted those whom I felt had done so.

Prior to participating in the research I gave all participants an information sheet (Appendix D) that provided information about the nature of the research, ways to withdraw from the study and how to manage any distress experienced during the process. They signed a consent form (Appendix F) and I left them with a debrief form which contained contact details for relevant organisations that could offer support following the interview if required (Appendix G).

By interviewing the participants in their own homes, I aimed to give them a greater sense of control over the interview. I did not enter locations I deemed unsafe. My experience of lone working and visiting people's homes, rehabilitation centres and care homes as part of my placement aided my safety. My lone worker practice involves carrying a mobile phone and using the standard safe buddy protocol. I also took a break following each interview to avoid fatigue and made notes to offload any psychological distress.

4.6.3 Data Protection

I anonymised all data from the participants during transcription to hide their identities, pseudonyms were used and all identifiable information was stored separately from the data. I compiled all demographic information into a table. Participants were given information on how the research will generate data and how personal information will be handled (Appendix D). This was given to them prior to consent, so they were fully aware of how information will be stored and handled and that I would be using quoted extracts from the interviews in any publications and presentations arising from the research.

Part 5: Analysis

Firstly, this analysis begins with a presentation of each case, including a pen portrait of each person's story, how our research relationship developed and the themes that arose from their stories. This is followed by a personal reflexive account of working on this research and, finally, a themed interpretation across the whole data set, illustrated by a diagram, is presented. As described in Part 4, I used the relationship between myself and participants, the narratives deployed and psychodynamic techniques and theories to interpret the narrative data. In my analysis I considered the Gestalt – as described in Subsection 4.1.6, including the participant's relationship to the topic of suicide and how it may have changed throughout their experience and across the cohort. Stages of the analysis with an example of the preliminary analysis table, the pro-forma and emerging themes table are shown in Appendices J to O and demonstrate the analysis emerging from the complete data set. Please find a key for transcription symbols in Appendix O.

Conducting this analysis inevitably meant I had to use different language throughout. The language moves from third person ("he" or "she") during the summary of the participants' stories, to first person ("I" or "we") when discussing my own reflexive account, and back to first person ("I" or "we") when discussing my reaction to their story, how our relationship developed and during the final themed interpretation account. Although I used differing language throughout, the analysis remained grounded in the data whilst I adopted the 'space between' position as discussed in Subsection 4.3.1.

5.1 Participants' Case Studies

5.1.1 Jim: An Introduction and Pen Portrait

Jim used the term “good suicide” (Interview 2, 92) to summarise his experience of losing his son, Sam, to suicide, aged 24, 14 years before the time of interview. Jim is clear about being a “very hard skinned… thick-skinned and business-like” (Interview 1, 22) character. He felt that he had concentrated solely on work following Sam’s death – as if he “was fine” (Interview 1, 40). Several years later, Jim started to become angry on occasions, at which point his wife (Beth) suggested he get some help for his son’s loss. He did so by getting some bereavement counselling from CRUSE, a bereavement charity, which was “nice” (Interview 1, 44) but Jim felt the counsellor didn’t know how to help him. Jim left counselling after 3 sessions, suggesting to CRUSE that if they wanted to start a counselling group for those bereaved by suicide he would be happy to help. Eventually, Jim set up his own SOBS group and has been leading it ever since.

Jim also volunteered supporting others through CRUSE and found it important to do a postgraduate counselling course in order to “be more effective in the counselling environment” (Interview 1, 46). This counselling training opened up a portal into his own “personal development” (Interview 2, 20).

At the time of interview, Jim had recently lost his wife to illness and he shared some of his experience of losing her. This demonstrated how Beth’s support was vital in order for him to process the loss of his son. Beth “was a very loving wife” (Interview 1, 43) who read “masses of stuff to try and help” (Interview 1, 35).

Jim’s business-like attitude and his wife’s holding appeared to give Jim the capacity to seek help, which was met with a lack of appropriate support. Hence he began his own support group which Jim was still leading at the time of interview. This ‘helping others’ instigated an integration of his story and his emotions because it led him into counselling training and becoming more emotionally connected to his

experiences. This allowed what Jim felt was more reflexivity and emotional growth, which ultimately led to a 'good' suicide – where Jim feels like a "very lucky, lucky, lucky, lucky boy" (Interview 2, 135).

Jim's story contained strong reconstructive/healing elements which gave him a strong sense of coherence around his story of Sam's death and his own personal growth – made possible by his business-like approach to life, the support and holding he received from his wife, the SOBS group he facilitates, and the counselling training he undertook:

> I think of myself as a curious mixture of somebody who is very, I'd say, hard-hearted and dispassionate about a lot of things, really, but I'm also extremely…erm…I can be very empathic and have a lot of feelings and I don't regard it as a split exactly…so I don't know, there's something about—there has been something suppressed, and I've done my best to unlock it over time. (Interview 2, 2)

I left both interviews feeling as if we had both worked hard to explore both Sam's death and Jim's emotional wellbeing, which seemed to be possible due to the containment we both felt which will be explored further below.

5.1.1.1 Researching Jim: Personal Growth

> I am struck by the warmth I feel. I have a pain in front of my head and feel sad and emotional. But I feel touched by his story and how the relationship has developed so quickly – how it's evolved between us – the connection. There was a want at the end to share my own story with him. (Journal, 28/1/20)

Jim and I were similar in terms of ethnicity, location, social class, counselling training and our desire to help others. We were dissimilar in terms of sex, age, relationship to the deceased and how long ago the death occurred. The extract from my journal

above demonstrates our strong relationship based on our counselling training and personal growth, which may have created containment for us during the interviews. This relationship can be seen in Jim's explanations of how "really, really helpful. Amazing" (Interview 2, 115) the interview process had been for him to understand himself further.

Jim had used strong metaphors to portray and process the experience he had gone through "just trying to stay alive" (Interview 2, 114): "[It is as if you are a] pod and you're in the middle of the arctic and you're just trying to keep warm and a candle flame is all you've got to keep warm" (Interview 2, 113). This visual metaphor appeared to offer Jim a safe way of explaining the immense isolation he had felt at the time. I sighed heavily when Jim concluded his own analysis of how he had coped, and noted how I felt relief from his reflection: possible countertransference of my own relationship with suicide – that there can be relief when we are able to process the loss in a safe way.

I identified three themes in my analysis of Jim's story and my relationship with him: (a) his business-like personality, (b) containment, and (c) the 'good' suicide – in other words, that Jim felt losing Sam, although painful and difficult to process, has had a positive effect on him:

It's been a massively constructive thing for me. I don't mean I'm glad he died, for God's sake but I do think my life is better because he died…I'm more satisfied with who I am. (Interview 1, 54)

5.1.1.2 Jim's Themed Analysis

5.1.1.2.1 Business-Like Personality

Jim's relationship with suicide was defined by reflexivity and continual reconstruction of his subjectivity of self. To investigate this from a psychosocial

perspective, I needed to consider his identity and the social narratives available to him at the time. As discussed, Jim was aware of his "business-like" (Interview 2, 22) attitude toward life. This was evidenced in his narrative, which contained a lot of specific details that he attempted to accurately convey. For example, he was very specific with the timing and details of the events following Sam's death:

> I went up into the loft…the rope was still hanging from a rafter, so I removed the hook and the rope. Just so that his mother wouldn't see it…er…so what – he had done is he'd screwed a…a big hook of some kind. Tied a rope around it. It was washing line or something like that. And then, he'd carefully thought about this – he was 6 foot 4, or 6 foot 5 so he needed to measure everything very carefully. (Interview 1, 21).

I was also alerted to Jim's business-like nature by the way he made meaning, or 'tried on the shoes' (Sands, 2009) of Sam in an analytical way when looking "for something that set him off on a path towards a suicide" (Interview 2, 9):

> I kept thinking about it and what might have made him the way he was. And why he ended up in that position without my being at all aware of it. So, I was sort of wondering how negligent I'd been as a father and whether I'd cared enough and, er. I went back and back thinking, well perhaps when he was a teenager in school a teacher humiliated him and it made him feel vulnerable in front of people. So, I came up with all sorts. (Interview 2, 9)

Jim's comment "how negligent I'd been as a father" (Interview 2, 9) indicated feelings of self-blame and internalised stigma and guilt (Corrigan, 2004) associated with suicide loss. These feelings seemed linked to his conception of himself as a father and how he impacted his son's wellbeing. While reflecting on Jim's search for answers, I imagined him finding an answer to the question. Jim's analytical mind

made his subjectivity of self during the meaning-making process significant. Jim described working out that his son had killed himself in a certain way so as not to leave scuff marks on the walls as he fell. He concluded that his son had done that to protect his mother from seeing the damage left from his suicide: “He’d taken the trouble to not damage his mother’s house” (Interview 1, 25). These findings made Jim feel “pride” (Interview 1, 24) in the way Sam had managed his death, and the meaning-making clearly gave Jim some peace. However, the process of meaning-making during the interview brought Jim to tears. Whilst sharing his story, he realised that the “kindness” (Interview 1, 29) his son had shown during his death activates strong emotions when Jim receives kindness from others now.

> -[crying] [pause whilst upset]. God I’ve just made a link with something. This is really strange. I knew talking to you might help…I’m very hard skinned I would say, thick-skinned and business-like- (Interview 1, 22)

Jim recognises that his business-like personality can stop him processing emotions when necessary but he still managed to process Sam’s act on an emotional level within the research itself. It appeared that by talking in detail about his son’s suicide had allowed Jim to process the loss further by projecting his sadness onto myself, another suicide loss survivor, who had the capacity to hold the story whilst Jim processed the loss – offering a container within the research encounter. However, these meaning-making processes, although done in a very reflective manner, still don’t feel enough to satisfy his search for meaning, shown by the sense of futility in his search for concrete answers:

> “I can’t explain how he got to the point he got to” (Interview 2, 9).

No matter how much Jim processes the death of his son, he may never reach a full conclusion, yet he is able to feel that he had experienced a “good suicide” (Interview

2, 92). We must look to the social narratives available to Jim at the time to consider why this was so.

5.1.1.2.2 Containment

One obvious social dimension for Jim was his marriage to Beth – his second wife, not the mother of Sam – who provided holding (as defined in Subsection 1.12.2) for Jim to grieve at his own pace: “Beth talked to me later and said, you know this can’t go on, you need to get help” (Interview 1, 42). “She stood by and let me grieve but knew when to intervene” (Interview 1, 43). With this holding, Jim searched for support but felt dissatisfied with the bereavement counsellor he had found: “There is no point in having someone supporting you or counselling you if you feel you’ve got to protect them from how you’re feeling” (Interview 1, 44). After searching for more specific support for suicide loss and not finding any with the capacity to support him in his grief, Jim set up a support group. In doing so, he appeared to adopt the wounded healer archetype (Jung, 1954) and Jim began training in counselling. I felt an emptiness in my chest when he described not feeling able to get the right support. When Jim started to describe his counselling training, I began to feel more hopeful because there can be transformation and healing through pain.

Jim’s counselling training was “fantastic” (Interview 1, 50) and was the container he needed to develop emotional capacity alongside his business-like attitude. Jim found the practical work within training helpful: He was able to use his own personal experiences to help others practice their counselling skills. The training helped Jim analyse his relationship with his own father and ultimately helped him to be “no longer driven to drink” (Interview 1, 51). This reminded me of my own journey outlined later in Section 5.2 - especially how Jim began supporting others and counselling as a way to integrate the suicide construct into his life and make sense

of it in terms of his identity: “The counselling has taken me on a journey where I understand myself better” (Interview 1, 55). The SOBS group also appeared to help his emotional growth (and therefore offer containment) while mourning. Because he has shared his story with others in the SOBS group, he has been able to make comparisons with theirs and feels his son had a “good” (Interview 2, 92) suicide.

5.1.1.2.3 The ‘Good’ Suicide

The SOBS group gave Jim opportunity to learn from other’s stories:

> One of the groups used to have thirty people there – you were listening to a lot of people…different people telling different stories…erm…so, it was that sense that “oh, yes I felt that,” or I can see why that would it was all that sort of listening to others go through similar experiences. (Interview 2, 123).

Jim referred a lot to how healing it was being part of the support group. He compared his story to others at various points in his story and at numerous times:

> By the time you’ve listened to and I’m going to guess, and I’m going to say three hundred stories you think, mine’s in the top, not the top ten percent. The top ten of those. You know, very few people have such a, I don’t say that to people it doesn’t make them feel any better. I’ve said once or twice to people it makes me realise how lucky I’ve been. (Interview 2, 136).

Whilst Jim said this, I was thinking about how grateful and how final this statement felt - as if he had it all sorted, yet it wasn’t. Confirmed through his comment that:

> I thought it was all done and dusted in a way. And I have, sort of come to terms with it, in a certain way. But, not perhaps emotionally as well as I could have. Despite having talked about it to death. But, really er. So I’m very grateful. I’m very pleased with… it feels much more, I don’t mean it’s finished,

> I don't mean that. But it feels like I've gone further down a particular road. I thought I'd got to the end of the road (Interview 2, 5)

This sense of completion was in stark contrast to the business-like search for meaning Jim had found no conclusion to. Therefore, we can assume that comparing his story to others in the support group appears to hold some sort of defensive function against the incomplete processing of his experience alongside his identity of being business-like. By comparing his story to others who had other "worse" (Interview 2, 156) stories, "it didn't take [him] long to think [his] suicide was a good one". (Interview 2, 123). This appeared to allow Jim to protect himself from the anxiety that he could not make meaning of his son's death fully and allow him to cope well with his loss. It wasn't until he told his story again within the containment of the research that he felt he had processed his son's death on a more emotional level.

> "I found that telling my story again. Which I've done many times. But probably not in a sort of, counselling environment where someone was really paying attention to me. When I tell it, I'm usually telling it to a group. And it's often to sort of illustrate something, or to help them with something. Erm, whereas I actually did just tell it for myself the other day and erm, since then I've been more tearful. That is thinking about Sam I have been able to cry. I have never tried to cry but it's just never something that's come. And it has now and I'm very happy that it has." (Interview 2, 1)

Alongside the natural drive of the wounded healer archetype (Jung, 1954) Jim was able to 'live out loud' through helping others, which resulted in his own healing. Because of the holding Jim received from Beth and the container of the support groups and Jim's counselling training, he was able to integrate the trauma of his

son's death with his story as much as possible and at that time this offered him solace: "I do really think that choices we made, things that we did, paths that we took, everything has been better" (Interview 1, 77). Specifically, Jim talked of how Sam's death had helped him become a "better" (Interview 1, 53) person. However, this research process shows how Jim continues to process the loss of his son today and the research itself gave him multiple layers of containment to do so.

5.1.1.2.4 Conclusion of Jim's Analysis

The holding environment Jim had in his marriage enabled him to recognise that he needed support. The failure of the search for it prompted him to find a container within his own support group - initiating the wounded healer archetype (Jung, 1954; Farber, 2017a) and counselling training - a journey in reflexivity. This reflexive attitude allowed much of Jim's story to focus on his own healing narrative and how 'good' a suicide it was. Although this had held a defensive function against, as a business-like person, his search for meaning which never reached full completion, this had helped him cope and live with a sense of self he could live with. His reflective journey during the interviews then allowed him to use the containment within our research relationship and process more around his loss: "I didn't expect to get this kind of, erm, emotional release and greater understanding of things." (Interview 2, 143). So much so that by the end of the interview his last words repeated his sense of coping with a sense of completion:

> I thought it was done and dusted. I could almost do this [sweeps hands together]. As far as, I've done so much work on it. I don't find it boring anymore but I just sort of think there's nothing more to learn. But I obviously thought. And look what happened, you take a chance, you think "oh, go on then." - I've been the main beneficiary here. (Interview 2, 145).

Jim's relationship with suicide is one of reflexivity, investigation, and continual reconstruction of his own identity. According to my journal, "It was much easier to analyse Jim's story than other peoples" (Journal, 6/12/20) which indicated to me that because we shared a similar relationship with suicide, I was able to analyse the data without significant projection from Jim or my own countertransference affecting the analysis.

5.1.2 Chris: An Introduction and Pen Portrait

Chris lost his wife, Kate, to suicide two years prior to the interview. They were married for 32 years and have three children, now adults. Chris's story was focused on Kate's illness and how it affected them all, their marriage and Kate's extended family. It wasn't until the second interview when I asked questions specifically about Chris's mental health, that Chris explored how Kate's suicide had affected him.

Chris's story was full of 'mini stories' that were coherently structured with flow and consistency around Kate's mental health issues and Kate's suicide. These 'mini stories' were carefully constructed with thought and consideration for all members involved, as demonstrated in this excerpt:

> My daughter was sat one side of it [the kitchen table] studying for an exam with her laptop and Kate was in the bedroom, erm, having I suspected taken an overdose and I'm not being able to raise her to consciousness. But, I'm not sure that it's super bad so without wanting to, kind of, jump into emergency action mode - So I was looking on my laptop which was back to back with my daughters. Researching how many of these tablets were a, constituted an overdose. You know, trying to keep, you know, things from my daughter. (Interview 1, 10)

My reaction to Chris's 'mini stories' was a mixture of horror, shock and deep empathy for all involved. I noted feeling "this is unbelievable/surreal/can't really have happened" (Journal, 5/10/19), and these feelings indicate cognitive destabilisation. These 'mini stories' led me to me believe that Chris was unconsciously preparing me for the suicide story to come– taking responsibility for the level of holding he needed to give me when sharing his painful story which has the capacity to destabilise people.

If we trace Chris's subjectivity and the subject of suicide there are three distinct periods of the narrative to consider: (a) the period before Kate's death when Chris had to care for her with a serious mental illness, (b) Kate's suicide, and (c) the period after Kate's death when he had to cope with integrating her illness, her death and his life without her. The first period was one of pain, care, frustration, anticipatory grief (Sweeting & Gillhooly, 1990) and a loss of his caring, practical sense of self. The second was one of trauma and relief that Kate was free from pain. The third is one of rebuilding his subjectivity of self as a caring, practical self with a new honouring of Kate's illness and a narrative of healing transformative reconstruction (Dransart, 2017):

> From my point of view, there is no better way to honour Kate's passing than to, to get on with a fruitful and active positive life. (Interview 1, 91)

Most of Chris's first narrative focussed on the first period. I will explore this period, alongside the 'mini stories', in terms of the possibility that Chris was heavily defended during this period from feeling anxiety about the fact that he could not be the self he wanted to be – he couldn't help Kate during her illness when society was saying it was preventable. However, this period ultimately gave him a level of mental containment after Kate's suicide because he could feel some peace.

5.1.2.1 Researching Chris: Containment

Chris and I are similar in terms of social class, ethnicity, our loss to suicide and our investment in close family bonds. We were dissimilar in age, sex, location, and type of relationship to the deceased. We do not share the same relationship to suicide – Chris's focus is on Kate's mental illness in relation to suicide, whereas mine is how suicide bereavement affects survivors – but these differences did not significantly affect the research relationship. Chris was warm, welcoming and I felt held during our interviews. During my analysis, I felt this may have been due to Chris's gendered narrative of taking responsibility for others and practically fixing what he can for them, which was compromised during Kate's illness:

I was really touched by Chris's story and as I left the interview I noted in my journal:

> That was such a touching story. I feel sad, moved, humbled to hear it and understand so clearly how mental health can affect a whole family. I feel so moved and feel like I want to help him. I want to buy him sunflowers next time we meet. To say thank you for sharing something so personal. (Journal, 20/6/20)

My instinct to bring Chris flowers demonstrates the transference of solidarity and the mutual sense of both parties feeling held. This was confirmed by the data panel when they free associated a sense of "warmth" (DP4, 1.09.14) when hearing Chris's extract. This extract was read by one of the data panel participants and as such was not projection from me to them, but their own response to the holding felt from Chris. The holding I felt came from Chris himself as well as our relationship as suicide-loss survivors, which created an experience where myself and the data panel may not have been as affected by his story. Chris's themed analysis includes: (a) the link

between suicide and mental health, (b) the prevention narrative of mental health, and (c) mental health illness and anticipatory grief.

5.1.2.1 Chris's Themed Analysis

5.1.2.2.1 The Link Between Suicide and Mental Health

In Chris's story, the narrative of suicide is inextricably linked to the narrative of mental health. In response to my open question: "tell me what it was like losing Kate to suicide" (Interview 1, 82), Chris shared 'mini stories' from life before Kate died. Chris was aware that Kate's illness was more significant: "For me it was all about, it was all about Kate's illness and the mental health (Interview 2, 82)," "… [It is] bigger, bigger than her passing, really" (Interview 1, 84).

Chris revealed the extent of the effect Kate's illness had on their life together when he explained how he and Kate used their holiday home over the different periods. During Kate's illness, they "didn't go there much. Because she, she wasn't very keen and also, I wasn't very keen for her to go out there and for something to happen, you know and for us not to be in range of help" (Interview 1, 22). When there was a period of respite from her illness, however, they "went [to France] and we had friends out there and had a wonderful time" (Interview 1, 22). Since Kate's death, Chris has spent two months (Interview 2, 119) there doing renovations on the house. Chris had to find a way to cope with these effects.

Chris described Kate as "fun, happy and lovely" (Interview 1, 7) and their life as "wonderful" (Interview 1, 22) before her illness and during an 18 month respite they had where Kate's mental health improved and they returned to a happier life. Kate had been sectioned under the Mental Health Act 1983 "four times" (Interview 1, 16) and "things were very difficult to deal with at home" (Interview 1, 16). It is clear from Chris's story that he tried to do everything to help Kate, but was unable to. Kate

would repeatedly say “You’re all better off without me. I can’t live like this anymore” (Interview 1, 39) which had a “big effect” (Interview 1, 18) on Chris and his ability to cope:

> I’d gone through all sorts of phases of you know, how to deal with it. By this point, I was in an exasperated, kind of condition. Not really knowing what to do, how to help. How to **be**, you know, whether to be supportive and conscious of it. Erm, or not. And I think in that particular phase, I was kind of, what can I do? (Interview 1, 40)

5.1.2.2.2 The Prevention Narrative in Mental Health

The significant changes in Kate’s character left Chris feeling powerless. When Kate became ill it seemed that no matter what Chris tried to do, he could not help, which was a significant challenge for his caring, practical character. To understand this from a psychosocial position, I considered the narratives in the social domain available at the time. As discussed in Section 2.3, mental health narratives in the media were changing and suggesting we care for each other’s mental health. When combined with Kate’s suicide attempts and the prevention narrative of suicide, it appeared that Chris attempted to invest in the mental health preventative narrative:

> It seemed however I tried to boost her, it didn’t really have a lot of effect. (Interview 1, 6)

Although Chris attempted to adopt the prevention narrative, he was unable to do so because of the significant effect Kate’s illness had on everyone in his family. When his subjectivity of self didn’t match his narrative of prevention, Chris became “flat” (Interview 1, 18) and “didn’t feel anything” (Interview 1, 18); as a result, he took the position of “we’ll just deal with it” (Interview 1, 18).

> …but it grinds your own, erm, erm, feelings down to…I felt like I had to, I had to be the one that, that stayed on a very level and even keel to, to kind of balance out the, the, the, you know the pitch of Kate's – moods and states of mind, really. (Interview 1, 17)

I felt helpless when Chris was describing this period, which I argue is PI of the helplessness Chris felt – he was unable to prevent her being ill and as such he felt he had to change his personality. However, we see how this changed when Kate died.

5.1.2.2.3 Mental Health Illness and Anticipatory Grief

Kate's suicide itself was situated in the middle of the narrative, carefully constructed with unity and coherence. This part of the story is very poignant in terms of its emotive power and shows clearly how surreal a situation this was for Chris to cope with. Chris recognises he felt relief, previously found in research after a period of mental health difficulties (Clark & Goldney, 2000):

> There was an element of relief in that loss… when I found her, as when I explained earlier, the look of relief in her face and, was, was just that.
> And, so, I felt like I was part way along the process of grieving at the point at which she died. So although she passed away 2 and a half years ago, in many ways for me it's more like 5. (Interview 1, 85).

When Chris said it, I felt more at peace more with the story of her death; the excerpt indicated anticipatory grief, which Lindemann (1944) first described as one which occurs when the wife of a soldier anticipates that her husband will not return from war and builds a life without him, leading to divorce on his return. Scholars have recently studied the phenomenon in terms of physical illness whereby the family of palliative patients grieve for a loved one before their death (e.g., Johansson &

Grimby, 2012). Although there is very limited research into the relationship between anticipatory grief and post-loss experience – largely due to the diversity of personal backgrounds, cultural orientations, and custom practices (Moon, 2016) – Chris's story indicates that he experienced anticipatory grief and a period of mourning before Kate's death:

> That's the point that I lost Kate. You know, the first bout of mental health was not nice to deal with, and it was challenging and it got to a point where it was all we talked about and it was totally engaging – but I lost her at that point completely. You know, she was never the same person after that. So, so when she actually died, it wasn't the total loss that, that, that you would have otherwise. (Interview 1, 84)

Chris was able to invest in a different narrative around his own self, healing, and his own mental health following Kate's death, which is consistent with research showing that the effects of a suicide death on a loved one will depend on the trajectory of the death (Jordan & McIntosh, 2014b) and the sudden death factor, which can be mitigated by previous suicide attempts (Clark & Goldney, 2000). This anticipatory grief appeared to offer Chris a container, which enabled him to process the loss before Kate's death and develop a relationship with suicide before her death, which will be discussed further in the full interpretative account in Section 5.3.

5.1.2.2.4 Conclusion of Chris's Analysis

Chris, as a defended subject, had to adjust his identity during Kate's illness to cope. His subjectivity of self being practical and caring broke down in the face of the mental health prevention construct. When he couldn't help Kate, he invested in an emotionless state where he just 'got on with it' and tried to stay positive for the sake of everyone else. His positioning and subjectivity around suicide appears to be one

of ‘mental health’ and ‘supporting others.’ This sense of self appeared to feel relief when Kate died because she was at “peace” (Interview 1, 85). He was relieved of the task of trying to fix something that became impossible, which enabled him to return to his sense of self as practical and caring after her death. Chris’s relationship with suicide is inseparable from mental health; combined with anticipatory grief and mourning, he was afforded a form of mental containment that allowed him to process Kate’s death and not invest in making meaning out of it. As such, he was able to return to an adjusted self that feels as positive as he can about her death. Despite this, his ‘mini stories’ demonstrated how hard a story it was to tell.

5.1.3 Angela: An Introduction and Pen Portrait

Angela’s relationship with suicide is unique in the interview cohort because she was nine years old when it occurred (35 years before the time of interview). Although Angela had experienced several losses to suicide, her story focused on her father’s death. She did not discuss the other losses until I specifically reflected on this in the second interview. Angela’s response, “I feel like my dad’s suicide is kind of mine, to own in a way” (Interview 2, 122), highlights how linked to her own identity the death of her father had been.

Angela describes her dad’s death as bringing some relief to the family. He had experienced a stroke a “number of years” (Interview 1, 17) before his death which led to alcoholism and violence. Angela felt his suicide had “relieved” (Interview 1, 9) the family from a life of “hell” (Interview 2, 91) which Angela used as a defensive line to defend him from “anyone criticising” (Interview 1, 23) his decision during her teenage years. This defensiveness was compounded by a family silence around her dad’s death, which left her unable to communicate about him.

Angela described having “no self-worth” (Interview 1, 101), which affected her whole life. A lot of her story describes a constant “dogged and determined” (Interview 1, 64) attitude throughout. She describes a resilience which continually pushed her to do bigger, more challenging events. Angela described a challenge where she pushed herself to the edge of extreme danger to prove she was “enough” (Interview 1, 99). After this “dangerous” (Interview 1, 100) experience, Angela realised she needed help and after years of intermittent “depressions” (Interview 1, 114), spent five months in a meditation retreat. At which point she recognised that she was “enough” (Interview 1: 99).

Angela is currently researching suicide bereavement in children through the Churchill Fellowship Trust. This has taken her across the world to support children bereaved through suicide and see how other culture’s care for the bereaved. Angela also illustrated many ways she has tried to get to know her dad better. For example, Angela sailed on the Clipper Round the World Race, which she felt was because one of her Dad’s “biggest ambitions was to sail around the world” (Interview 1, 68).

> I suppose it brings me closer to him and, like, the core of what was in his mind. To, understand – and then I suppose, the understanding of suicide and, trying to like, understand that state of mind (Interview 2, 22).

We can see from this evidence that Angela’s relationship with her dad and suicide is complex, which appears to lead to a reflexive attitude to herself and others who are bereaved as part of the meaning-making process of integrating suicide into her life. However, no matter how reflective she is, she often gets stuck in the complexity of the subject itself.

> I don't think it's possible to ever actually understand it. Unless you're there… I just don't think… I don't think it's kind of explainable (Interview 2, 22).

Throughout Angela's interviews, it was apparent that her relationship with suicide was defined by a reflective journey full of defensiveness, complexity and strong investments in the constructs of suicide and healing.

5.1.3.1 Researching Angela: 'This is Business'

Angela and I are similar in that we are both White middle-class women in our 40s. We easily slipped into our meeting with informal chat, but this didn't last long; we started the interview itself shortly after I arrived. We are different in many aspects: such as children, family, location, and occupation. It transpired that Angela and I hold similar subjectivities of suicide: We were both researching the subject to help others, we have both run the London Marathon for charity, and we have both volunteered with suicide-loss survivors. Even so, we have a different relationship to suicide in terms of the age we were when it happened, how many losses we have experienced, and how long ago it happened. These differences did not seem relevant to our requirements as researcher and participant. The two interviews lasted 1 hour 30 minutes each, and we spent over 30 minutes after the first interview discussing our experiences of suicide and our passion for helping others who have experienced suicide loss, which appeared to help us contain each other within the relationship (discussed further in the reflexive account in Section 5.2).

The focus on suicide and our intersubjectivity of suicide helped the interview process flow in a business-like manner. Both of our relationships with suicide are strong, and transference showed in the way we treated each other. This shared investment in suicide may have been due to the link between our loved ones'

identities and suicide, which I will discuss according to the following themes: (a) defensiveness and resilience, (b) investment in the suicide construct, and (c) complexity.

5.1.3.2 Angela's Themed Analysis

5.1.3.2.1 Defensiveness and Resilience

Angela's reply to my first question "So tell me your story of suicide and the people you have lost through suicide" (Interview 1, 1), was filled with pauses and fragmented speech.

> Ok. So, erm, I lost my dad to suicide when I was 9. I'm 44 now. So, it's 36…35 years ago…35…yeah…35 years ago, erm, and, yeah…and then…since then I also lost my Mum's partner of 22 years, who she was with after my Dad died…also took his own life and that was in, erm, 2009…and I've also lost a friend who was a member of my support crew. (Interview 1, 2)

An effective story begins with an introduction to the subject being explored (Goodwin, 1984). Angela appeared to be using many pause fillers to give herself time to think about what she was going to say whilst creating ad hoc coherence within her story. Angela is a professional speaker and is used to delivering engaging stories. Her use of pause fillers in the interviews shows how difficult the story was for her to communicate – especially at the start of each interview when she adopted the position of storyteller. In the following sections, my analysis will show how this may have been due to her heavy investment in her relationship to suicide and the difficulty she may have been experiencing due to her ongoing struggle to integrate trauma into her thinking and knowledge (Bion, 1962).

Angela described herself adopting a "defensive" (Interview 1, 108) narrative as a child: She would doggedly defend her father's choice in killing himself. She had

been internally armed with evidence that life for her dad was “a living hell” (Interview 1, 14) and he felt like a “burden” (Interview 1, 14) to his family. Life was full of “alcohol and real… self-loathing” (Interview 1, 25) hence he did the most “logical” (Interview 1, 19) and “rational” (Interview 1, 15) thing for them all by killing himself. As a teenager, Angela recollects going “off the rails” (Interview 1, 49) and “being hauled in front of” (Interview 1, 50) an educational psychologist. Angela explained how she responded when asked if she was unhappy because of her dad’s death:

> I’d have come out, probably, with my defensive line saying “that was his right to do that” you know, this, kind of, this, this is his, his, choice and his, he was setting us free from his hell…and la-di-da. (Interview 1, 51)

Her final comment, “la-di-da,” may indicate that this was an old story Angela had to invest in. Nonetheless, as a child, she used a defensive narrative to keep others away, which suggests Angela was a defended subject and her ego had denied the experience, which will be discussed across the whole interpretative account in Section 5.3. As in the other cases, it is important to attend to the social dimensions of the time to see what anxiety this may have been protecting her from. Her immediate social network was silent – it was “taboo” (Interview 1, 29) to mention him. Angela shared that she used to visit the crematorium and her dad’s family in secrecy throughout her teens. Angela linked her defensive attitude towards her dad’s suicide to the discourse of “choice” (Interview 1, 51) – if her dad had chosen to kill himself, then she wasn’t worth him staying alive for. Hence it had been internally destructive.

> Cause to me that feels like the ultimate, like, abandonment and rejection… a parent – Daddy chose to die rather than to stay alive and be my Dad. (Interview 1, 103).

As a young child, her father's suicide shook Angela's subjective experience of self. The silence that surrounded her dad's death provided little holding or containment, which Bion (1962) and Winnicot (1960) argued was the requirement for integrating the experience with her own sense of self:

> Him opting to die rather than stay alive and be here to be my dad left me with absolutely zero self-worth. It made me just feel totally worthless. And that, when I then looked back at everything I'd done. From the high achieving at school. The drinking at university. The, erm…just everything. All these things just trying to fix that wound. (Interview 1, 102)

Whilst searching to understand her father unconsciously, silently, through extreme challenges which involved sailing (which her father loved) and swimming, Angela's defensiveness continued through her 20s and 30s. Angela's recollections demonstrated her investment in being defensively resilient to survive the anxiety of being unlovable. That is, she challenged herself to endurance feats and continually got back up and started again with the next challenge. The achievements Angela has collected appeared defensive and formed a positive resilient narrative:

> It's almost like I'd sort of, taken on this, erm… this really positive narrative, which is like, this has made me into a really strong and resilient person that can, like, achieve these remarkable feats because I refuse to give up. And I've got this appreciation of the fragility of life. Because when someone so important is taken away from you so young, you have a, an appreciation for the fragility of life that you don't otherwise have.

However, Angela has linked this idea of success with her relationship with her dad and his suicide.

5.1.3.2.2 Investment in the Suicide Construct

> I was always like, like, quite, sort of fascinated to understand about suicide and what it was… what drove people to it, how people took their own lives, and, erm, cause it was like this thing that had happened. I knew it had happened but it hadn't been unpacked in any way (Interview 1, 48).

For Angela, her dad's identity is linked to suicide. To get to know him better, she had to get to know suicide better. For example, she described campaigning for suicide bereaved families and doing research on the effect of suicide grief, allowing this time to explore the subject of suicide and suicide loss. This reminded me of Freud's (1917) theory of melancholia (as outlined in Section 1.9) and how her ego had possibly split at a young age and she had used the defence of identification in order to cope with the ambiguity of loving and 'hating' her dad, which resulted in her directing her hate inwards at herself. The way Angela had got to know suicide through research, it was as if, because she had identified her dad with suicide, she had taken on that forbidden truth as something in herself that made her unworthy. It wasn't until Angela said she engaged in a long, hard, focussed meditation retreat, that she became conscious of her own anxiety about being unworthy and realised that she was "enough" (Interview 1, 99), which enabled her to lose her investment in the defensive positive narrative. She began to challenge this belief and recognised that she was a "being and not a doing" (Interview 1, 99) and could stop being the defensive resilient self she had previously been. In my view, this is when she appeared to adopt the position of the wounded healer (Jung, 1954), which appears to have been a driving force that gave Angela permission to 'live out loud' with the support from others and her investment in the suicide construct.

Angela continues to research, help others, and adopt a continually reflexive attitude towards the topic. As Angela began to research children's suicide bereavement she spent time with children in other countries, which led to a very painful breakdown of her own:

> But it was afterwards…it was, erm, when I left there - I just totally collapsed for about 10 days…just, like, absolutely unable to function at all. And just cried and cried. I felt like I just couldn't…couldn't pick myself up from it. And I think it was because…it had just triggered the grief that had just been packed away for, like, 34 years. (Interview 1, 94)

Angela felt that this triggered grief, although extremely painful, was a "positive thing" (Interview 1, 93) which "needed to come out" (Interview 1, 96) because she felt that by "not dealing with it" (Interview 1, 96) she had been battling numerous depressive episodes over the years. The driving force of the wounded healer (Jung, 1954) appeared to impel Angela to support others and resulted in her own "positive" (Interview 1, 83) release of strong emotions, which Angela thinks allows her to continually heal from her loss: "Just by having conversations with people like you, and others that I meet along the way…is kind of helping the whole process along" (Interview 2, 140). Angela and I are both unconsciously driven by the social narratives of silence, the relationship we are investing in suicide, and the healing journey of the wounded healer. As we transferred these relationships onto each other, we were able to form a 'business-like' relationship within this research as both participant and researcher, both container and contained.

The wounded healer is said to be a gift (Farber, 2017a); because wounded healers come to their relationships with experiences of trauma and pain, they impact the experience of others. Angela's story, and my own, show how this archetype can

be triggered when we are unable to integrate the prevention narratives of suicide and the somatic trauma into our own thinking and our own subjectivity of self. The triggering of this archetype can lead a person to develop a strong 'business-like' attitude towards 'living out loud'. For Angela, this meant completing her research and writing a book on her life and her dad's death:

> It's almost like it's not a desire to do it…it's like I feel I've got to. It's like an absolute burning purpose. It's not kind of a…oh it would be nice to write a book. It's like I've got to do this. It's like…it feels non-negotiable. I feel like I…I owe it to myself and the world. (Interview 2, 111)

According to Angela, this burning desire makes writing the book feel like a "big mission" (Interview 2, 140).

5.1.3.2.3 Complexity

Angela used the phrase, "I don't know," 29 times in the first interview and 23 times in the second. She appeared unable to settle on the 'right' narrative, demonstrating the complexity of her unique experience. This led to Angela hitting stumbling blocks as she as she tried to write her research and book:

> …it's just so hard. It's so challenging. It really is. And I've been…I've done…you can't imagine the things I've done to kind of make it happen and, and…yeah, I've been on…been on lots of writing retreats. I've been and locked myself in places in the middle of nowhere. (Interview 2, 106)

Angela's experience speaks to the continually defended nature of 'living out loud.' I related to her account strongly especially in terms of my journey of academic writing and I felt this connection deeply as I analysed Angela's account. I kept repeating the phrase, "This is hard," in the journal I kept during the period of analysis, which may have been projection from Angela or a result of my journey with suicide.

Moreover, the strong defences we put up against the complexity of our grief are hard to break down:

> Cause it's so strong, that protective layer. It really is like a…it's…it's…the only way I can, like, describe it…it…it's like your life depends on it. You know…it's…it's…it's protecting your very being. (Interview 2, 52)

Angela felt that this defensiveness continually blocks her journey with the subject:

> I am feeling increasingly like, a bit of a futility. I felt really hopeful at the start. I felt like I'd been given this opportunity to really, like, shine a light on this issue and to open up a debate and really improve things. And then, I don't know, I just realised that's like…really…optimistic when I look at the underlying factors. And it's just everything. The fact there's no statistics gathered about how many children are bereaved by suicide. There's no kind of…provision of care. There's no real…I don't know…understanding or focus. It just seems so huge of a mountain to climb and…and I suppose part of it comes out of anger. Like, I am really adamant…partly 'cause no one else is doing it. Like, to me it's like, for God's sake. Like, how is this okay? (Interview 2, 133)

Angela said this towards the end of her second interview and in doing so neatly summarised her own journey with suicide. Angela appears to be trying to 'live out loud' from her perspective as a hopeful wounded healer (Jung, 1954) – "I'd been given this opportunity to…shine a light on this issue" – which also having a close, defensive relationship with suicide. This relationship has made her determined ("I am really adamant") to make a difference to others, and resilient "[be]cause no one else is doing it." Yet, she also expressed that 'living out loud' felt like "too huge of a mountain to climb" with no close holding, which resulted in her projecting anger and

resentment (“how is this okay?”) as the sharing of the suicide construct with others touches on the very trauma and anxiety we are defending against.

5.1.3.2.4 Conclusion of Angela’s Analysis

As a defended subject, Angela invested in positive resilience that defended against the anxiety of not being “enough” (Interview 1, 99). Whilst her resilient self was charging through life with dogged determination, Angela invested in the suicide construct to get to know her dad better – as if his identity had become inseparably connected to suicide. As Angela’s relationship with suicide deepened, she felt a drive to ‘live out loud’ and share her story with others. When her defensive resilient narrative broke down decades after her father’s death, she underwent a significant healing process for five months. Once she became aware of her own feelings of not being enough, she was able to fully embody the wounded healer archetype (Jung, 1954) and become invested in helping others; however, she still experiences continual trauma triggers. Although Angela continues to heal through talking, the memories are painful and heavy and cause blockages that feel impossible for her to overcome at times. No matter how much Angela tries to incorporate the loss of her dad into her own life, she is unable to retroactively prevent the suicide itself so she invested in her own healing narrative by preventing other’s emotional distress as much as she can.

5.1.4 Macy: An Introduction and Pen Portrait

Macy lost her brother, Jack, to suicide eight years before the interview. Macy set the context to her story very quickly with how important her relationship with Jack had been:

> I’m the youngest child, Jack – three years older. Big sister, very close, quite intense family. So I pretty much grew up with him being: best friend, soul

> mate, everything. And, erm… yeah, into adulthood we went to university together, we lived together, you know, so we were really… he was my absolute best friend (Interview 1, 3-4).

Since Jack's death, Macy threw herself into her work like a "mad thing" (Interview 1, 81), feeling "very driven and… not really talking about it" (Interview 1, 81).

> I'd thrown everything into trying to be a great parent and – I just came to work the whole time. Made myself four jobs out of one because that was my coping strategy. And I'd get in the car and think "shit, it's really true" and cry all the way home. (Interview 1, 46-47).

After some time, Macy remembers feeling as though she "can't stand at that grave and scream and cry anymore" (Interview 1, 51), so she approached SOBS to find a support group in her local area. She found there wasn't one so decided to set one up herself. She then "found the first few months of meeting people who've experience suicide incredibly cathartic because "people just say stuff that you feel exactly" (Interview 1, 52). The group allowed her to share her story in a safe space. Macy found a therapist deliberately to "practice" (Interview 1, 71) telling her story without breaking down and this became long term therapy that helped her accept her brother's suicide more.

Macy's story was very emotional in terms of how her brother's suicide had affected her life:

> What's been so horrific, well, it's just that anyone that loved can do that. It's – that there's a real life before and a life after. Because nothing stacks up anymore. That landscape that you could really trust in, has just sort of gone. You know, someone that loved. That loved and that gifted. Can sort of, do that. (Interview 1, 33)

Jack's suicide considerably affected Macy's subjectivity of self. In the following sections, I will argue that this may be due to the complexity and the painfulness of her experience and how she threw herself into work trying to deny the effect it had had on her whilst finding a way to cope with the pain in a manageable way. Macy continues to feel like "one big grief ball" (Interview 2, 67), which she copes with as best she can by having private therapy and continuing to lead a SOBS support group.

5.1.4.1 Researching Macy: Vulnerable

Macy and I are similar in terms of sex, age, social class, ethnicity and location. We also both lost our older brothers to suicide around the same time and we had similar family dynamics in childhood. We shared intersubjectivity around our brothers – both were part of our safe attachment in childhood, both were seen as the "golden boys" (Interview 1, 25) by our mothers and we both tried to support our brothers before their deaths. This appeared to offer a psychological holding space (Ogden, 2004) for Macy and enabled her to share her emotional story very openly at the first interview – so much so that Macy said after the interview she "sat in the bath and cried" (Interview 2, 5).

It took me some time to arrange the second interview with Macy. I tried to negotiate an appointment, but Macy was quiet in her responses and appeared resistant. I gently reminded Macy of her rights to withdraw but she quickly said she would be happy to carry on. Although I reconciled this with thoughts about her busy life and heavy workload, I also suspect the renewed commitment to carrying on may have been the defensive 'get on with it' narrative she continues to use to cope with the pain of her grief. It was hard to analyse and process Macy's story, shown in my journal: "I keep getting stuck on Macy's story – why is

it so hard to process?" (Journal, 10/6/21). I believe this shows how painful it is for Macy to continually integrate her brother's loss to suicide into her life. In the following sections, I explore this in Macy's story through the following themes: (a) painful series of unfortunate events, (b) 'get on with it', and (c) taking responsibility.

5.1.4.2 Macy's Themed Analysis

5.1.4.2.1 A Painful 'Series of Unfortunate Events'

Macy set the context for her story by saying that the period leading up to her brother's death "was this series of unfortunate events" (Interview 1, 2). When she said this, I felt a cold shiver through me as if we were about to watch a disturbing film. What followed was a "horrific" (Interview 1, 28) story that she told using emotional, dramatic speech; her story felt surreal to me at times, and appeared so for Macy in various places:

> But you don't really expect…somebody to do that…commit suicide. You know, that isn't in your own risk radar. Until it becomes an actual… an act that's in your family. (Interview 2, 115)

As if to combat the surreal nature of her story, Macy also kept some of her descriptions disarmingly simple. For example, when introducing her family's history with suicide, she said:

> My great-grandfather had committed suicide. And we had a really aged aunt that just put a bag over her head one day because she'd used all of her resources up. A really frighteningly clever one. (Interview 1, 16)

Macy said this very simply and matter-of-factly. It felt as though Macy was keeping the story simple due to the complexity of its legacy. I was alerted to this legacy when Macy said her family's suicides made her consider Jack "the sort of character that

probably could take his own life" (Interview 1, 16). With such a traumatic story, Macy has had to learn how to talk about Jack's death without the full weight of her grief overtaking her. She has learned to use coping mechanisms, such as humour, to help:

> That's something that people really laugh about at SOBS group. We have a…such laugh about that. And again they say they, they accuse me of a very dark humour. Erm…yeah. That's often, you know my sister's just died of cancer. So what? They didn't, she didn't shut herself [laughs] in a car with a hose. [laughs]. (Interview 2, 116)

This "dark humour" is something she uses within her group to share her story whilst remaining calm. Macy's language when talking about her brother's death was very revealing of her pain and the heaviness of her story. She used words such as "horror" (Interview 1, 4), and described the experience by saying "[it] feel[s] as if your heart has been put in a blender" (Interview 1, 27). The word "trauma" also came up repeatedly:

> I was bonkers, you know, absolutely bonkers and distraught in that first year definitely. Like completely off the Richter scale bonkers, you know, it's visceral, my trauma was just all over me. (Interview 2, 29)

Macy used the word "trauma" 17 times in the first interview and eight times in the second. She was also not afraid to swear when describing the effect Jack's death had on her and her family's life:

> So you know, it's that, him doing that has fucked our entire family really [laughs]. And I think that's, again, that's something that erm, we talk about in SOBS. It's like you've got your own grief and your own story, and your own relationship and your own response to that trauma and the way that is in your

> body. But then there's how you go about negotiating all those other people with complete raw trauma and their own response to it. (Interview 1, 36)

Macy's dramatic style of storytelling allowed Macy to project the effect his suicide had on her and her family members' lives and explains why she needed to develop a 'get on with it' narrative following his death. The data panel noticed that the word "fucked" felt angry and strong in terms of the effect it had on the family. One data panel participant, after listening to Macy's story said:

> How can therapy help? I mean there is such a huge journey. And if I look at her narrative, I mean, it has been 8 years. It's nothing really. It's as raw as anything…I mean the level of trauma, hurt and anger is so strong… still. (DP4: 49min50sec)

5.1.4.2.2 Get on with it

To consider Macy's pain from a psychosocial perspective, I needed to consider her subjectivity of self. Macy identifies with a gendered caring narrative of herself, as demonstrated in her comments about her relationships with people and her family:

> …inhabiting my Mum's pain has made it extra hard for me…actually her having a complete breakdown. It's sort of a relief because I don't have to spend the whole time worrying about her pain about Jack. Because I can't reach her anymore. (Interview 1, 45)

Macy's role within her family was the "joyful – emotionally intelligent one" (Interview 1, 44) so it was natural that Macy took responsibility for Jack's wellbeing before his death and felt she "could have saved him" (Interview 1, 37). When she could not do so, her subjectivity of self had been shattered and had to be rebuilt: "it has totally defined who I am" (Interview 1, 42). This familial role explains why she used such

strong words when describing the lead up to Jack's death – she had been unable to prevent her brother's death, which went against her own beliefs about herself and her family's beliefs about her

In her description of her behaviour in the year after Jack's death, she mentioned working like a "mad thing (Interview 1, 81)," but then would "cry all the way home" (Interview 1, 47). In "getting on with it," she put up strong defences to cope with the enormity of her loss but allowed herself to mourn when alone. These defences were also demonstrated in our relationship; the differences between the first and second interview were very telling from my journal after the second session:

> I feel more defences this time. Like a heavy need to protect her from speaking about it. She felt much more guarded. I feel it demonstrates her difficulty in talking about the subject. (Journal, 15/5/20)

In the first interview, Macy had felt contained enough to share her story emotionally with dramatic speech; in the second interview, however, she reflected on how much doing so had affected her. As mentioned in Macy's case study (Subsection 5.1.4), Macy described going home after the first interview and "ly[ing] in the bath and cr[ying]" (Interview 2, 4). This painful response to the first interview may have instigated mourning work with ferocity and led to a weakening of her defences, adopting a defensive position in the second interview as explained on pages 96 and 97. Macy reflected that she is in this painful place "much less often now" (Interview 2, 4) but I was left wondering how hard the second interview may have been for her.

Macy experienced an extremely traumatic event that shook her subjective experience of self. From a psychosocial perspective, she also had difficulty assimilating the effect Jack's wife had on his wellbeing. Macy felt angry and that there has been an injustice in how his wife had been implicated in Jack's death – as

if it could have been avoided and prevented if Jack's wife had not been involved. Macy explained that her family has had severe difficulties around his death, which contributed to a lack of containment in her social environment – especially because she felt she was the one who could have prevented Jack's death.

With Macy's social world providing little holding, she looked for other ways to contain the processing of her grief. In doing so, she started a SOBS support group (Bion, 1962). As Macy's investment in the 'get on with it' narrative disintegrated, she reached out for help. She started the SOBS groups because she wanted her own support, which instigated the wounded healer archetype (Farber, 2017a; Jung, 1951):

> Yeah I suppose the whole, trying to set up a SOBS group, erm, I think it was about like seven years in I thought, I can't go and stand by that grave and scream and cry anymore. I just can't do it. (Interview 1, 51)

I was alerted to the holding the group provided when Macy continually talked about the safety within the support group:

> That humour bit about SOBS is – that really is a significant thing – because we've all got it in common, we can make light and laugh about the most awful things ever. Knowing we've all had our hearts ripped out and we're totally traumatised but…so it's a safe space to…a few of them would say that's been the greatest thing about our SOBS group. Is that we say really raw, we model…it's really okay. (Interview 2, 117)

The SOBS group provided the holding she needed because it allowed her space to discuss her own feelings openly and honestly, however this did not appear enough to help her process her loss further, which did come from the counselling she had, once she had found the right counsellor who could hold her story:

> I went to a bit of counselling here and there. I did go to a therapist who was crap really. I had this coach who was pretty traumatised by what happened to me and then he died… And then when I, erm, ran SOBS I said to this therapist woman I want to book in by myself and I'm paying you to hear my story and if it takes longer than an hour then I'll pay for two cause I've got to practice my story. Cause I'm going to have to share it, erm, and she was a bit horrified. (Interview 1, 71).

This highlights how hard it was for Macy to share her brother's suicide with professionals. She concluded in her story that once she found the right therapist she "had quite a lot" (Interview 1, 37) which has helped Macy to "step away from it" (Interview 2, 10). Even so, throughout the interview she continued to sound heavily invested in Jack's story.

5.1.4.2.3 Taking Responsibility for Jack in the Suicide Construct

Macy spoke emphatically when describing the events before Jack's death and how she had tried to help him: "I'd get a desperate phone call" (Interview 1, 10) and "He had this horrific nerve pain. All the time." (Interview 1, 11). Macy appeared to be heavily invested in sharing Jack's story rather than her own when speaking like this, which indicates that she may have been trying to understand Jack and why he did what he did. This finding resonates with other participant narratives – she has had to invest in suicide itself in order to understand her brother better and integrate her experiences into her life story. This investment is also reminiscent of Sands' (2009) description of trying on of the person's shoes as a way of understanding.

It appeared that Macy was protecting Jack when she expressed strong words of anger towards her sister-in-law and her implication in her brother's suicide: "John disclosed to me that she'd said a few times "yes please, take your

own life, it'll make our life a whole lot better" (Interview 1, 18). Macy said she couldn't believe "[her sister-in-law] will get away with this" (Interview 2, 18). Which is indicative of the blame factor in suicide loss discussed in Section 3.2. Macy, however, could not be angry at her brother:

> That comes in and out of SOBS – anchoring where we all put anger in it all. And, erm, I absolutely refuse to, I don't know if I refuse, I just did not feel anger. I just felt nothing, I just wanted to protect him. You know that whole sort of stigma around suicide, and people's thoughts about him being a bad person and I, I sort of felt nothing but empathy and compassion and, er, remorse about some of the things I could have done, or should have done. But not angry with him. And I couldn't really bear anyone else to be angry with him. (Interview 1, 43)

I was struck by how this protectiveness felt like a defence and Macy herself was concerned that her relationship with anger is blocking her healing. Macy felt angry at her sister-in-law but could not do anything about it. Although Macy is trapped in her anger and unable to express it, it still reveals itself in her use of language. The complexity of a suicide loss – the anger, responsibility, shame, blame and responsibility – was mirrored in the projection I felt after our first interview:

> I have just left and have a big headache. I know I am tired as this interview is late. But I could feel the sadness and heaviness of her trauma on a visceral level. (Journal, 13/2/20)

The first interview, our shared relationship with suicide, and the holding provided by the research itself appeared to allow Macy to share her painful story as much as possible – so much so that she and I appeared to both feel the heaviness of her story. During analysis I found myself unsettled and unable to analyse

Macy's story easily. Macy's story seemed to flip between defensiveness and reflexivity during the story itself and during the interview process. Macy continually lost coherence in the story when she kept flipping between how Jack's wife had treated him in direct contrast to the "coach and carer" (Interview 1, 9) role Macy felt she had been "thrown into" (Interview 1, 9) whilst supporting him:

> "my parents thinking that I should have been the one to have stopped it (Interview 1, 38).

Macy felt she was expected to help Jack but no matter how hard she tried, she couldn't, leaving her conflicted in the interviews about whether she could have stopped him or not. Macy said "I certainly felt like I could have saved him" (Interview 1, 37), quickly saying "I do actually know that if I'd have been standing on the bridge with him, John would have just said "I'm sorry Luce" (Interview 1, 37). You know, and he would have done it anyway. I'm sure he would have" (Interview 1, 37). My feelings during analysis seemed to highlight the failure of the reality principle (Freud, 1911). Macy's conflicts appear to illuminate the defensive nature of the psyche moving between the paranoid-schizoid position and depressive position (Klein, 1946) – searching for a subjectivity of self she could live with amongst the expectations of others and societal influences. This may have affected me strongly in this research due to the projection that may have been occurring in our relationships, particularly as we are similar in many respects in terms of losing our much-loved brother's within the past ten years and being of similar age. Hence, I may have identified strongly with Macy and easily introjected her pain into my own experience, discussed in my own interpretative account in Section 5.2.

5.1.4.2.4 Conclusion of Macy's Analysis

As a defended subject, Macy was surrounded by the heavy, painful discourse of her brother's death. She got on with it, which defended against the anxiety of not being able to prevent Jack's death. This defence broke down after some years of chaotically going from grief to coping. After seeking help through her GP and a therapist, she was able to 'live out loud' with her story in a contained way through leading a support group, which was likely led by the drive of the wounded healer (Jung, 1954; Farber, 2017a). Macy's experience with the support group appeared to psychologically hold her and therapy helped her to integrate her experience into her subjectivity of self as best she could when faced with the enormity of her brother's suicide. However, Macy continues to invest in the dramatic narrative of her brother's suicide as if she wants those listening to her story to know how significant the loss has been to herself and her family. This desire, coupled with her gendered 'caring' self, likely drove her to take part in this research; the significance of returning to her memories was reflected in her reaction after the first interview and the hesitancy she experienced between interviews. Showing that no matter how much Macy tries to incorporate the anger and loss of her brother into her own life, she is unable to retroactively prevent the suicide itself and therefore settle on a self she can live with. Nonetheless, taking part in this research and leading the support group has enabled Macy to 'live out loud' by sharing her story with others, which helps Macy to painfully heal - illuminating the complexity of suicide loss and the integration of the experience with the subjectivity of self.

5.2 Reflexive Account

5.2.1 My Relationship to Suicide

My relationship with suicide and suicide bereavement has its own story. My early response to my own brother's death to suicide was one of anxiety and

campaigning to invest in the narrative of ‘hero’ to defend against my feelings, informed by the societal narrative, that suicide is a crime and a sin. Consistent with the history of suicide outlined in Section 2.1, the dominant societal discourse at the time conveyed to me that this incident was one of the unspeakable things that happen in society. I could not fit my brother’s suicide into my subjectivity of self as a counsellor and champion of mental health problems. This led to more anxiety, until I campaigned for mental health awareness by telling his story in local and national newspapers whilst raising money by running the London Marathon. When I used the words “he was my knight in shining armour,” I may have been investing in and constructing a hero discourse (McAdams, 1993) of him as a defensive function to make meaning of such a ‘forbidden’ act. In pushing myself on a physical and mental level, I legitimised my experiences of confusion and hopelessness. I defended myself on an unconscious level from my feelings about my compromised identity of being ‘a good girl’ whilst I merged the story I had constructed of him with one of my own – being a ‘hero’ running the marathon.

The significance of historically laden social effects and gendered dominant narratives on my psyche appears to be relevant. My psychological need to be a ‘hero’ and ‘good girl’ (by running a marathon) was my way of protecting an idea of myself as a ‘good’ woman. I believe my own powerlessness in the face of my brother’s mental state was framed historically first by my gendered narrative of being a ‘good girl’, second by social historical religious beliefs about suicide as an unspeakable act (Barbagli, 2015) and third by social policy, which suggests suicide is preventable. This research is the continuation of the story. The reflective journal I kept illustrated my healing through the containment that this research provided and

my drive to ‘live out loud’ because my wounds have been a burden too heavy to carry in silence. This research has given me permission to speak.

5.2.2 This Research as a Container

> Felt very poorly and drained for over a week. Jim’s story of his son’s hanging has stayed in my mind somewhat and I have felt connected to memories of [my brother’s] death more. (Journal, 7/3/20)

This extract from my journal reminded me of the collective wounded healer archetype as discussed earlier in Section 1.10. This driving force to help others (Jung, 1951), that is triggered when traumatic wounds are a burden is relevant to my sense of completing the London Marathon, and this research – like an unconscious internal drive to make purpose out of the burden of processing my suicide loss.

As I attempted to use this research to provide a platform for others who had lost someone through suicide, I recognised that I was investing in the narrative of being a ‘survivor’ of suicide loss and ‘living out loud’ by sharing my story and healing others, which is common behaviour for suicide-loss survivors as section 3.4 and this analysis shows. ‘Living out loud’ has been painful and has personally affected me throughout the research process, especially in respect to my academic writing:

> I often wonder why I had chosen this as my research topic. It feels so hard putting academic words to such a personal thing. (Journal, 8/11/20)

These feelings continued whilst I heard and transcribed the interviews. My thoughts often focussed on stories I had heard, and I experienced regular headaches. I took a long break after transcribing the data and my journal became quiet for a few months while I gave myself space to come away from the research completely. I stumbled throughout the process with my academic writing, which was unusual for me; it would appear to hold some function of anxiety and possible introjection of projections

from participants. My struggles also demonstrated my position as a defended subject and ability to consider the Gestalt during this research. My thoughts fragmented as I found it hard to mentally contain my emotional experience. As discussed in Subsection 1.12.2, according to Bion, when a mind is bombarded by significant sensory experiences during trauma, there is a detrimental effect on thinking (Szykierski, 2017). It was unclear to me whether my struggle was a result of projection, my own trauma, or both. When analysing the cases, I found some easier to write than others. Overall, the effect it had on me would depend on how significant other participants' projection was in conjunction with my own trauma. For example, when analysing Jim and Chris's story, I felt very contained and found it easy to analyse, whereas with Macy I felt more unsettled by her story and found it very difficult to analyse, which may have been because of our similarities in terms of our age and having lost our brother within the same time span.

Nevertheless, when listening to the stories for the fourth time, I could cope better: I could listen without physical reaction. This demonstrates containment and making sense within the healing element of hearing other's suicide stories as suggested by the tripartite model of suicide bereavement (TMSB) (Sands, 2009), whereby transformative grief processes are led by emotional engagement with others. Although these stories were hard to hear, the process of projection and my capacity to contain appeared to have a healing element: I have integrated suicide into my life story further and succeeded in some personal growth.

My own defences were evident throughout the research, which meant that the data panel procedure was helpful in highlighting defences I could not recognise. During the data panel, I noticed that I was attempting to protect the rest of the group

from the difficult parts of the participants' stories and the data panel confirmed these defences were evident.

> DP, Sue: I apologise, it's New Year and you are going to be listening to stuff… I didn't sort of, I didn't pick out highlights of when they actually found bodies or when you know the real traumatic parts, I thought that feels like if I just highlighted that… why am I avoiding these bits maybe to protect you guys?... I'm sorry if there is anything upsetting in any of it really, I want to say that first of all [laughs]…mmm….but it's not the really heavy stuff because I have deliberately stayed away that stuff… mmm but it's not exactly enjoyable listening to other's experiences of losing someone to suicide. (DP, 2.05)

In retrospect, it was clear that I was trying to take responsibility for the panel members and their feelings when choosing which parts of the transcripts I gave. I also apologised at the beginning of the data panel for telling them stories that might upset them. I wanted to prepare and protect them and take responsibility for the stories I was about to share, which the data panel confirmed in comparison to Jim's story:

> DP2: what he was saying was that at the beginning he tried to start working with a therapist but he felt he was trying to protect the therapist from his feelings because it was too overwhelming, or he thought this could be too overwhelming for the therapist so he needed to protect the therapist. And that's what Sue did to us. She started the panel by saying you know, I am protecting you from bad pieces, or the really rough pieces. (DP, 33.38)

Taking responsibility for others when sharing our story is related to the issues of stigma and shame, as discussed in Section 3.2 (Barrett, 2013). My example here,

however, highlights that this may also entail taking responsibility for suicide as a topic as well as the suicide of our loved ones.

We can look further at the data panel discussion to see evidence of why I took so much responsibility for those who did not share insider status. As discussed further in the interpretative account in Subsection 5.3.4, the data panel had difficulty in thinking and had uncomfortable somatic responses to hearing the stories. They were relating to the stories as if they were their own. One data panel participant wore a warm hat and sat under a heated blanket before we met in order to be ready "to be hit" (DP4, 3.46). This made me consider whether their capacity to create a holding space was weak, because the stories were relatable to their own fears of death and suicide and their concern as to how it may affect them. The fact that I prepared them for the data panel by apologising indicates that I put their wellbeing before my own. From a psychosocial perspective, my underlying need to be a 'good girl' and care for them may have driven this, but alongside the silent and heavy discourses of suicide, I found it hard to be held by others who did not have an insider perspective. During my analysis, it became clear to me that this was because I felt responsible for the suicide construct (as discussed later due to the internalisation of the historical prevention discourses of suicide and feeling as if I have done something wrong) and therefore responsible for projecting it into people who would fear it happening to them. When I spoke to the participants before and at the actual interviews, however, I felt as held as much as possible with such a difficult subject. Together, we provided a holding space between us that allowed them to express themselves without taking responsibility for my story. Suicide was a topic we shared responsibility for and therefore was not theirs nor mine to own alone. I will explore this further within the context of the relationships we formed and the full interpretative account.

5.2.3 Conclusion

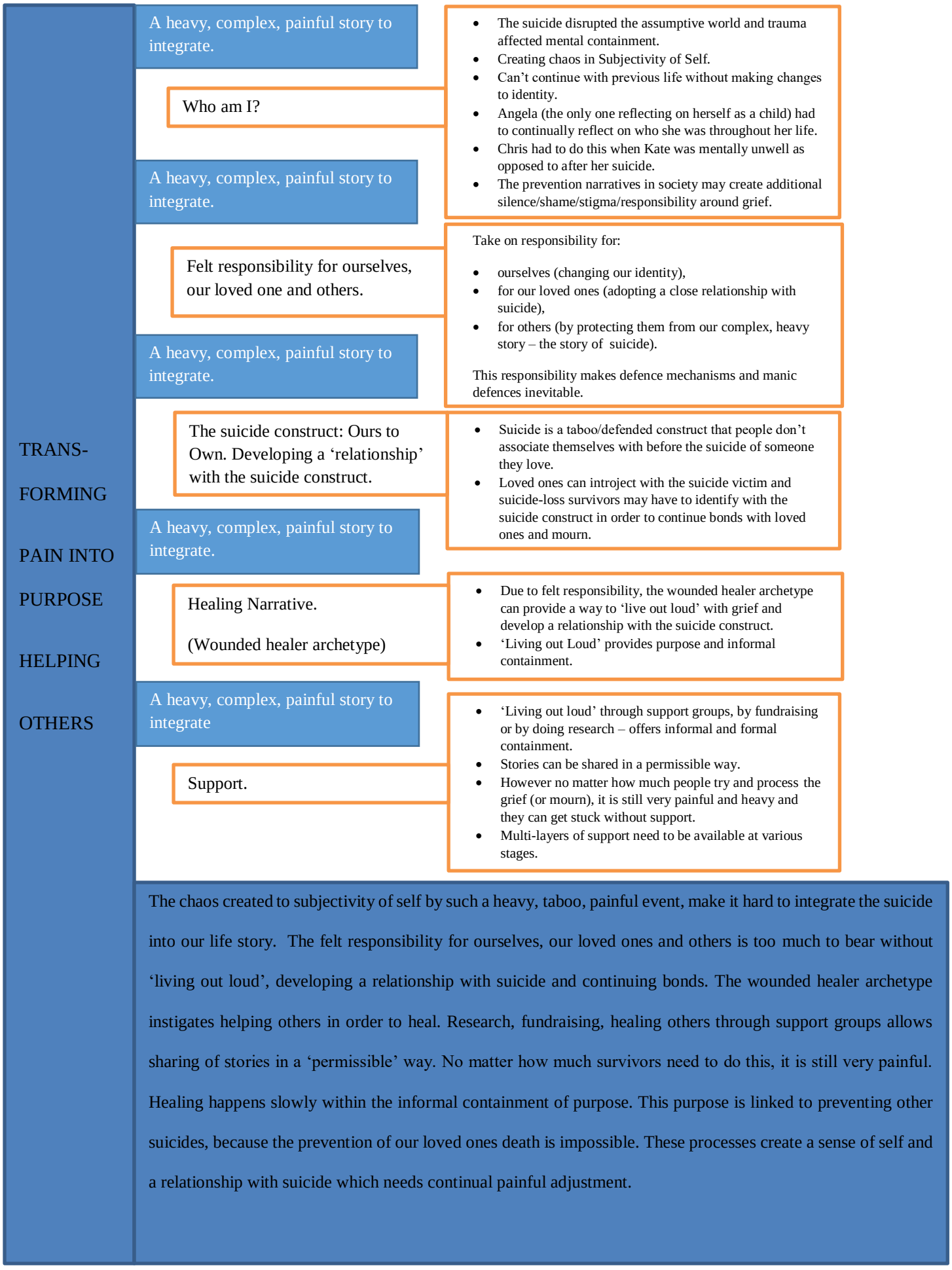
Bion (1962) believed that learning from experience is crucial for mental survival. I propose that the trauma from my brother's suicide ruptured my mental containment and, to mentally survive the bombardment of horrific sensory experiences related to memories of my brother's death, I sought containment by acquiring knowledge through my research. Accordingly, this research enabled me to integrate my experience into my life story. Although I have been driven by the wounded healer archetype (Jung, 1954) to heal others from my own suffering, I have still had my own strong emotions, confirming Jung's views as discussed in Section 1.11. For example, as I conducted the research, I have been triggered by my own suffering and been fragmented in thought, which required significant reflection and containment to allow my own grief to be present. It would seem no matter how much I heal from my learning, I still try to protect other people from my process of 'living out loud', perhaps because I feel so invested in prevention and as a result, I feel responsible for the complex, intense stories that suicide brings.

5.3 Interpretative Themed Analysis across the Gestalt

There are constructs and narratives within society that surround mental health, suicide and suicide bereavement. This themed analysis focusses on the Gestalt of the data set – my reflexivity, the data panel discussion, and the four stories from the participants – to explore what may have motivated participants' investment in various narratives while sharing their story with a fellow suicide-loss survivor. In this interpretative analysis I found one overarching theme, transforming pain into purpose, and three subthemes: (a) who am I? (b) the suicide construct – ours to own, (c) the healer narrative, holding and containment. These themes are

demonstrated in the following diagram and will be explored in the remainder of this part of the thesis.

5.3.1 Diagram of Themes



5.3.2 Who am I?

One integral theme across the cohort was that suicide loss shook the survivor's assumptive worlds, which created chaos in their coherence of self (Neimeyer et al., 2006) and highlighted the cognitive destabilisation of violent loss (Clark & Goldney, 2000). This was evident in the difficulty participants had when trying to tell a coherent story: Angela's pauses, Chris's 'mini stories', Macy's heavy language and Jim's use of metaphors. Alongside my reflexive account of difficulty writing academically, this overall struggle with narrative coherence suggests that the trauma from the suicide loss can impact a person's thinking when processing their experience (Szykierski, 2017).

In considering this further, I found that participants' identities were interwoven with their loved one and the suicide act, and after the suicide loss they had to rebuild their subjectivity of self – in other words, "who am I?" (Chris, Interview 2, 72). Jim described how much his son's suicide had affected his identity in terms of personal growth:

> I just feel that my life changed. Erm and it's been a better life. A less selfish life. I'm not congratulating myself. I'm just saying it went like that. It went in a direction. And I owe that to Sam's death. (Jim, Interview 2, 11)

Similarly, in Macy's case, her caring-self broke down when she realised that she had not been able to prevent Jack's death. She worked like a "mad thing" (Macy, Interview 1, 81) until that too fell apart and left her struggling to find a way to reconcile her identity with her brother's suicide, which ultimately led to seeing a therapist to practice telling her story in a support group. The dramatic, heavy language she used in her story made me and the data panel feel hopeless and that, because her brother's suicide is hard to live with, her investment in the suicide

construct is still very painful and needs to be projected out. Across the sample, the death of loved ones had become a part of who they were; in the context of mourning, it is evident how much painful effort it takes to integrate a suicide loss into a person's own subjectivity of self and maintain a healthy psyche.

From a psychosocial perspective, suicide-loss survivors try to rebuild their assumptive world and subjectivity of self through the reality principle in the face of prevention constructs which surround suicide and mental health and the ensuing silence, stigma and self-blame, shame, and rejection (Scocco et al., 2017). All participants, except Chris, went through a period of denial through work and supporting others. They all defended their anxiety about not being able to prevent their loved one's death with defensive 'get on with it' behaviour to cope: Macy and Jim with work and Angela with her swimming and sailing challenges. It was only Chris who appeared to grieve immediately after his wife's funeral; however, he had time to accept he couldn't prevent his wife's illness prior to his wife's death throughout her mental health illness and attempts at suicide. Chris knew that he had to be the one to "stay on a very level and even keel to – balance out the pitch of Kate's moods" (Chris, Interview 1, 17), which illustrates how Chris reshaped his identity whilst she was ill – he couldn't help Kate no matter how hard he tried, which resulted in him numbing his feelings. It wasn't until she passed away that he was able to rebuild an identity he could connect with and become aware of positive feelings, such as being "proud" (Chris, Interview 1, 72).

Denial may be defensive positions we invest in when faced with a loved one with mental health issues or who has died by suicide. Denial can be present in all types of grief (Kübler-Ross & Kessler, 2014) as it can help a person temporarily withstand the pain of loss (Szykierski, 2017). Thus the cases analysed here show

that the ego (or sense of self) became damaged and in order not to enter intolerable conflict with another part of the ego, certain functions were split off and defensive 'get on with it' behaviour took over. In the cases here, however, we can see that the avoidant behaviour could not be maintained because suicide could not be ignored and had to become part of who they are (Lukas & Seiden, 2007), as Angela noted:

> [Suicide is] such an integral part of my story. That, yeah, like it's kind of, it really is who I am – I am, in so many ways – not a by-product of it but like, how I am so shaped by, not just the experience of suicide itself but then all the things that have come after. (Angela, Interview 2, 109)

Angela strongly invested in the suicide narrative to understand her father better and make meaning of his suicide. By doing so, she was able to recognise that thinking her dad chose to leave her was an unhelpful belief and led to a lack of self-worth. Once she challenged this belief and recognised that she was a 'being' and not a 'doing' she could stop being the defensive resilient self she had been since her dad's death.

The participants had to reconstruct their assumptive worlds and subjectivity of self after they lost their loved one to suicide. They became protective in defence of their identities when they accepted that they could not have retroactively prevented their loved ones' deaths. The cognitive destabilisation they experienced when attempting to integrate the traumatic loss required existential reconstruction (Owens et. al., 2008), a process that involved developing a relationship with the suicide construct itself in order to survive.

5.3.3 The Suicide Construct: Ours to Own

As discussed, death has historically been a subject of denial (Kellehear, 1984). Grief literature shows that by developing a relationship with death, people can

come to terms with existential beliefs and, as such, grieve for others (Arnason & Hafsteinsson, 2003). Suicide is a taboo subject (Chapple et al., 2015) and therefore a psychologically defended construct. The prevention construct runs throughout the history of suicide because it was (and in some cases, is) considered a crime or a medical problem which needs to be treated (Hjelmeland, 2016). Many people will not have a relationship with suicide until they face it in their lives. This analysis illustrates how those who lose a loved one to suicide, through the mourning and defensive process of identification, may develop a relationship with suicide, which demands a meaning-making process to integrate the event into their life story (Sands et al., 2014). All four participants had a meaning-making narrative in their stories, which I commented on in my journal during analysis:

> All of the stories spent over half the time of the first interview explaining why their loved one had done what they had done – they barely spoke about how they managed the bereavement. (Journal, 20/12/20)

Initially, the participants' stories were dominated by an explanation of why their loved ones had taken their own lives. I had asked them what their experience had been losing a loved one to suicide, but they answered as if they were describing their loved one's suicide. This impulse indicates a kind of ownership:

> I feel like my dad's suicide is kind of mine, to own in a way. (Angela, Interview 2, 122).

Donna Barnes highlighted in her conference talk outlined in Section 3.4 that she felt her son who suicided became identified by the suicidal act. Angela also attempted to understand her father by investigating suicide grief whilst "doggedly" (Interview 1, 65) enforcing her defensive narrative that suicide is a choice for some. She seemed to feel a responsibility for defending her dad and adopting the suicide construct as her

own. In terms of the continuing bonds theory of grief (Klass, Silverman & Nickman, 1996), whereby we continue bonds with the deceased wherever possible (e.g., visiting their burial site or talking to a picture of them), I suggest that Angela had to invest and identify herself with the suicide construct to continue the bond with her father.

Jim also invested in the suicide construct in his search for meaning by working out his son's death. Overall, the participants had to get to know suicide. Chris felt that he "lost" (Chris, Interview 1, 84) Kate to mental health illness and had to rebuild a life with her illness centre stage. Jim and Macy both invested in the suicide construct by leading SOBS groups and Jim also completed counselling training to support other suicide loss survivors. Like myself with this research, all had to find significant ways to develop a relationship with the forbidden topic of suicide.

As discussed in Section 1.9, identification is an integral component of grieving, which after suicide loss is clearly complicated. For example, Angela's story illustrates how she both loved her father and felt he had been disruptive in the family home. Losing him at such a young age without emotional support to mourn, she defensively identified with him by doing activities he enjoyed (e.g. sailing) and was unable to mourn until she recognised this melancholia and went on a long meditation retreat in order to make sense of who she was.

Klein suggested one form of manic defence was to control and obliterate any awareness of separateness, denying it has a life of its own (Klein, 1940) - that is, you have all the capabilities of the lost object so there is no need to deny it exists within your sense of self. This would explain the adoption of the suicide narrative and the development of a strong relationship with suicide - weakening

the ego through the love/hate relationship with the internalised object so self-recrimination and self-hate ensued, adding to the felt responsibility, guilt and shame felt. Chris's anticipatory grief highlights this process well. Chris appeared to mourn after his wife's suicide because he had spent a long time in the melancholic position during the difficulties with her mental health. Because he did not have to introject 'suicide' into his identity once she had physically gone, he was able to slowly let-go of his wife without the pressure of suicide being something he had to continue to live with – he had done that whilst she was alive: "She wasn't the person, you know, that she used to be by a long way" (Interview 1, 39). "I couldn't see a way for her to get back to, I won't say normal but to usual, to, to the way she was" (Interview 2, 80).

This analysis has highlighted regular fluctuations between reflexivity, rational thinking, manic defences and defence mechanisms and in order to heal from the experience of suicide. As in my own story, we had to use safe ways to mourn and feel our grief whilst separating the act of suicide from our sense of self – but only when we had mental containment or some other way to be held or contained in order to do so.

5.3.4 The Healer Narrative, Holding and Containment

Peters et al. (2016) found that suicide-loss survivors can feel other people's discomfort when sharing their story. These findings indicate an even deeper level of taking responsibility for others: Angela's reaction to the people around her as a teen, Macy in her dramatic speech, Chris in how Kate's illness affected the whole family, and in my own presentation of the extracts to the data panels. In Jim's case, he felt he had to "protect" (Interview 1, 44) the bereavement counsellor and, when unable to find a specific suicide support group, set one up himself:

> There is no point in having someone supporting you or counselling you if you feel you've got to protect them from how you're feeling. (Jim, Interview 1, 44)

The experiences of the data panel may highlight another reason why we take on this responsibility. As discussed throughout this interpretative account, humans tend to have some form of death anxiety, which is significantly heightened with a suicide death, which may impact others. The data panel's reactions helped to identify why this may be so:

> DP1: [sigh] Got really impacted by that one.
>
> DP2: Yeah, I just feel really sad for the mum. I was just like, she's really kind of, lost it hasn't she – she is lost in the world now isn't she. And similar age to me again – not that I'm 60 but…you know. Horrible.
>
> DP1: Yeah. I really feel quite, so, very impacted by that one. It's hard to think actually.
>
> DP2: Yeah. Totally. (DP, 48.06)

Data panel member 2 felt she could relate to the feelings of being a mother who has lost a son to suicide. This was found at other times in the data panel: relatability of, and identification with the experiences was high. The hearing of stories also had a significant impact on the data panels thought processes:

> DP4: It's really heavy. I found it really… I struggled to read it. Part of my brain refused to engage with it. (DP: 49.36)

In many examples, the data panel members became confused:

> DP1: When she started talking about her mother, I got really confused at that point. I got confused about what was going on…mmm…who are we talking about…who's died? (DP: 51.02).

And another example of confusion after a different extract was read:

DP2: Can I just ask do we know how that person died? That Sam.

Me: It's all, everyone is through suicide.

DP2: Sorry. I just got really side-tracked then and forgot all that and thought he had been in a car accident… (DP: 1.32.48)

Confusion and thought fragmentation happened often within the data panel, which confirms that just hearing the heavy stories of suicide affects the mental containment of the experience (Bion, 1962) and highlights the traumatic experience of suicide loss. The data panel were not only affected through thought but somatically too:

DP1: I know it is cold today, But I'm feeling very cold. (DP: 1.16.17)

These extracts illustrate the response people have to suicide stories and why the heaviness of the topic can leave suicide-loss survivors feeling the burden of responsibility: reluctant to share their stories without the support they need. Particularly bearing in mind my offering of psychological holding to the data panel before the stories were shared, as discussed in my own reflective account in section 5.1.

All participants expressed how important sharing stories is. First, Jim found that his support group and counselling training had given him a safe space to hear other people's stories and compare them to his own. Macy found it helpful to share her story within her support group and, Angela demonstrated a slow sharing of her dad's suicide in the fundraising and research she has done and concluded that "just by having conversations with people like you, and others that I meet along the way. Is kind of helping the whole process along" (Angela, Interview 2, 140). According to these findings, sharing our stories is vital and when sharing with others who are insiders to suicide loss, we are held enough to do so. Because we all identify with, and share the heaviness of the suicide construct, we do not have to take as much

responsibility for other people's emotions when being contained by other suicide loss survivors. However we must be aware of the need for mourning work and if the person is unable to mourn due to the suicidal act making this hard, they may use unconscious defensive mechanisms to cope. Therefore support groups may involve many forms of projection, identification, splitting and introjection that must be well thought through and contained effectively.

The wounded healer archetype (Jung, 1954) and healing narrative was present in three of the stories as well as my own reflexive account. Macy, Jim, and Angela found a way to be around others who have experienced suicide, which made it easier to share and heal from their stories. Chris's story did not contain the wounded healer (Jung, 1954) element, possibly because of anticipatory grief, which helped him to come to terms with losing Kate before her suicide.

As discussed in Section 1.11, the wounded healer archetype defensively impels some to help others because of their own immense pain. But when they do so, the identity of healer and wounded may split and the powerful healer may be identified within. In order to integrate the wounded and the healer, they must process their own pain whilst they support others, or their own pain and identity as wounded will be repressed and the other person may become the patient, needing fixing. This suggests that the capacity to hold the heavy pain of existential qualities of suicide grief can be obtained when the healer is reflective of their narrative constructions of suicide and grief. This was confirmed by Jim's account of personal growth as he integrated counselling training whilst working with support groups and my own account of healing during this research. Overall, this research has shown that my transparency within the research relationship gave me and my participants the capacity to hold space for each other, and some of us gained some personal growth

in the process. The wounded healer journey for suicide-loss survivors does not come without pain because we can be constantly activated by the anxiety we are defending against (Farber, 2017a). This triggering process appears to also be a part of the healing process and allows survivors to integrate discrepancies of the experience in their own sense of self without projecting it outward or repressing it. These findings suggest that the wounded healer is a defensive position someone may adopt in order to work through melancholy. Due to the lack of appropriate support and feeling the burden of suicide within our identities, all but Chris were impelled to support others who had lost to suicide. The position of healer gave us permission to 'live out loud' and mourn – it gave us permission to feel our grief and be held by others whilst we processed it.

These findings highlight the difference between informal and formal holding and containment. Formal includes the bereavement counselling Jim received and the support groups all participants have been involved in. Informal includes this research, our relationship with other suicide loss survivors, and sharing our story with others. Although all types of holding and containment are important with such a significant loss, formal may be more acknowledged by professionals than informal.

There was a stark difference between Jim's story and the rest of the cohort – as if the holding he had from his wife, who wasn't the mother of his son, allowed Jim to explore his feelings and use it for personal transformation (Dransart, 2017). Contrastingly, in the others' stories, social holding and containment was not readily available: Macy was faced with conflict within her family, Angela was faced with silence, and Chris had to create his own mental containment through anticipatory grief. I noted Jim's mental containment in my journal:

> Jim's story has been much easier to analyse. I felt he was much less defensive and positive about his own growth. (Journal, 25/1/21)

The period that had passed since Jim's loss was greater than that in the case of the other participant's losses. It may be the containment Jim received in addition to time is what he needed to integrate a suicide loss with his life story.

Both Angela's and my own stories show how vulnerable we feel facing our research and how it constantly triggers memories which lead to struggling with our academic work. Although this "mission" (Angela, Interview 2, 140) is an internal drive that has to happen to heal ourselves, it remains very complex and painful. This vulnerability was also shown in Macy's story: Although it was helpful to share her story and she adopted a storytelling narrative to cope, it was still very traumatic for her to share and she appeared conflicted throughout the process. Although the capacity to contain offers a place to feel our emotions, it remains a hard, painful task to integrate the trauma of a suicide loss with our thinking. This demonstrates continual moments of cognitive destabilisation (Clark & Goldney, 2000) and regular switching between the depressive position (feeling the reality of our grief) and the paranoid-schizoid positions (splitting good and bad parts of the grief – avoiding, denying and repressing elements of the grief) (Klein, 1946) when trying to process our loss and integrate the experience with our subjectivity of self.

5.3.5 Concluding Theme: Transforming Pain into Purpose

There is a transformative/reconstruction element to trauma (Frank, 2013) and suicide loss (Sands, 2009), which this study has confirmed. The act of suicide shook the survivors' assumptive worlds and their perceptions of their loved ones and themselves. They had not identified with suicide until it happened to them. In each story, the suicide-loss survivor had to integrate the suicide into their life story and

their subjective sense of self. This includes my own journey after my brother's suicide. As we looked outward to society, we were met with the prevention narrative of mental health and suicide and adopted strong 'get on with it,' coping behaviours within the paranoid-schizoid position (Klein, 1946) that left us unable to effectively grieve. When the weight of responsibility broke down these behaviours, we had to do something to integrate the loss with our views of self and mourn our loved ones whilst in the long-term process of mourning and melancholia - fluctuating between the depressive position, the paranoid-schizoid position and manic defences. The stories showed that one way to do this was to understand suicide via a process of identification and helping others. This research suggests that purpose and the wounded healer archetype is a defence we may use to defend against the pain of suicide loss. Due to the felt responsibility of sharing the 'forbidden' suicide prevention construct with our loved ones and the effect it has on others, participants were unable to mourn quickly or easily. By starting support groups, fundraising or doing research, we have been given permission to share our story (live out loud) and feel our pain, hence while these have offered us holding and containment they have also been driven by our defensive selves – inevitable when losing someone to suicide, which is perceived to be forbidden and preventable in society.

Having a purpose after suicide loss offers a way to 'live out loud' and helped the participants to 'survive' and reconstruct their loss within their own psyche and assumptive worlds (Feigelman et al., 2009). For example, Chris honours his wife's mental health problems and her suicide by managing his own mental health:

> I respected her for it really. And, and, and I really felt that one of the reasons for her doing it was to free myself and the children and the extended family, mum, sisters, you know. So I felt well if she's done that and she's done that,

> you know, to ease her own pain but also to, to, to relieve us of her suffering as well. Then the only true way to, to make value of that is, is, you know, to honour her life and to be positive about her life and about her leaving and, and, to live my own. (Chris, Interview 2, 81)

Similarly, Jim feels his purpose (Jim, Interview 2, 92) has come from becoming a better person.

> It's been a massively constructive thing for me. I don't mean I'm glad he died, for god's sake but I do think my life is better because he died…I'm more satisfied with who I am. (Jim, Interview 1, 54)

Jim reconstructed his own identity to one with more purpose. From a psychosocial perspective, this is likely to be because of his business-like personality and the holding he received from his wife that allowed him to mourn, make meaning of his son's death reflectively within a supportive group environment and his counselling training. It also highlights the wounded healer archetype (Jung, 1954) and how pain became an inner drive to help others. However, helping for over ten years in support groups and bereavement counselling wasn't enough for it to become processed fully. This confirms the wounded healer archetype (Jung, 1954) in as much as Jim needed to process his own grief whilst he supported others, and this study's interview process helped with that due to the containment it provided for reflexivity, indicating a long-term process of mourning and melancholia. It is no surprise then that the term suicide-loss survivor, has arisen in line with the construct of something having such a large impact on our lives which we had to 'survive'.

My relationships with the participants demonstrated how shared experience can offer us informal holding and containment in order to heal. Moving from pain to purpose is a helpful way to assimilate suicide into our life story, but the process is

vulnerable and requires containment to be able to reflect on our own feelings and mourn. Informal holding and containment comes in various forms (such as others who have experienced suicide loss, research and fundraising) and in order to allow people to mourn more easily in the future we must change the stigmatised nature of suicide and the dominance of the prevention narrative. This will require significant changes in medical discourse – changes that counselling psychologists can support.

Part 6: Discussion

This study has provided insight into why some people invested internally in the narratives of healing/purpose and 'live out loud' to process the loss of a loved one to suicide. This discussion highlights how defensive narratives indicate how a felt responsibility can come from the prevention narrative around suicide itself and these impact the need to adopt constructs of suicide itself, the wounded healer and PTG, and is broken down into six parts. First, I discuss the relevance of psychodynamic and psychosocial principles within counselling psychologists' research practice. Second, I discuss how psychologists can address the constructions of suicide bereavement as they consider the best interventions and capacity to support those left behind - in particular, by separating suicide prevention support from suicide bereavement support. Third, I discuss the importance of psychologists considering the complex psychological dynamics which may be present in the therapeutic relationship and the effect it has on therapeutic interventions and their own wellbeing – both through practitioners' defensive narratives and the projection they may feel. Fourth, I discuss limitations of this research. Fifth, I discuss clinical implications, and finally I provide suggestions for future research.

6.1 Relevance of Research

Critical realism and psychosocial principles (Hollway & Jefferson, 2013) offer counselling psychologists, as researchers in the field of counselling and psychotherapy, a perspective relevant to our scientific reflective practice (Woolfe, 2016). In this research I applied psychosocial and psychodynamic principles to develop a deep understanding of how social constructs and personal biographies interact under the surface of a first-hand account described by a defended subject.

When integrating these principles with a sound research practice, I argue that reflexivity offers a suitable method of inquiry for counselling psychology professionals due to their experience of working within the complexity of the collaborative therapeutic relationship and the inevitable subjective experience of clients and self. Specifically, they have a relationship of 'being with' clients rather than 'doing to' (Strawbridge & Woolfe, 2010, p. 11) in which therapy becomes a process of "mutual discovery" (p. 12) between therapist and client.

This research was made possible using an adaptation of FANI, which regards the research relationship as central to data collection and analysis. Without conflating the values of the therapeutic and research relationship, by adapting concepts from the FANI methodology, I have been able to see the hidden nuances beneath the surface (Hollway & Jefferson, 2000, 2013) that are often unavailable in research that assumes there is a transparent subject who is able to share their full experience. For example, previous research has shown that there is a felt responsibility for suicide loss. In this research, I have accounted for this responsibility in terms of the identification of, and investment with, the heavy and complex suicide construct of prevention and the effect it had on processing grief. This deep level of analysis allows us to assess how counselling psychologists can challenge these constructs through our social justice practice (Onyett, 2007). Ultimately, allowing counselling psychologists to pursue a wider social justice agenda position, which can function as a potential bridge between critical approaches and applied psychology.

The FANI method also allows practitioners to consider how these social constructs and our own defences may impact therapeutic outcomes and indicates how we may formulate appropriate therapeutic support. If counselling psychologists can foster a critical psychosocial stance, the social justice agenda of the discipline

will be met more consistently, and we can create a more coherent and consistent professional identity.

6.2 Counselling Psychologists' Social Agenda Positioning and the Suicide Prevention Construct

These findings suggest that mental health and suicide constructs affect how someone experiences suicide loss and their subjective sense of self. Psychology is productive: it regulates, classifies, and administers (Parker et al., 1995). For example, NHS suicide bereavement support is embedded within suicidology and suicide prevention discourse, which this research concludes adds to the significant amount of responsibility, guilt and shame felt by those bereaved. As counselling psychologists, we are responsible for recognising these feelings and deconstructing them where possible to facilitate the most appropriate support.

Some charities still integrate suicide prevention with suicide grief (e.g., Sunflowers Suicide Support, n.d.). Although this is inevitable and explainable by the funding available for suicide prevention that is unavailable for suicide grief, I would argue that this research demonstrates that, when providing support, we need be aware of the discourse and the reification of the term suicide-loss survivor and separate it from the suicide prevention narratives where possible. Doing so would indicate to the bereaved that their suicide grief is important enough to provide unique support whilst avoiding the prevention and pathologising suicidology discourse, especially when funding for services arising from the suicide preventative 'zero' suicide aim of the public health care system.

McDonnell et al.'s (2020a) study confirmed that support needs to be available long term and these findings explained why this is necessary. Suicide loss affects people throughout their life due to the shift in their assumptive world and their

integration of suicide into their subjectivity of self. Jim's story highlights this – he continues to live and learn about suicide 14 years after his son's suicide. In the UK, long-term support is recognised by services such as Amparo, who state they provide support "Free and confidential, for as long as you need it" (Amparo, n.d. para. 1). Additionally, Public Health England's practical resource on providing local services (Public Health England, 2016), highlights the Mayo Suicide Liaison Service (part of Western Health and Social Care in Northern Ireland) as good practice. The service offers proactive support: The police notify them of a suspected suicide and within 48 hours they contact the next of kin and offer a home visit. At the home visit, everyone who has been affected can attend, which provides a place to talk about suicide and reduce the stigma whilst offering suitable services. Additionally, they have an open referral system where anyone who has been affected can refer themselves at any point. This research gives examples of why the Mayo Service includes aspects that are vital parts of an effective service specifically for suicide-loss survivors – timely, proactive, long-term and available to anyone has been affected.

Counselling psychologists are well placed to advocate for a separate provision of support services for suicide bereavement. Although the value and relevance of the need for separate provision is becoming acknowledged, it conflicts to some extent with what is normal practice in NHS services, which largely ignores contextual factors by predominantly working within the medical model and emphasising the diagnosis of illness, disease, and pathology. The impact this may have on those bereaved "takes careful manoeuvring to navigate" (Walsh et al., 2004, p. 326). Counselling psychologists have the skills required to negotiate with others' world views (Walsh et al., 2004) and are well equipped to find ways to shape services by creating specific suicide bereavement support using relevant research.

Counselling psychologists must deconstruct the historical medicalisation of suicide and suicide bereavement and consider how someone bereaved by suicide may feel when attempting to find support. The discourses around suicide and suicide prevention will impact clients before they enter the therapy room. It is therefore a practitioners' responsibility to be aware of this and have the capacity required to contain the heavy feelings of those bereaved by suicide and provide effective supervision for those who support them. For example, in first point of contact literature, we must have empathy towards their unique, heavy, and complex grief journey. However, we need to do this without medicalising suicide-loss survivors as if they are a problem which need to be fixed. Therefore, an empathic supportive environment without medical terminology can be helpful; using the language around the healing journey they are on.

6.3 Providing Support

McDonnell et al.'s (2020a) large UK study clarified that there needs to be tailored, proactive, targeted, long-term support to meet everyone's needs using well-connected services. The findings in this study have highlighted the complexity of suicide grief and suggested that support can come from varying sources due to the various de-stabilising defences following a suicide loss.

6.3.1 The Mourning Process and Suicide Grief

Freud's later theories (Freud, 1923) of long-term mourning with aspects of melancholia are confirmed by this research. However, it is clear when adopting the suicide grief construct within our identity, long term mourning will be painful and, amongst the discourse of suicide prevention we may need to use narratives of healing and the defensive wounded healer position in order to 'live out loud', make-meaning and heal. We could see in Part 1 that many people who suffer a suicide

loss move forward by helping others. This research highlights why this is so in terms of how people are able to mourn the loss of their loved one and re-adjust their subjectivity of self, carrying the heavy object of suicide within.

As discussed, in object-relation terms, for mourning to take place the person needs to be externalised, however this takes place in the depressive position where the main characteristic is guilt. That is that the pain and recognition that the loved one is lost from the internal object of self is recognised and any guilt of the externalisation of the loved one is accepted. The crucial aspect of mourning is that the loved person is loved and 'hated' but this can be avoided within paranoid-schizoid position through unconscious defence mechanisms (such as projection and identification) and within the depressive position (Klein, 1946) by denying any guilt or dependence is felt and importance of the loved one is denied. As identified in previous research, guilt and responsibility are main findings within suicide grief (Scocco et al., 2017) which makes it likely that mourning will be significantly affected.

The analysis shows that there are characteristics within each story of manic defences and strong defence mechanisms at play. This research does not address full psychological formulations of each case, so it isn't possible to interpret exactly what defences the participants were using in each case. However, professionals need to be aware that manic defences and unconscious defence mechanisms will be occurring in the therapeutic relationship which will affect the mourning process and may be why people continue to need to process the loss for a very long time (illustrated by Jim and Angela's case). When the responsibility and guilt can be made aware of and tolerated, through appropriate support to aid reflexivity, the ego is driven to seek ways of repairing the damage done to its sense of self and the harshness to the self is softened and elements of forgiveness can develop.

6.3.2 The Support needed for Post-traumatic Growth

The main theme of ‘transforming pain into purpose’ illustrates how the suicide-loss survivors were able to find formal and informal holding and containment (or support), for their complicated, heavy grief. To feel safe enough to process their grief, they found support through helping others within research, fundraising, and support groups whilst developing a relationship with suicide. This confirms research that shows the interpersonal factors of belongingness and social support are important to PTG after suicide loss (Levi-Belz, 2019) and emotional connection with others is important (Sands, 2009). Psychosocial principles illuminate the complexity of each story and that, even though some in this study have had PTG, this healing journey does not come easily. As shown in Angela’s and my own story, when trying to process such a personal experience through academic writing, we are constantly activated by the anxiety we are defending against. In doing so, however, we can integrate the experience into our subjectivity of self and allow personal growth.

These findings confirmed Bion’s argument that containers are multi-layered. Containers came from immediate family (Jim), support networks (Macy, Jim), counsellors (Macy, Chris), our research relationship (all), research (myself and Angela), and fundraising (myself and Angela). We all received containment in different ways depending on our subjectivity of self and the support easily accessible to us, and by creating our own purpose. Counselling psychology is positioned to address these multiple layers of support required for those bereaved, whether they appear to be coping or not. Support is not always readily available and, as shown in this research, people have had to ‘live out loud’ in various ways to find their own support. I argue that we need to integrate all levels of informal and formal support for an individual to find the most appropriate for them at the right time.

Researchers have long been interested in the relationship between the power of the meaning-making process and personal growth – especially how narratives can help make meaning of trauma (Frank, 2013). Within this context, many who lose loved ones to suicide may go on to help others, in order to do the mourning work necessary. Support must include various options to understand suicide, including connections with other suicide-loss survivors and platforms to tell their story, fundraise or campaign when and if they are ready to do so. Those who oversee support groups need to be fully supported, where they can process and reflect on their own emotions, alongside the ones in the support group. Furthermore, professionals who go on to help others with suicide grief need to be specifically trained and supported through specialist supervision. Particularly understanding the wounded healer theme throughout this research, where it is possible those who go on to provide support for others may have lost someone to suicide themselves. Unless reflective practice is undertaken, some of their own pain from grief and death anxiety may be suppressed and not processed healthily, as discussed. Importantly this may create a power differential between healer and patient and the suicide loss survivor may become medicalised, adding to the aforementioned reification of suicide as a problem that needs to be fixed (see Section 2.2). Providing different levels of support such as this can help create a network of well-connected, integrated services that give people options (McDonnell et al., 2020a), including therapeutic support from a health professional.

6.4 Possible Impact on the Therapeutic Relationship

Reflective practice demands that counselling psychologists consider both conscious and unconscious dynamics within the therapeutic relationship. After specialising in clinical practice of suicide-loss survivors for 40 years, Jordan (2020)

confirmed that we need to be aware of the nuances of suicide grief when working with those affected. The findings of this study have highlighted challenges that may occur within the therapeutic encounter, namely our own defensive narratives, manic defences, projection, introjection and identification, which are likely to occur within the therapy room, and how to address fragmenting thoughts from the trauma.

6.4.1 Our Own Defensive Narratives and Projection

The findings from this research show that defensive attitudes towards death and suicide may impact a counselling psychologist's relationship with someone bereaved through suicide. For example, the data panel could relate so strongly with the hopelessness and sadness of the stories that they were physically affected. The psychodynamic principle of projection enabled me to consider the defences of the participants. We must be prepared for the heavy effects of suicide grief to be projected into us during therapy and have adequate supervision for this. As practitioners, we will also likely have countertransference to process when hearing a story of someone having such turmoil from a suicide loss.

Specialist supervision needs to be provided to practitioners who work with suicide grief to provide a container to reflect on any defensive attitudes towards death and suicide and how they may be impacted by a client who is bringing the heavy story of suicide. This reflection is essential to allow the creation of a safe formal container for those bereaved. Seeking support from professionals is hard for suicide-loss survivors (Wilson & Marshall, 2010) for reasons that are not fully known. This research offers one explanation: survivors may not feel comfortable sharing their story with people who have not experienced this type of loss due to the evidence of the data panels and the process of identification they appeared to make with the suicide prevention construct. Suicide grief is heavy, complex, relatable,

difficult to mentally contain and may mean they take responsibility for the feelings of the suicide construct itself and those they are sharing their story with. This research has highlighted that this responsibility is more significant than internalized or perceived stigma as outlined in Section 3.2 because they carry the history of suicide itself within their own identities. The history, as outlined in Part 1, is steeped in discourses and constructs of suicide being a crime, a sin, forbidden and preventable within the western world.

6.4.2 Self-Disclosure

Levi-Belz (2019) found that one of the three interpersonal factors important for personal growth after a suicide is loss is self-disclosure. Self-disclosure has regularly been discussed in the therapeutic community (Danzer, 2018). Across therapeutic disciplines, it is generally thought that self-disclosure is helpful if it is appropriate for the client, rather than to provide something for ourselves (Danzer, 2018). Although therapists always need to be aware of using therapy for their own purposes, this research has highlighted the relativity of the wounded healer archetype (Jung, 1954) throughout the suicide-loss community and the importance of sharing any experience we may have had of losing someone to suicide when supporting others. Doing so shows that we are invested in the suicide construct too and reduces the need for them to protect practitioners from it. However, the reflective practice of self-disclosure needs to be carefully managed through appropriate supervision due to the complexity of the wounded healer journey to support all involved.

6.5 Limitations of Research

While the present study provides a wealth of rich and detailed information, it is not without limitations which need acknowledgement. Firstly, the cohort was recruited through a support group network, so it is likely they were those who found

containment through support groups. This pool of possible participants was chosen for the ethical reasons detailed in Sections 4.4 and 4.6. Deep analysis requires a limited research pool, and an ethical study such as this required participants to have processed the death of the loved one to some degree due to the impact deep analysis may have on participants. Leaders of the groups were first to see the advertisement for participants and this led to participation by two (50%) support group leaders and two participants (50%) who were not group leaders. With only a small sample size, this allowed a deep analysis, but ignored certain subsets of those bereaved who may have volunteered for research.

Secondly, a strong limitation is the lack of inclusion of diverse ethnic and social classes due to homogenous enrolments of White, middle-class individuals. All participants were White, middle-class and living in the South of England. Social class will no doubt have an impact on stigma and availability of support. The small group does not allow a depth of diversity to occur and this must be addressed in further research.

6.6 Conclusion and Clinical Implications

This research has combined the situated accounts of narrative inquiry with psychosocial considerations to consider the complex psychological dynamics in the research relationship. The findings are highly relevant to the counselling psychology profession where we work within the therapeutic relationship with an awareness of the narratives of situated accounts and the unconscious phenomenological experiences we formulate. These findings have demonstrated that qualitative inquiry can be used with reflexivity from an insider position whilst adopting the ‘space between’ as an insider to the subject under scrutiny, which is highly relevant for practitioners who work from a scientific reflective position when supporting others.

The findings encourage health professionals, as both supervisee and supervisor, to deconstruct the historical medicalisation of suicide, suicide prevention and suicide bereavement and consider how they may be affected when working with someone bereaved through suicide. With the complexity of suicide grief, different levels of informal and formal support are needed long term as part of a well-integrated system. PTG and helping others can be part of the healing process and trauma is a reality they have to live with; as a result, professionals must consider the different levels of support necessary for individuals who have lost a loved one to suicide.

This research has shown why suicide loss survivors are supported well by others who have lost to suicide due to identification with the heavy historical discourses surrounding suicide, which may significantly impact how they are able to seek support and how easy it is to share their grief with others. Moreover, these findings show why support groups are one of the important options that need to be available for those bereaved through suicide. The reparative nature of storytelling can integrate trauma into cognition and integrate the construct of suicide into our coherence of self. We must provide opportunities and platforms for suicide-loss survivors to share their story in a safe way; however, they must also be proactively supported throughout this process due to unconscious defence mechanisms and manic defences that may be present. Anyone working with suicide grief needs to be adequately supervised with specialist formal supervision to ensure unconscious projections and transferences are processed safely. Self-disclosure and specialist supervision are particularly important because many health professionals can enter the profession after their own trauma (Farber 2017b). Particularly after a suicide loss, where, illustrated by the main theme of this research, those who lose to suicide often

go on to help others. As such, I argue that specialist supervision training should be provided to supervisors working with suicide grief to be prepared to contain their supervisees.

Finally, and highly importantly, we must be aware of the discourses within society on mental health, suicide, and suicide prevention. As practitioners concerned with social policy and social justice, we must continue to deconstruct the social and historical stigma around suicide and suicide loss. One very significant, important alteration to services would be to offer specialist suicide grief services away from the rhetoric of suicide prevention, another would be changing the discourses through NHS services that are implicated by social policy and the medicalisation practices of postmodern society.

6.7 Future Directions for Research

Trauma research investigates the impact that trauma can have on the mind and body (Van Der Kolk, 2015). Post-Traumatic Stress Disorder (PTSD) has been found to be likely after a suicide loss (Mitchell & Terhorst, 2017), even if the bereaved were not eyewitnesses to the death itself (Jordan, 2008). This research has highlighted the cognitive destabilisation component of suicide loss and the effect this can have on a person's assumptive world. Angela's story in particular shows that no matter how hard she tries to **think** through her research, she comes up against barriers to writing. Similarly, this research has been hard for me to write; this thought fragmentation and somatic experiences (Szykierski, 2017) are likely due to the trauma of suicide loss. This phenomenon could be explored further in terms of suicide grief and the effectiveness of specific trauma therapy (e.g., Eye Movement Desensitisation and Reprocessing [EMDR]) (Leeds, 2016) and Narrative Exposure Therapy (Schauer et al., 2011).

Chris's story highlighted the relationship between mental health and suicide, and more notably anticipatory grief in relation to suicide. No research has been conducted to date in terms of this relationship and this requires further exploration, particularly in terms of the individualised support needed for those who have been affected by suicide risk over a long period.

Although suicide grief research is growing, those practitioners who specialise in the area continue to see it as a very under-researched area (e.g., Jordan, 2020), not adequately understood and not effectively supported (McDonnell et al., 2020b). This thesis will add to the research already seeking to develop more effective postvention support by offering a deep level of analysis which can continue to be added to academic research literature, practical guidelines for practitioners and wider societal constructions of suicide and suicide grief support.

References

Acker, S. (2000). In/out/side: Positioning the researcher in feminist qualitative research. *Resources for Feminist Research*, *28*(1/2), 189–208. http://proquest.umi.com

Alexander, V. (1991). *Words I never thought to speak: Stories of life in the wake of suicide*. Lexington Books.

American Association of Suicidology [AAS]. (2020a). *About AAS.* https://suicidology.org/about-aas/#mission

American Association of Suicidology [AAS] (2020b). *32nd Annual Healing After Suicide Loss Conference*. https://www.aasconference.org/healing-after-suicide-loss

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.

Amparo (n.d.) *Amparo: Support following suicide*. https://amparo.org.uk/

Andrews, M., Sclater, S. D., Squire, S., & Treacher, A. (2000). *Lines of narrative: Psychosocial perspectives.* Routledge.

Andriessen, K., Krysinka, K., Hill, N. T. M., Reifels, L., Robinson, J., Reavley, N., & Pirkis, K. (2019). Effectiveness of interventions for people bereaved through suicide: As systemic review of controlled studies of grief, psychosocial and suicide-related outcomes. *BMC Psychiatry, 19,* Article No. 49.

Archard, P. (2020). Psychoanalytically informed research interviewing: notes on the free association narrative interview method. *Nurse Researcher*, *28*(2), 42–49.

Armstrong, M. S. (2001). *Women leaving heterosexuality at mid-life: Transformation in self and relations* [Unpublished doctoral dissertation, York University, Toronto, Ontario, Canada].

Arnason, A., & Hafsteinsson, S. B. (2003). The revival of death: expression, expertise and governmentality. *The British Journal of Sociology*, *54*(1), 43–62.

Asselin, M. E. (2003). Insider research: Issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Staff Development*, *19*(2), 99–103.

Atkinson, R. (1998). *The life story interview.* SAGE.

Barbagli, M. (2015). *Farewell to the world: A history of suicide.* Polity Press.

Barrett, T. W. (2013). *Life after suicide: The survivor's grief experiences.* Aftermath Research.

Barton, S. (2016). *Facing darkness, finding light: Life after suicide*. Findhorn Press.

Beaton, S., & Forster, P., & Myfanwy, M. (2013, February). Suicide and language: Why we shouldn't use the 'C' word. *InPsych: The bulletin of the Australian Psychological Society Limited*, 30–31.

Begley M., & Quayle, E. (2007). The lived experience of adults bereaved by suicide: A phenomenological study. *Crisis*, *28*(1), 26–34.

Bion, W. R. (1962). The psycho-analytic study of thinking. *International Journal of Psycho-Analysis*, *43*, 306–310.

Bion, W. R. (1967). *Second thoughts: Selected papers on psycho-analysis*. Heinemann.

Bolton, I. (1995). *My son…my son: A guide to healing after death, loss or suicide.* Bolton Press Atlanta.

Bonin E., & McDaid. D. (2011). Bridge safety measures for suicide prevention. In M. Knapp, D. McDaid, & M. Parsonage (Eds.), *Mental health promotion and mental illness prevention: The economic case.*

http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf.

Braun, V., & Clarke, V. (2013). *Successful qualitative research*. SAGE.

British Psychological Society [BPS]. (2005). Division of counselling psychology. *Professional Practice Guidelines.*

British Psychological Society [BPS]. (2016). *Understanding and preventing suicide*. https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Understanding%20and%20preventing%20suicide%20-%20a%20psychological%20perspective.pdf

Buber, M. (1965). *The knowledge of man: Selected essays edited with an introductory essay by Maurice Friedman*. Humanities Press International.

Cabaniss, D. L., Cherry, S. Douglas, C. J., & Schwartz, A. R. (2016). *Psychodynamic Psychotherapy: A clinical manual* (2nd ed). John Wiley & Sons Ltd.

Cambridge Dictionary. (2018). *Commit.* https://dictionary.cambridge.org/dictionary/english/commit

Carmichael, V., & Whitley, R. (2019). Media coverage of Robin Williams' suicide in the United States: A contributor to contagion? *PloS one*, *14*(5), e0216543.

Carr, W. (1986) Theories of theory and practice. *Journal of Philosophy of Education*, *20*(2), 177–186.

Caruso, K. (n.d.). *'Harry Potter' author J. K. Rowling: "I considered suicide."* https://www.suicide.org/jk-rowling-considered-suicide.html

Casement, P. (1985) *On Learning from the Patient.* London*:* Tavistock

Cerel J., Brown, M. M., Maple, M., Singleton, M., van de Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. *Suicide and Life-Threatening Behavior*, *49*(2), 529–534.

Cerel, J., Maple, M., Aldrich, R., & van de Venne, J. (2013). Exposure to suicide and identification of a survivor. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *34*(6), 413–419.

Chapple, A., Ziebland, S., & Hawton, K. (2015). Taboo and the different death? Perceptions of those bereaved by suicide or other types of violent death. *Sociology of Health & Illness*, *37*(4), 610–625.

Clandinin, D. J. (2008). The life story interview as a bridge to narrative inquiry. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: A critical review.* SAGE.

Clark, S. (2002). Leaning from experience: Psychosocial research methods in the social sciences. *Qualitative Research*, *2*(2), 173–194.

Clark S. E., & Goldney, R. D. (2000). The impact of suicide on relatives and friends. In K. Hawton & K. van Heeringen (Eds.), *The international handbook of suicide and attempted suicide* (pp. 467–484). Wiley & Sons.

Clarke, S., & Hoggett, P. (2009). *Researching beneath the surface: Psychosocial research methods in practice*. Karnac Books.

Cleiran, M. P. H. D. (1993). *Bereavement and adaptation: A comparative study of the aftermath of death.* Hemisphere Publishing.

Cleiran, M. P. H. D., Grad, O., Zavasnik, A., & Diekstra, R. F. W. (1996). Psychosocial impact of bereavement after suicide and fatal traffic accident: A comparative two-country study. *Acta Psychiatrica Scandinavica*, *94*, 37–44.

Clompus, S. R., & Albarran, J. W. (2016). Exploring the nature of resilience in paramedic practice: A psychosocial study. *International Emergency Nursing*, *28*, 1–7.

Corrigan, P. (2004). How stigma interferes with healthcare. *American Psychoanalysis*, *59*, 614–625.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative and mixed methods approaches.* SAGE.

Crossley, M. L. (2000a). *Introducing narrative psychology: Self, trauma and the construction of meaning*. Open University Press.

Crossley, M. L. (2000b). Narrative psychology, trauma and the study of self/identity. *Theory & Psychology*, *10*(4), 527–546.

Cvinar, C. V. (2005). Do suicide-loss survivors suffer stigma: A review of the literature. *Perspectives in Psychiatric Care*, *41*(1), 14–21.

Danzer, G. D. (2018). *Therapist self-disclosure.* Taylor & Francis.

Davis, C. G., Nolen-Hoeksema, S., & Larson, J. (1998). Making sense of loss and benefitting from the experience: Two construals of meaning. *Journal of Personality and Social Psychology*, *75*, 561–574.

Day Sclater, S. (2003). What is the subject? *Narrative Inquiry*, *13*(2)*,* 317–330.

Dean, C. (2020, April 21). “I keep waiting for it to feel easier”: Dawn O'Porter candidly details her struggles with grief after the death of her close friend Caroline Flack. *Daily Mail*. https://www.dailymail.co.uk/tvshowbiz/article-8242999/Dawn-OPorter-candidly-details-struggles-grief-death-friend-Caroline-Flack.html

Department of Health and Social Care [DHSC]. (2019). *Suicide bereavement support to be made available across England*. https://www.gov.uk/government/news/suicide-bereavement-support-to-be-made-available-across-england

Donati, M. (2016). Becoming a reflective practitioner. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed., pp. 55–73). SAGE Publications Ltd.

Dransart, D. A. C. (2017). Reclaiming and reshaping life: Patterns of reconstruction after the suicide of a loved one. *Qualitative Health Research*, *27(*7), 994–1005.

Dunne E. J., & Dunne-Maxim, K. (1987). Preface. In E. J. Dunne, J. L. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its aftermath: Understanding and counseling the survivors.* Penguin Books Canada.

Dunne, E. J., McIntosh, J. L., & Dunne-Maxim, K. (1987). *Suicide and its aftermath: Understanding and counseling the survivors.* Penguin Books Canada.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Studies*, *8*(1), 54–63.

Eisma, M. C., Riele, B., Overgaauw, M., & Doering, B. K. (2019). Does prolonged grief or suicide bereavement cause public stigma? A vignette-based experiment. *Psychiatry Research*, *272*, 784–789.

Ellenbogen, S., & Gratton, F. (2001). Do they suffer more? Reflections on research comparing suicide-loss survivors to other survivors. *Suicide and Life-Threatening Behavior*, *31*, 83–90.

Elliott, S. (2001). Book review: Doing qualitative research differently: Free association, narrative and the interview method. *Qualitative Research*, *1*(2), 261–262.

Ellis, C. (2004). *The ethnographic I: A methodological novel about autoethnography.* Altamira Press.

Ely, M., Anzul, M., Friedman, T., Garner, D., Steinmetz, A. M. (1991). *Doing qualitative research: Circles within circles*. Falmer Teachers Library.

Epston, D. (1999). Co-research: The making of an alternative knowledge. In D. Epston (Ed.), *Narrative therapy and community work: A conference collection* (pp. 137–157). Dulwich Centre Publications.

Evans, A., & Abrahamson, K. (2020). The influence of stigma on suicide bereavement: A systematic review. *Journal of Psychosocial Nursing*, *59*(4), 21–27.

Farber, S. K. (2017a). The concept of the *wounded healer*. In S. K. Farber (Ed.), *Celebrating the wounded healer psychotherapist: Pain, post-traumatic growth and self-disclosure* (pp. 24–53). Routledge.

Farber, S. K. (2017b). The wounding healer psychotherapist and the self-wounding healer. In S. K. Farber (Ed.), *Celebrating the wounded healer psychotherapist: Pain, post-traumatic growth and self-disclosure* (pp. 121–134). Routledge.

Farmer, C. (2020, February 27). "This is for Caroline and the rest of the human race": Love Island's Laura Anderson unveils 'be kind' wrist tattoo in tribute to the show's late host Flack. https://www.dailymail.co.uk/tvshowbiz/article-8051769/Love-Islands-Laura-Anderson-unveils-Kind-tattoo-Caroline-Flack.html

Fay, B. (1996). *Contemporary philosophy of social science: A multicultural approach*. Blackwell.

Feigelman, W., Jordan, J. R., & Gorman, B. S. (2009). Personal growth after a suicide loss: Cross-sectional findings suggest growth after loss may be associated with better mental health among survivors. *OMEGA*, *59*(3), 181–202.

Fine, C. (2002). *No time to say goodbye.* Broadway Books.

Finlay, L. (2015). *Relational integrative psychotherapy: Process and theory in practice.* Wiley.

Fisher, C. (1987). *Postcards from the edge.* Simon & Schuster.

Florence, J. (2021). *Identification in Psychoanalysis: A Comprehensive Introduction.* Routledge.

Frank, A. W. (2013). *The wounded storyteller: Body, illness & ethics* (2nd ed.). The University of Chicago.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology in context. In R. Woolfe, W. Dryden., & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp 3–22). SAGE.

Freud S. (1910). The future prospects of psycho-analytic therapy. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII (pp.3-12).* Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1911). Formulations on the two principles of mental functioning. In J, Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (pp. 213-226).* Hogarth Press and the Institute of Psycho-Analysis.

Freud S (1912). The dynamics of transference. In J. Strachey (Ed.*), The Standard Edition of Complete Psychological Works of Sigmund Freud, Volume XII (pp 97-108).* Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1915). Observations on transference-love. In J. Strachey (Ed.), *The Standard Edition of Complete Psychological Works of Sigmund Freud, Volume XII (pp. 1911-1913).* Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1917). *Mourning and Melancholia*. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (pp. 239-258)*. Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1923). *The ego and the Id*. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud Volume XIX (pp. 12-66).* Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (2005). *Sigmund Freud on Murder, Mourning and Melancholia.* Penguin Classics.

Frosh, S., & Baraitser, L. (2008). Psychoanalysis and psychosocial studied. *Psychoanalysis, Culture and Society*, *13*(4), 346–365.

Gadd, D. (2004). Making sense of interviewee–interviewer dynamics in narratives about violence in intimate relationships. *International Journal of Social Research Methodology*, *7*(5), 383–401.

Gall, T. L., Henneberry, J., & Eyre, M. (2013). Two perspectives on the needs of individuals bereaved by suicide. *Death Studies*, *38,* 430–437.

Gavron, J. (2015). *A woman on the edge of time: A son's search for his mother.* Scribe.

Gillies, J., & Neimeyer, R. A. (2006). Loss, grief, and the search for significance: Toward a model of meaning reconstruction in bereavement. *Journal of Constructivist Psychology*, *19*(1), 31–65.

Goodwin, C. (1984). Notes on story structure and the organization of participation. In M. Atkinson & J. Heritage (Eds.), *Structures of social action* (pp. 225–246). Cambridge University Press.

Gottesman, T. (2016, April 4). Beyoncé wants to change the conversation: These days, the superstar-turned-supermogul is slaying—pop charts, music-industry standards, societal labels, and now, the athleticwear biz—all on her own. *Elle*. https://www.elle.com/fashion/a35286/beyonce-elle-cover-photos/

Grant, J., & Crawley, J. (2002). *Transference and projection.* OU Press.

Green, J. (2020, February 24). You will shine on forever: Caroline Flack fans are left in tears as London Underground board pays 'perfect' tribute to the late Love Island host. *Daily Mail*. https://www.dailymail.co.uk/femail/article-8037441/Caroline-Flack-fans-left-tears-London-Underground-pays-tribute-Love-Island-host.html

Groos, A. D., & Shakespeare-Finch, J. (2013). Positive experiences for participants in suicide bereavement groups: A grounded theory model. *Death Studies*, *37*, 1–24.

Guggenbühl-Craig, A. (1998). *Power and the healing professions*. Spring Publications.

Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1984). *Changing the subject: Psychology, social regulation and subjectivity.* Routledge.

Hibberd, R. (2013). Meaning reconstruction in bereavement: Sense and significance. *Death Studies*, *37*(7), 670–692.

Hickman, A. (2019, January 10). “Bravery, audacity & vision” – Campaigns that shifted the conversation on suicide. *PR Week*. https://www.prweek.com/article/1522377/bravery-audacity-vision-campaigns-shifted-conversation-suicide

Hinshelwood, R. D. (1989) *A Dictionary of Kleinian Thought.* Free Association Books.

Hinshelwood, R. D. & Fortuna, T. (2018). *Melanie Klein: the basics.* Routledge.

Hjelmeland, H. (2010). Cultural research in suicidology: Challenges and opportunities. *Suicidology Online*, *1*, 34–52.

Hjelmeland, H. (2016). A critical look at current suicide research. In J. White, I. Marsh, M. J. Kral, & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for the 21st Century* (pp. 31–55). UBC Press.

Hollway, W., & Freshwater, D. (2007). *Narrative research in nursing.* Blackwell Publishing.

Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. SAGE.

Hollway W., & Jefferson, T. (2001). Free association, narrative analysis and the *defended subject*: The case of Ivy. *Narrative Inquiry*, *11*(1), 103–122.

Hollway, W., & Jefferson, T. (2013). *Doing qualitative research differently* (2nd ed.). SAGE.

Hollway W., & Volmerg, B. (2010). *Interpretation group method in Dubrovnik tradition.* International Research Group for Psycho-Societal Analysis. http://oro.open.ac.uk/id/eprint/34374

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* Free Press.

Johansson Å. K., & Grimby A. (2012). Anticipatory grief among close relatives of patients in hospice and palliative wards. *American Journal of Hospice and Palliative Medicine*, *29*(2), 134–138.

Joiner, T. E. (2005). *Why people die by suicide.* Harvard University Press.

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behaviour*, *31*(1), 91–102.

Jordan, J. R. (2008). Bereavement after suicide. *Psychiatric Annals*, *38*(10), 1–6.

Jordan, J. R. (2020). Lessons learned: 40 years of clinical work with suicide loss survivors. *Frontiers in Psychology.*

Jordan, J. R., & McIntosh, J. L. (2014a). Suicide bereavement: Why study survivors of suicide loss? In J. R. Jordan & J. L. McIntosh (Eds.), *Grief after suicide: Understanding the consequences and caring for the survivors* (pp. 3–17). Routledge.

Jordan, J. R., & McIntosh, J. L. (2014b). Is suicide bereavement Different? A framework for rethinking the question. In J. R. Jordan & J. L. McIntosh (Eds.), *Grief after suicide: Understanding the consequences and caring for the survivors* (pp. 19–42). Routledge.

Jung. C. (1951). *Fundamental questions of psychotherapy.* Princeton University Press.

Jung, C. (1954). On the psychology of the trickster-figure. In H. Read & M. Fordham (Eds.), G. Adler (Ed., Trans.), & R. F. C. Hull (Trans.), *The archetypes and the collective unconscious: Collected works of C. G. Jung* (Vol. 9, Part 1, pp. 225–274). Princeton University Press.

Kanuha, V. K. (2000). “Being” native versus “going native”: Conducting social work research as an insider. *Social Work*, *45*(5), 439–447.

Kellehear A. (1984). Are we a ‘death-denying’ society? A sociological review. *Social Science & Medicine*, *18*(9), 713–723.

Kelly, G. A. (1991). *The psychology of personal constructs.* Routledge.

Klass, D., Silverman, P. R., & Nickman, S. L. (Eds.) (1996). *Continuing bonds: New understandings of grief.* Routledge.

Klein, M. (1940). Mourning and its relation to manic-depressive states. *International Journal of Psychoanalysis, 21,* 125 – 153.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis, 27,* 99-110. Republished (1952) in Heimann, P., Isaacs, S., Klein, M., & Riviere, J. (Eds.). *Developments in Psycho-Analysis*. Hogarth, pp. 292-320.

Klein, M. (1988a). *Love, guilt and reparation and other works, 1921-1945*. Virgo.

Klein, M. (1988b). *Envy, gratitude and other works, 1946-1963.* Virgo.

Knapp, M., McDaid, D., & Parsonage, M. (2011). *Mental health promotion and mental illness prevention: The economic case*. http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf

Kral, M. J., & Idlout, L. (2009). Community wellness and social action in the Canadian Arctic: Collective agency as subjective well-being. In L. J. Kirmayer & G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 315–354). UBC Press.

Kübler-Ross, E., & Kessler, D. (2014). *On grief and grieving: Finding the meaning of grief through the give stages of grief*. Simon & Shuster.

Leeds, A. M. (2016). *A guide to the standard EMDR therapy protocols for clinicians, supervisors, and consultants* (2nd ed.). Springer.

Lees, P. (2017, August 9). Thank you, Sinéad O'Connor, for showing the messy reality of mental illness. *The Guardian.* https://www.theguardian.com/commentisfree/2017/aug/09/sinead-o-connor-reality-mental-illness

Levi-Belz, Y. (2015). Stress-related growth among suicide-loss survivors: The role of interpersonal and cognitive factors. *Archives of Suicide Research*, *19*, 305–320.

Levi-Belz, Y. (2019). With a little help from my friends: A follow-up study on the contribution of interpersonal characteristics to postraumatic growth among suicide-loss survivors. *American Psychological Association*, *11*(8), 895–904.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, *151*(6), 155–160.

Longhofer, J., Floersch, J., & Hoy, J. (2013). *Qualitative methods for practice research*. Oxford University Press.

Lukac-Greenwood, J. (2019). *Let's talk about sex: Female therapist's experience of working with male clients who are sexually attracted to them* [Doctoral dissertation, Middlesex University/Metatonia Institute]. http://metanoia.eprints-hosting.org/id/eprint/218/1/JLukac-Greenwood%20thesis.pdf

Lukas, C., & Seiden, H. M. (2007). *Silent grief: Living in the wake of suicide.* Bantam.

Marsh, I. (2016). Critiquing contemporary suicidology. In J. White, I. Marsh, M. J. Kral, & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for 21st century* (pp. 15–30). UBC Press.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self.* Guilford Press.

McAndrew, S., & Warne, T. (2010). Coming out to talk about suicide: Gay men and suicidality. *International Journal of Mental Health Nursing*, *19*(2), 92–101.

McDonnell S., Hunt I. M., Flynn S., Smith S., McGale B., & Shaw J. (2020a). *From grief to hope: The collective voice of those bereaved or affected by suicide in*

the UK. University of Manchester. https://supportaftersuicide.org.uk/wp-content/uploads/2020/11/From-Grief-to-Hope-Report-FINAL.pdf

McDonnell, S., Nelson, P. A., Leonard, S. McGale, B., Chew-Graham, C. A., Kapur, N. Shaw, J., Smith, S., & Cordingley, L. (2020b). Evaluation of the impact of the PABBS suicide bereavement training on clinician's knowledge and skills: A pilot study. *Crisis*, *41*(5), 351–358.

McIntosh, J. L. (1993). Control group studies of suicide-loss survivor: A review and critique. *Suicide and Life-Threatening Behavior*, *23*, 146–161.

McIntosh, J. L., & Jordan, J. R. (2014). The impact of suicide on adults. In J. R. Jordan & J. L. McIntosh (Eds.), *Grief after suicide: Understanding the consequences and caring for the survivors* (pp. 19–42). Routledge.

Midgley, N. (2006). Psychoanalysis and qualitative psychology: Complementary or contradictory paradigms? *Qualitative Research in Psychology*, *3*(3), 213–231.

Mishara, B. L., & Weisstub, D. N. (2016). The legal status of suicide: A global review. *International Journal of Law & Psychiatry*, *44*, 54–74.

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

Moon P. J. (2016). Anticipatory grief. *American Journal of Hospice & Palliative Medicine*, *33*(5), 417–420.

Moore, M. M., Cerel, J., & Jobes, D. A. (2015). Fruits of trauma? Post-traumatic growth among suicide-bereaved parents. *Crisis*, *36*, 240–248.

Morgan, M. (2018). The psychosocial impact of prison culture on Black women employees. *Journal of Psychosocial Studies*, *11*(2), 61–92.

MTV. (2015, April 1). *Kendrick Lamar talks about 'u,' his depression & suicidal thoughts (pt. 2)* [Video]. YouTube. https://www.youtube.com/watch?v=Hu4Pz9PjolI

Murphy, G., & Kovach, J. K. (1972). *Historical introduction to modern psychology* (6th ed.). Routledge & Kegan Paul.

Murphy, S. A., Clark Johnson, L., & Lohan, J. (2003). Finding meaning in a child's violent death: A five-year prospective analysis of parents' personal narratives and empirical data. *Death Studies*, *27*(5), 381–404.

National Health Service (NHS). (2020a). *Zero suicide.* http://www.awp.nhs.uk/advice-support/conditions/suicidal-feelings/zero-suicide/

National Health Service (NHS) (2020b). *Suicidal feelings.* http://www.awp.nhs.uk/advice-support/conditions/suicidal-feelings/

National Institute for Health and Care Excellence [NICE]. (2019). *Suicide prevention. Quality statement 5: Supporting people bereaved or affected by a suspected suicide.* https://www.nice.org.uk/guidance/qs189/chapter/Quality-statement-5-Supporting-people-bereaved-or-affected-by-a-suspected-suicide

National Suicide Prevention Alliance [NSPA] (2020a). *Home page*. https://www.nspa.org.uk/#:~:text=The%20National%20Suicide%20Prevention%20Alliance%20%28NSPA%29%20is%20an,and%20support%20those%20bereaved%20or%20affected%20by%20suicide.

National Suicide Prevention Alliance [NSPA] (2020b). *Our members.* https://www.nspa.org.uk/members/page/4/

Neimeyer, R. A. (2001). Reauthoring life narratives: Grief therapy as meaning reconstruction. *The Israel Journal of Psychiatry and Related Sciences*, *38*(3-4), 171–183.

Neimeyer, R. A. (2006). Widowhood, grief and the quest for meaning: A narrative perspective on healing. In D. Carr, R. M. Nesse, & C. B. Wortman (Eds.), *Spousal bereavement in late life* (pp. 227–252). Springer.

Neimeyer. R. A., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology*, *19*, 127–145.

O'Connor, R. (2018, April 2). Dwayne Johnson opens up about depression: "I was crying constantly." *The Independent*. https://www.independent.co.uk/arts-entertainment/films/news/dwayne-johnson-the-rock-depression-mental-health-mother-suicide-attempt-latest-a8284821.html

O'Connor, R. (2021). *When it is Darkest: Why People Die by Suicide and What we Can Do to Prevent It.* Penguin House UK.

Office for National Statistics (2021). *Suicides in England & Wales*. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables

Ogden, T. H. (1994). *Subjects of analysis.* Karnac.

Ogden, T. H. (2004). On holding and containing, being and dreaming. *International Journal of Psychoanalysis. 85,* 1349-64.

Onyett, S. (2007). *New ways of working for applied psychologist: Working psychologically in teams*. British Psychological Society. http://www.wiltshirepsychology.co.uk/Working%20Psychologically%20in%20Teams.pdf

Owens, C., Lambert, H., Lloyd, K., & Donovan, J. (2008). Tales of biographical disintegration: How parents make sense of their sons' suicides. *Sociology of Health & Illness*, *30*, 237–254.

Parker, I., Georgace, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. SAGE.

Peters, K., Cunningham, C., Murphy, G., & Jackson, D. (2016). “People look down on you when you tell them home he died”: Qualitative insights into stigma as experienced by suicide-loss survivors. *International Journal of Mental Health Nursing*, *25*, 251–257.

Pitman, A., Osborn, D. P. K., King M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *Lancet Psychiatry*, *1*(1), 86–94.

Pitman, A. L., Osborn, D. P. J., Rantell, K., & King, M. B. (2016). The stigma perceived by people bereaved by suicide and other sudden deaths: A cross-sectional UK study of 3432 bereaved adults. *Journal of Psychosomatic Research*, *87*, 22–29.

Proudfoot, J. (2019, October 9). For World Mental Health Day, 20 celebrities speak honestly about their mental health battles. *Marie Claire*. https://www.marieclaire.co.uk/news/celebrity-news/celebrities-speak-out-about-mental-health-12047

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

Rando, T. A. (2000). *Clinical dimensions of anticipatory mourning: Theory and practice in working with the dying, their loved ones, and their caregivers.* Research Press.

Rosenthal, G. (1993). Reconstruction of life stories: Principles of selection in generating stories for narrative biographical interviews. In R. Joesselson & A. Leiblich (Eds.), *The narrative study of lives* (Vol. 1, pp. 59–91). SAGE.

Roth, P. (2001). The paranoid-schizoid position. In Bronstein, C. (Ed.) (20010. *Kleinien Theory: A Contemporary Perspective.* Whurr.

Roth, P. (2009). Discussion of “Mourning and Melancholia.” In L. G. Fiorini, T. Bokanowski, & S. Lewkowicz (Eds.), *On Freud’s “Mourning and Melancholia” (pp. 37-55). Routledge.*

Rycroft, C. (1995) *A Critical Dictionary of Psychoanalysis* (2nd ed). Penguin.

Sands, D. (2009). A tripartite model of suicide grief: Meaning-making and the relationship with the deceased*. Grief Matters: The Australian Journal of Grief and Bereavement*, *12*(1), 10–17.

Sands, D., & Tennant, M. (2010). Transformative learning in the context of suicide bereavement. *Adult Education Quarterly*, *60*(2), 99–121.

Sands, D., Jordan, J. R., & Neimeyer, A. (2014). The meanings of suicide: A narrative approach to healing. In J. R. Jordan & J. L. McIntosh (Eds.), *Grief after suicide: Understanding the consequences and caring for the survivors* (pp. 249–282). Routledge.

Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders.* Hogrefe Publishing.

Schneidman, E. S. (1972). Foreword. In A. C. Cain (Ed.), *Survivors of suicide* (pp. ix–xi). Charles C. Thomas Publishing.

Scocco, P., Castriotta, C., Toffol, E., & Preti, A. (2012). Stigma of Suicide Attempt (STOSA) scale and Stigma of Suicide and Suicide-loss Survivor (STOSASS) scale: Two new assessment tools. *Psychiatry Research*, *200*, 872–878.

Scocco, P., Preti, A., Totaro, S., Ferrari, A., & Toffol, E. (2017). Stigma and psychological distress in suicide-loss survivors. *Journal of Psychosomatic Research*, *94*, 39–46.

Seena, F., & Bo, R. (2020). Suicide*. The New England Journal of Medicine*, *382*(3), 266–274.

Selvin, H.C. (1958). Durkheim's Suicide and Problems of Empirical Research. *American Journal of Sociology, 63*, 607 - 619.

Serrant-Green, L. (2002). Black on black: Methodological issues for black researchers working in minority ethnic communities. *Nurse Researcher*, *9*(4), 30–44.

Shaw, E., & Carroll, N. (2016). Becoming a reflective practitioner. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed., pp. 244–258). SAGE.

Spitznagel, E. (2012, August 15). MH Interview with Dolph Lundgren*. Men's Health*. https://www.menshealth.com/trending-news/a19555014/dolph-lundgren-interview/

Strawbridge, S. (2002). McDonalisation or fast-food therapy. *Counselling Psychology Review*, *17*(4), 20–24

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology in context. In R. Woolfe, W. Dryden., & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp 3–22). SAGE.

Stroebe, M., & Schut, H. (2001). Meaning making in the dual process model of coping with bereavement. In R. R. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss.* American Psychological Association.

Sunflowers Suicide Support. (n.d.). *Home*. https://www.sunflowerssuicidesupport.org.uk/

Support After Suicide Partnership [SASP] (n.d). *Who we are.* https://hub.supportaftersuicide.org.uk/about/

Sveen, C. A., & Walby, F. A. (2008). Suicide-loss survivor's mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behaviour*, *38*, 13–29.

Sweeting, H. N., & Gilhooly, M. L. M. (1990). Anticipatory grief: A review. *Social Science & Medicine*, *30*(10), 1073–1080.

Szykierski, D. (2017). The traumatic roots of containment: The evolution of Bion's metapsychology. *The Psychoanalytic Quarterly*, *79*(4), 935–968.

Taylor, S. (1989). *Positive illusions: Creative self deception and the healthy mind.* Basic Books.

Tedeschi, R. G., & Calhoun, L. G. (2004). Postraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, *15*, 1–18.

Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behaviour. *The Lancet*, *387*(1004), 1227–1239. https://doi.org/10.1016/S0140-6736(15)00234-2.

Travis, K. D. (2019). *Life after suicide: The story is never over; it's just being retold.* Divine House Books.

Van Der Kolk, B. (2015). *The body keeps the score. Mind, brain and body in the transformation of trauma.* Penguin Books.

Van Der Pol, S., & Pehrsson, D. (2015). Examination of the grieving process of suicide-loss survivors. *Qualitative Research Journal*, *16*(2), 159–168.

Van der Wal, J. (1989). The aftermath of suicide: A review of empirical evidence, *Omega: Journal of Death and Dying*, *20*, 149–171.

Van Poppel, F., & Day, L. H. (1996). A Test of Durkheim's Theory of Suicide--Without Committing the "Ecological Fallacy." *American Sociological Review*, *61*(3), 500–507.

Vernon, P. (2020, February 16). Caroline Flack: The complex woman I met. *The Times*. https://www.thetimes.co.uk/article/caroline-flack-the-complex-woman-i-met-mmjq9mb56

Walsh, Y., Frankland, A., & Cross, M. (2004). Qualifying and working as a counselling psychologist in the United Kingdom. *Counselling Psychology Quarterly*, *17(3*), 317–328.

Wheeler, O. (2020, April 1). It's really hard to take: Nick Grimshaw reflects on the pain of losing pal Caroline Flack and says late star was 'really vulnerable.' *Daily Mail*. https://www.dailymail.co.uk/tvshowbiz/article-8175703/Nick-Grimshaw-reflects-pain-losing-pal-Caroline-Flack.html

White, J. (2012). Youth suicide as a "wild problem": Implications for prevention practice. *Suicidology Online*, *3*, 42–50, http://www.suicidology-online.com/pdf/SOL-2012-3-42-50.pdf

White, J. Marsh, I., Krat, M. J., & Morris, J. (2016). Introduction. In. J. White, I. Marsh, M. J. Krat, & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for the 21st Century* (pp. 1–11). UBC Press.

Whitehouse-Hart, J. (2012). Surrendering to the dream: An account of the unconscious dynamics of a research relationship. *Journal of Research Practice*, *8*(2), Article M5. http://jrp.icaap.org/index.php/jrp/article/view/302/269

Wilson, A., & Marshall, A. (2010). The support needs and experiences of suicidally bereaved family and friends. *Death Studies*, *35*, 625–640. doi: 10.1080/07481181003761567

Winnicot, D. (1956). *Through Paediatrics to Psycho-Analysis.* Routledge.

Winnicott, D. (1960). *The theory of the parent-child relationship*, *Int. J. Psychoanal.*, 41:585-595.

Winnicott, D. (1965). *The maturational process and the facilitation environment* (1st ed.). The Hogarth Press and the Institute of Psychoanalysis.

Winnicott, D. (1969). The use of an Object. *International Journal of Psycho-Analysis*, *50*, 711–716.

Woodward, K. (2015). *Psychosocial studies: An introduction.* Routledge.

Woolfe R. (2012). Risorgimento: A history of counselling psychology in Britain. *Counselling Psychology Review*, *27*(4), 72–78.

Woolfe, R. (2016). Mapping the world of helping: The place of counselling psychology. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed., pp. 55–73). SAGE.

Woolfe, R., & Strawbridge, S. (2009). Counselling psychology: Origins developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds), *Handbook of counselling psychology* (3rd ed., pp. 3–22). SAGE.

World Federation for Mental Health (2020a). *World Mental Health Day history.* https://wfmh.global/world-mental-health-day/

World Federation for Mental Health (2020b). *World Mental Health Day 2019*. https://wfmh.global/world-mental-health-day-2019/

World Health Organization. (2021). *Suicide.* https://www.who.int/news-room/fact-sheets/detail/suicide

Wubbolding, R. E. (1988). Professional issues: Signs and myths surrounding suiciding behaviors. *Journal of Reality Therapy*, *8*(1), 18–21. https://psycnet.apa.org/record/1989-26829-001

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*(2), 215–228. doi:10.1080/08870440008400302

Young, S. (2019, February 11). Grammys 2019: Lady Gaga delivers emotional speech about mental health awareness. *The Independent*. https://www.independent.co.uk/life-style/lady-gaga-grammys-2019-speech-mental-health-shallow-star-born-a8773216.html

Zisook, S. Shear, M. K., Reynolds, C. F., Simon, N. M., Mauro, C., Skritskaya, N. A., Lebowitz, B., Wang, Y., Tal, I., Glorioso, D., Wetherell, J. L., Iglewicz, A., Robinaugh D., & Qiu, C. (2018). Treatment of complicated grief in survivors of suicide loss: A HEAL report. *Journal of Clinical Psychiatry*, *79*(2). doi: 10.4088/JCP.17m11592

APPENDICES

Appendix A: My Family's Permission for Reflexivity

Removed for confidentiality reasons

Appendix B: Ethical Approval from UWE

Removed for confidentiality reasons

Appendix C: Research Flyer Used to Recruit Participants

Call for participants

The stories of those bereaved through suicide

Hello, my name is Sue Egan and I am a Professional Doctorate in Counselling Psychology trainee at the University of the West of England, Bristol. I am seeking adults aged 18 and older who have been affected by a suicide loss over 2 years ago, to participate in the research I am completing for my doctoral thesis. I am interested in this topic because I lost my brother to suicide in November 2014 and have directly experienced the impact of suicide to a close member of my family.

Brief introduction to the study

This study aims to explore how dominant cultural stories and psychological aspects influence the narratives of someone who has been affected by a suicide loss. I hope to explore my own story and how it might, or not might interact with others from the same cohort in the research relationship.

Although official data shows that there were 5,821 deaths by suicide in the United Kingdom in 2017; leaving behind many people affected by the loss, understanding suicide bereavement and how to support those people is relatively new in psychological research.

There is no research exploring the way dominant social stories affect the experience of people bereaved through suicide. Thus, this study's aim is to provide clinicians with an understanding of what it means to be bereaved by suicide, and inform the practice of health professionals including GPs, psychologists and counsellors in supporting those bereaved and challenge the stories that currently dominate feelings around suicide based on historical and current cultural beliefs.

How to get involved.

If you wish to take part in the study, please email me on susan2.egan@live.uwe.ac.uk to discuss the research further. If you are then still interested, we will complete a short screening questionnaire to assess your current circumstances and identify any exceptional risk circumstances that mean participating is not advisable. Following this we will arrange to meet for 2, 60-90 minute interviews at a convenient place to suit you.

Appendix D: Participant Information Sheet

The stories of those bereaved through suicide

Who are the researchers and what is the research about?

My name is Sue Egan and I am completing a Professional Doctorate in Counselling Psychology in the Department of Health and Social Sciences, at the University of the West of England, Bristol. I am completing this research for my thesis project. My research is supervised by Dr Stella Maile (see below for her contact details), the Associate Head of Health and Social Sciences and a member of the Psychoanalytic Council and Dr Zoe Thomas, a Senior Lecturer in Counselling Psychology, programme lead for the professional doctorate and a member of the British Psychology Society.

Thank you for your interest in this research. This research project focuses on those who have been affected by a suicide death no less than 2 years ago, in order for them to share their stories around their loss. It's hoped the research will improve our understanding of social and psychological influences on the suicide loss and the bereavement that follows in order to provide more effective psychological support for those bereaved.

What does participation involve?

You are invited to participate in two qualitative interviews – a qualitative interview is a 'conversation with a purpose.' You are fully in control of the story you wish to tell around your suicide loss. The questions I may ask will flow from the story you tell. We will discuss a suitable location that suits both of us which will be confidential and where you will remain anonymous.

The interviews will be audio recorded and I will transcribe (type-up) the interview for the purposes of analysis. On the day of the first interview, I will ask you to read and sign a consent form. You will also be asked to complete a short demographic questionnaire. This is for me to gain a sense of who is taking part in the research. I

will discuss what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have. You will be given another opportunity to ask questions at the end of the interview.

Who can participate?

I am seeking any adult over 18 years old who has been affected by a suicide loss over 2 years ago. You must currently self-define as having 'processed the death' and already receiving support from a support group or mental health professional.
Prior to interview you will be asked to complete a brief risk screen questionnaire. These are standard questions that are asked of all participants to assess their suitability to participate in the study at this time.

This information is strictly confidential.

How will the data be used?

Your interview data will be anonymised (i.e., any information that can identify you will be removed or changed) and analysed for my research project. This means extracts from your interview may be quoted in my dissertation and in any publications and presentations arising from the research. The demographic data for all of the participants will be compiled into a table and included in my dissertation and in any publications or presentations arising from the research. This information will be processed by the University of the West of England in accordance with the General Data Protection Regulation. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data.
What are the benefits of taking part?

You will get the opportunity to participate in a novel research project on an important social and psychological issue for the suicide bereaved community. You may find it helpful to tell your story to someone who has experience of suicide and may find it helps make sense of what you have experienced.

How do I withdraw from the research?

If you decide you want to withdraw from the research, please contact me via email Susan2.egan@live.ac.uk. Please note that there are certain points beyond which it

will be impossible to withdraw from the research – for instance, when I have submitted my thesis. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data. I'd like to emphasise that participation in this research is voluntary, and you can stop the interview at any point without giving a reason.

Are there any risks involved?

I do not anticipate that talking about suicide will cause any risk to you. However, sometimes talking about events from the past can be distressing and you might like to seek some counselling support after the interviews. For this reason, I have provided information about the different resources, which are available to you below.

Support services

Survivors of Bereavement by Suicide (SOBS) offers local support groups for those affected by suicide, a national helpline: 0300 111 5065, support by email: email.support@uksobs.org or forum: www.uksobs.org

CRUSE Bereavement Care. Specialising in support for those bereaved for any reason, CRUSE offer advice online: www.cruse.org.uk, have a free helpline: 0808 808 1677 and offer free specialist bereavement counselling within the UK.

The Samaritans is a 24 hour listening service providing confidential emotional support to anyone wanting to talk. Telephone: 116 123 (freephone); calls to this helpline number not appear on the phone bills.

If You Care Share Foundation's aims are: prevention, intervention and support after suicide. They offer the opportunity to speak to other people who have life experience around suicide. National helpline, 0191 387 5661, email share@ifucareshare.co.uk and local support in County Durham.
Facebook, Twitter, Instagram pages

The CALM (campaign against living miserably) Helpline offers confidential, anonymous and free support, information and signposting to men anywhere in the UK through their helpline. Telephone: 0800 58 58 58

Website: www.thecalmzone.net
Facebook group

The Silver Line is a friendship and advice for older people and is the only free confidential helpline providing information, friendship and advice to older people. Open 24 hours a day, every day of the year. Telephone: 0800 4 70 80 90
Website: www.thesilverline.org.uk

Big White Wall offers online mental wellbeing support 24/7 where you can share your concerns with others who feel like you. It is a safe, anonymous and has wall guides (counsellors) available 24/7. This service is free to veterans. Website: https://www.bigwhitewall.com/info/keep-safe-on-big-white-wall/#.WOYWKdIrLHY

Improving Access to Psychological Therapies (IAPT) is a free counselling and psychological talking therapies available through the NHS. To find your local service and self-refer visit and enter your postcode: http://www.nhs.uk/Service-Search/Psychological%20therapies%20(IAPT)/LocationSearch/10008
You can also ask your GP to refer you.

If you have any questions about this research please contact my research supervisor: Dr Stella Maile, Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY. Email: Stella.maile@uwe.ac.uk

This research has been approved by the Faculty of Health and Applied Sciences Research Ethics Committee (FREC)

Appendix E: Risk Screening Tool

Risk Screening Tool Prior to Interview

Risk screening assessment tool to be used at time of recruitment to determine suitability for study.

GP: Contact details and address_____

These are taken in case of an increase in risk and notification of the GP is required for clinical support.

Harm to Self

Is there a history of previous harm to self? Including suicide attempts, deliberate self harm (DSH), unintentional self harm, self-neglect or hazardous behaviour?

Yes

No

Thoughts or plans which suggest there is an immediate risk of suicide?

Yes

No

Suffers from a major mental illness?

Yes

No

Current problems with alcohol or substance misuse?

Yes

No

An expression of concern from others about you being at immediate risk of harm?

Yes

No

ACTION PLAN – GP NOTIFICATION.

Appendix F: Participant Consent Form

The stories of those bereaved through suicide

Consent Form

Thank you for agreeing to take part in this research on how dominant cultural stories and psychological aspects influence someone who has been affected by a suicide loss when talking to another suicide bereaved person.

My name is Sue Egan and I am a counselling psychology postgraduate student in the Department of Health and Social Sciences, at the University of the West of England, Bristol. I am collecting this data for my thesis research. This information will be processed by the University of the West of England in accordance with the General Data Protection Regulation. Please see more specific details attached.
If you need to contact me after your interview then my contact details are on your 'Participant Information Sheet', which you get to keep after completing this interview.

My research is supervised by Dr Stella Maile. She can be contacted at the Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY [Tel: (0117) 3281234; Email: Stella.maile@uwe.ac.uk] if you have any queries about the research.
Important points:

Your participation is entirely voluntary.
You are free to refuse to answer any question.
You are free to withdraw at any time. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my thesis. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data. I'd like to emphasise that participation in this research is voluntary, and you can stop the interview at any point without giving a reason. Please read the 'Participant Information' sheet

regarding confidentiality and your participation in this study. By signing this consent form you are agreeing to me contacting your GP in the event of exceptional circumstances of immediate risk to yourself.

You have chosen to be interviewed (please insert location)

……..

Please sign this form to show that you have read this form and the participant information sheet, and you consent to participate in the research:

_____ (Signed)

_____ (Printed)

_____ (Date)

Researcher signature _____

Date _____

Please return the signed copy of this form to me; you will receive a copy of this consent form signed by me.

This research has been approved by the Faculty Research Ethics Committee (FREC)

Attachment: GDPR privacy notice

The personal information collected for the Study will be processed by the University of the West of England in accordance with the General Data Protection Regulation as applied, enacted and amended in UK law. The data controller is the University of the West of England. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used and processed as follows:

a) The data you provide will be collected by the University of the West of England for the purposes of academic research and shall be stored, used, analysed, disseminated and published for these purposes

b) No dissemination or publication of the data you provide shall identify you individually. Your data will be disseminated and published in aggregate form, combined with other study participants although non-aggregated de-identified demographic data relating to you as an individual may be included in such dissemination and publication

c) The data you provide will be stored securely by the University of the West of England on its secure servers and/or in a locked cabinet and shall be kept for a period of 3 years. After this time it will be permanently destroyed or deleted

d) The data you provide will also be held by the survey provider (Qualtrics as a data processor). The University of the West of England has terms in place with this party require such data be held by it in a manner consistent with applicable legislation

In respect of your personal data held by us, you have the following qualified rights to:

i. access it
ii. receive it in a structured machine readable format
iii. rectify it if it is not accurate or complete
iv. erase it
v. restrict its processing
vi. withdrawing any consent provided or otherwise object to its processing
vii. complain to the Information Commissioner's Office (ICO)

To find out more or to exercise any of these rights please contact the University of the West of England's Data Protection Officer.

All personal data is processed in accordance with the applicable UK data protection legislation. The Data Controller is the University of the West of England. For data protection queries, please write to the Data Protection Officer, UWE Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY, or dataprotection@uwe.ac.uk

Appendix G: Participant Debrief Form with Contact Details of Support Services

The stories of those bereaved through suicide

Thank you for your participation in this research, which aims to explore how dominant cultural stories and psychological aspects influence the narratives of someone who has been impacted by a suicide loss.

It can be difficult talking about past events involving significant losses and although I do not anticipate that talking about your loss will cause any risk to you, you might like to seek some psychological support after the interviews. For this reason, I have provided information about the different resources which are available to you below. If you have any questions about this research please contact my research supervisor: Dr Stella Maile, Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY. Email: stella.maile@uwe.ac.uk. Survivors of Bereavement by Suicide (SOBS) offers local support groups for those affected by suicide, a national helpline: 0300 111 5065, support by email: email.support@uksobs.org or forum: www.uksobs.org

- CRUSE Bereavement Care. Specialising in support for those bereaved for any reason, CRUSE offer advice online: www.cruse.org.uk, have a free helpline: 0808 808 1677 and offer free specialist bereavement counselling within the UK.
- The Samaritans is a 24 hour listening service providing confidential emotional support to anyone wanting to talk. Telephone: 116 123 (freephone); calls to this helpline number not appear on the phone bills.
- If You Care Share Foundation's aims are: prevention, intervention and support after suicide. They offer the opportunity to speak to other people who have life experience around suicide. National helpline, 0191 387 5661, email share@ifucareshare.co.uk and local support in County Durham. Facebook, Twitter, Instagram pages

- The CALM (campaign against living miserably) Helpline offers confidential, anonymous and free support, information and signposting to men anywhere in the UK through their helpline. Telephone: 0800 58 58 58
Website: www.thecalmzone.net
Facebook group
- The Silver Line is a friendship and advice for older people and is the only free confidential helpline providing information, friendship and advice to older people. Open 24 hours a day, every day of the year. Telephone: 0800 4 70 80 90
Website: www.thesilverline.org.uk
- Big White Wall offers online mental wellbeing support 24/7 where you can share your concerns with others who feel like you. It is a safe, anonymous and has wall guides (counsellors) available 24/7. This service is free to veterans. Website: https://www.bigwhitewall.com/info/keep-safe-on-big-white-wall/#.WOYWKdIrLHY
- Improving Access to Psychological Therapies (IAPT) is a free counselling and psychological talking therapies available through the NHS. To find your local service and self-refer visit and enter your postcode: http://www.nhs.uk/Service-Search/Psychological%20therapies%20(IAPT)/LocationSearch/10008
- You can also ask your GP to refer you.

This research has been approved by the Faculty of Health and Applied Sciences Research Ethics Committee (FREC)

Appendix H: Examples of Extracts from Journal

19 Jan 2020

People have actually applied! Feel excited, nervous and very happy – starting to feel real. Very quick response to advert – just shows how telling their story is important to this cohort.

22 January 2020

Spoken to 6 group facilitators now. Wow – so nice to speak to others that understand what it is like. So lovely to hear their stories and feel they have used ways of helping others to put something right that was so wrong (like my own story).

Have some dilemmas over which participants to use – can't use all facilitators or their stories will all be similar – also want to get mix of lost family member and how long ago the death occurred. Or maybe it is better to get all that it happened a long time ago to, so can really get a true picture of the grief process and the integration into their life over time?

I have lots of questions and although feels so nice speaking to people, where is my defensive anxiety? DOS feels it is in our relationship together – is it also in my work? How will it appear in my interviews? I can feel it in my passion for the research and my dedication in doing it as well as I can - for the participants and myself. Have told them all that this is really important to me and I want to give myself as much depth as I can to their interviews and the analysis.

4 February 2020

Just listening to Jim's recording and find it fascinating how to read between the lines and where it takes me. Not sure how to do this sensitively to them. Have drafted second interview questions and glad I can run them over with DOS on Thursday.

10 February 2020

Difficult period of time – found out was anaemic, had a breakdown of tears after university lesson on capitalism and went inward for a few days – rejecting any support or help.

Considered how I need to look after myself more and especially my spiritual side.

Felt very poorly and drained for over a week. Jim's story of his son's hanging has stayed in my mind somewhat and I have felt connected to memories of my brother's death more.

18 February 2020

Day after visiting 2nd and 3rd participants.

Felt myself wondering on the way home why I don't connect with healthy memories of my brother as much as his suicide and ill health. Perhaps Chris' story of Kate reminded me that that might be helpful.

Feel a bit brighter today than have done for a while. Have thoughts about yesterday's interviews and reaching out to say thank you but also concerned don't want to step over the researcher mark. Tired from all of the driving, looking forward to seeing them all again.

Appendix I: 'Dubrovnik' Data Panels (taken from a presentation at UWE by Jo Whitehouse-Hart)

1. SELECTION. Researcher selects a SMALL data extract (I page -1.5 ideally)

- *The extract the researcher selects should be something they are struggling with, or that they had a strong emotional response to, irritating phrases, odd repetition, or something that just feels difficult. Usually the researcher instinctively chooses the extract also with a view to something that might have an impact on the interpretation group.*

2. EXTRACT READ ALOUD TO WHOLE GROUP. The group reads the whole transcript aloud with group members reading parts.

- *The key point is NOT TO INTERPRET!! As group members take different parts the whole group takes notes of intonation, tone etc. They look at the language – for instance checking meaning of words (particularly if there are members who speak different languages)*
- *Identify broad themes or cluster passages and include ALL THE DATA in the extract at this point. Don't rule anything out.*

3. MEMBERS OF THE GROUP TAKE TURNS TO SAY SOMETHING ABOUT THEIR IMMEDIATE REACTION. Each group member takes a turn to offer an immediate responses, thoughts and feelings,

- – this made me feel… I wanted the story to… but remember stick with feelings and reactions DO NOT INTERPRET. Note if you feel you want to step in and rescue someone, or if you don't like the interviewee.

4. LINE BY LINE, PHRADE BY PHRASE DETAILED ANALYSIS.

- The group then goes through the text line by line or phrase by phrase in a detailed analysis -vocabulary, hesitations, repetitions, odd word choice – but this is done on a line by line basis – working out what might be going on but not interpreting
- Three questions to guide analysis :
- 1. What is said?- Manifest meaning

- 2. How is it said?
- 3. Why is it said in this particular way?
- Leads to latent meaning and what is excluded, unsaid but present in the text and suggests a ‘scenic’ understanding. This draws on your unconscious imagining yourself in the scene, your feelings if you were the interviewer, interviewee.

5. AN ATTEMPT TO DRAW THINGS TOGETHER.

- At the end of the session – it is possible to make some TENTATIVE SUGGESTIONS, using concepts and theories of what might be going on, which the researcher can then take away and think more about (and in Bion’s terms ‘live with this’ and allow thought to grow from feeling)

Appendix J: Steps of Analysis

1. Write down my assumptions about suicide and put them aside to avoid ignoring assumptions and notice *countertransference*.

With each participant:

2. Transcribe the data.
3. Immerse myself in the transcript whilst considering the *Gestalt*.
4. Do a 'pen portrait' of the participant (this allows a substitute *whole* or *Gestalt* available to the reader, who does not have access to the raw data).
5. Fill in a pro-forma (see Appendix K).
6. Free associate whilst making notes on this participant.
7. Make notes in separate columns of the transcript of my reactions taken from my journal, phenomenological occurrences, narratives deployed and possible theory (see Appendix L). This records descriptive detail.
8. Immerse myself in all of the above and create a table of themes for each participant (see Appendix M).
9. Immerse myself in all of the above and create an initial case study psychosocial interpretation for each participant.
10. Repeat above for each participant. Keep reflective diary at all times.
11. Conduct data panels.
12. Revise individual case studies considering findings from the data panels (Presented in Section 5.1 of main findings).
13. Write my reflective interpretative account (Presented in Section 5.3 of main findings).

Across all data above:

14. Synthesise across all examples: finding any narrative themes which occur (Presented in Section 5.3 of main findings).
15. Create a diagram of emerging themes across the whole *Gestalt* (shown in Subsection 5.3.1)

Consistent with Hollway and Jefferson's model (2000, 2013), I considered four questions during these steps:

- What do we notice?
- Why do we notice what we notice?
- How can we interpret what we notice?
- How can we know that our interpretation is the 'right' one? (Hollway & Jefferson, 2000, p. 55).

These questions are essential whilst keeping the whole of the data set in mind, using reflexivity, making links, and using theory (Hollway & Jefferson, 2000).

Appendix K: Step 2 of Analysis

Example of Pro-Forma adapted from Hollway & Jefferson (2013)

Details removed for confidentiality reasons.

ANGELA

Our relationship – THIS IS BUSINESS

Participant number: 3

Location Home: South

Age:

Sex:

Race:

Employment:

Marital Status (history):

Family (history):

Children/grandchildren: Pregnant

Health (history):

Suicide loss in brief (relationship, age at loss, time since loss):

Appendix L: Step 3 of Analysis

Preliminary Analysis Table

Each story was transcribed into a table shown below, read and re-read several times until a high degree of familiarity with the text was obtained. Following this, notes were taken from my reflective journal and were inputted into column ‘Reflective Notes’. I re-read the accounts again and began to make preliminary interpretations in column 4 and 5 of narratives used and my hunches of possible themes. This ensured a data led analysis.

PRELIMINARY ANALYSIS TABLE

Time	Time Stamp	Researcher	1st participant	Reflective notes	Narratives deployed/themes	Possible theory

Appendix M: Step 4 of Analysis

Example of Emerging Themes Table

I worked on one case interpretation at a time. For example, I took Jim's case study and used the preliminary table (Appendix L), my journal and the data panel transcript to map out emerging themes that were arising from the interpretation. This informed the initial interpretation for each case as shown below. This enabled a data led analysis to continue with emerging themes.

Original table of emerging themes per participant when taken as a case in itself.

Jim

The Narrative	Emerging themes	Evidence
Very descriptive	Who am I? Subjectivity of self – analytical. Meaning-making. Business-like.	His analytical description of stories. Attempting to make meaning. My imagination of him working it all out. He found new insights during our conversation. Data panel confirmation.
Reflective – making meaning	Making-meaning. Analytical. Counselling training/Support Group healing narrative.	New insights from telling his story. Evidence found in his descriptions of events.
Painful story	The story is painful to analyse during the meaning-making process.	Metaphor's used. Jim's tears once he worked out that Sam had been kind with the way he killed himself. My pain (projection) hearing the analytical story of the way Sam killed himself.

Tried to get on with life – got angry	Containment from wife to get help Denial – Get on with it	Carried on with work until got angry with daughter and wife intervened. Wife was not the mum of Sam, so Jim said she offered him a place to grieve without being in too much grief herself.
Looked for help	Felt responsibility for bereavement counsellor	"there is no point in having someone supporting you or counselling you if you feel you've got to protect them from how you're feeling"
No specific services available	Specific support is necessary	Know from his story about the bereavement counsellor. My hopeless feelings around readily available specific support.
Started SOBS support group	Wounded healer. Investment in suicide construct. Healing narrative.	Know from his story. I sensed it just had to be done.
Undertook counselling training	Developed emotional self and ability to be reflexive. Invested in suicide construct to enable his identity to integrate the painful suicide into his subjectivity of self. Transformative growth. Healing Narrative.	His reflexive story. Reminded me of my own journey helping others in order to make sense of the pain and the shift in his identity. I feel lifted and hope again when he describes how the counselling training helped him.
'The Good Suicide'	Containment from the groups. 'Live out Loud.' Pain to Purpose. Reflexivity supports transformative growth. Wife's containment supported his growth. Defensive function because couldn't make full meaning.	His narrative kept comparing his story to others. He kept comparing his story to others – his story had been a 'good one' due to his support from his wife and his financial freedom to have the time to start a support group. Positive narrative.

		He said hearing other's stories have helped him. He feels he wouldn't be the person he is today if Sam hadn't died by suicide.
SUMMARY OF RESEARCH RELATIONSHIP	**EMERGING THEMES**	**EVIDENCE**
Intersubjectivity – Our 'easy' research relationship	Personal Growth when contained.	Shared subjectivity of counselling and reflexivity. Projection of it being 'easy' analysing his story. Strong relationship. Reflexivity used in his storytelling.
Relationship to suicide	Making-meaning. Investment in suicide construct. Positive – He had a 'good suicide.'	See above

Appendix N: Step 5 of Analysis

Case by Case Analysis

Again one case at a time, I immersed myself in each story for weeks at a time – allowing my conscious and unconscious processing to happen whilst immersed. Alongside all of the above information Appendices J through Q, the data panel recording, the literature review and my journal, I wrote a full case analysis for each participant as presented in the main findings (Section 5.1) before I moved onto the next participant.

These case studies and my own reflexive account were then formed into a themed account across the whole data set, whilst incorporating the findings from the literature review. This interpretative account is presented in the main findings.

Appendix O: Key to Analysis

Journal = an extract from my journal

DP = an extract from the data panel conversation (followed by the number of the data panel participant or my name for my contributions)

Interview = an extract from the interview transcript (followed by identification of the interview number and the time stamp)

- = additional text was present in original

… = a slight pause in speech

[ ] = my words within quotes

Appendix P: Summary of Thesis

Word Count: 5,524

Introduction

A reported 5,691 people died by suicide in England and Wales in 2019 (Office for National Statistics, 2021). It is difficult to discern how many people are impacted by each of these deaths, however, recent estimates report it can be up to 135 individuals (Cerel et al., 2019). Of particular concern, is the finding from a study in the United Kingdom (UK) that showed family and friends bereaved by suicide are more likely to attempt suicide than those bereaved by sudden natural causes (Pitman et al., 2014). The British Psychological Society's (BPS) *Position Statement on Understanding and Preventing Suicide* (2016) acknowledged the need for further research into the effects of suicide on vulnerable others and how professionals can support them.

This study explores the defensive use of narratives using theories and tools from psychoanalysis in order to identify key themes across a group of suicide-loss survivors. For example, the analysis included a consideration of transferential material and the potential meaning of these. Sometimes my responses felt overwhelming and physical and the use of psychodynamic theories, which I explored in supervision, was useful.

Social Constructs of Suicide

Dominant social constructs may influence how a person reacts when suicide happens to someone they love and practitioners supporting them. In the Middle

Ages, society had rules to follow during the rise of the Christian church. Suicide was seen as self-slaughter and a crime. Outspoken challenges to the belief that voluntary death was a crime developed within literature throughout the 18th and 19th centuries. Intellectuals (such as Shakespeare) used characters in plays to challenge laws and reassess the customs they knew with a critical eye. Outside of literature, the first theory about suicide was put forward by in 1897 by French academic, Emile Durkheim. His theoretical work led to the study of suicide by sociologists, psychologists, psychoanalysts, and physicians (Barbagli, 2015). For Durkheim, suicide rates were related to social trends and reflected the shifting structures and values of society. This shift in thinking showed that suicide could be viewed through different lenses. Investigation into the various lenses led to the development of suicidology in the 19th century (Marsh, 2016).

Suicidology is the scientific study of suicidal behaviour (AAS, 2020a), first developed by psychologists, sociologists, and psychiatrists in the 1800s. Such research has tried to identify the genetic, biological, psychological, physiological, personality characteristics, or social factors that influence suicidal behaviour (Marsh, 2016). The discourses around the causes and complexity of suicide may significantly impact how suicide is considered as a public and policy issue. For example, a social research project published by the Department of Health and Social Care (DHSC) and supported by the Institute of Psychiatry investigated the economic case of mental health (Knapp et al., 2011). Based on their findings, the DHSC claimed that, based on the economy in 2009, each suicide cost the UK £1,450,000.00 (Bonin & McDaid, 2011). Discourses such as these can reduce suicide prevention to

screening for risk, managing risk and providing the right intervention to minimise the global suicide rate (Marsh, 2016).

Outside of medical discourse, since the 1980s mental health and suicide has caught the attention of the world on social media and the mainstream news, leading to the creation of charities and groups designed to support those struggling with mental health and suicidal ideation, and address the lingering cultural stigma. Although the reification to suicide as a preventable risk is being challenged, suicidology constructs and medical discourse will no doubt affect the social constructs and narratives of suicide bereavement.

Reviewing the Literature

Within the past decade, suicide bereavement research has largely been conducted in the United States (US) and the UK and has been practitioner-driven, focussing on understanding the differences and nuances of suicide grief and how to provide appropriate postvention support.

Suicide bereavement and suicide prevention are often discursively linked. For example, the DHSC's cross-government prevention plan, published in January 2019, aims to ensure every health service across the UK has a zero-suicide ambition plan for inpatients. Avon and Wiltshire NHS have recently published their zero-suicide ambition (NHS, 2020a). They have one helpful leaflet for survivors of suicide. It is entitled "support following suicide" and is buried within the Suicidal Feelings webpage (NHS, 2020b). This feels a confusing way to access support after suicide. On your journey through the website, there are headlines such as "Our suicide Prevention Strategy" and "Zero Suicide Ambition." When someone has already been

bereaved by suicide and could not prevent their loved one's death, this pathway could possibly impact on the stigma, guilt, responsibility and blame which has been found throughout suicide grief research.

Social acceptance of death by suicide is less likely than other traumatic deaths (Pitman et al., 2016), as confirmed throughout qualitative research and literature investigating the lived stories of survivors (e.g. Evans & Abrahamson, 2020). Blame, shame, taking responsibility for the death and others discomfort, and guilt have been noted throughout research and are integral to internalised stigma defences (Peters et al, 2016). These feelings often lead to survivors concealing the cause of death (Sveen & Walby, 2008) and unable to share their stories, which complicates their grieving process (Peters et al., 2016).

Since the 1980s, there have been numerous autobiographical books written by *suicide-loss survivors*, such as: *No Time to Say Goodbye* (Fine, 2002). These published stories give a glimpse into the experiences of loss. Many of these authors, after publication, were approached by people who wanted further help with their grief, which led to the authors sharing their experiences at conferences and events. It would appear they needed to 'live out loud' following their grief in order to heal and grow.

There is a growing body of research into posttraumatic growth (PTG) in terms of suicide grief (e.g. Levi-Belz, 2015). PTG is defined as positive growth that comes from a stressful, traumatic event (Tedeschi & Calhoun, 2004). Levi-Belz (2019) conducted an 18-month longitudinal study of 156 suicide-loss survivors in order to investigate the interpersonal factors relevant to growth after suicide, rather than the adverse effects many find. The study found belongingness, self-disclosure and social

support were significantly important factors in facilitating PTG (Levi-Belz, 2019). All suggesting that having others to share their stories with was vital due to the impact it can have on the meaning-making process. Although McIntosh and Jordan (2014) argued that the need to make meaning of the death of a suicide is no different than other traumatic deaths, the benefits of a narrative approach to integrate the violent death of a loved one (by accident, homicide, or suicide) is associated with a more favourable bereavement outcome (Groos & Shakespeare-Finch, 2013). Researchers have suggested this is because "traumatic events and losses can shatter a person's assumptive world – the network of cognitive schemas that bear on the benevolence and meaningfulness of the world and the worthiness of the self" (Janoff-Bulman, 1989 as cited by Gillies & Neimeyer, 2006, p. 34).

Much of suicide bereavement research to date has been conducted assuming all survivors can adequately share all aspects of their experience. There remains a question of how people manage the more subliminal aspects of shame and guilt, which are harder to talk about. Narrative inquiry, when situated in psychosocial principles, can attend to the stories that are in the cultural realm (as a way of understanding a subject) and the stories people tell about their own experiences (Andrews et al., 2000).

This Study

Scholars who subscribe to the narrative school of thought have suggested that the desire and ability to tell stories is an innate part of being human (Atkinson, 1998). With an ongoing narrative of our self, we can predict and understand our lives; with an ongoing narrative of society, we can know how to behave within it. To

create our subjectivity of self we look to constructs that support our sense of unity whilst knowing we can be anything we choose to be in any given moment. Psychosocial studies have attempted to avoid the polarised positions of society and the individual when understanding the subjective human experience (Clarke & Hoggett, 2009). It is essential to consider narrative inquiry from a psychosocial position in order to overcome both social reductionism (reducing psychology to the social) and biological reductionism (reducing psychology to a physical level), a condition often critiqued in purely narrative investigations. This requires us to explore the dynamic psyche that makes up the subjectivity of self, which often unconsciously, impacts our thoughts, feelings and behaviour.

Hollway and Jefferson (2013) emphasised the role of anxiety in the research relationship. They suggested both the researcher and participant may have uncomfortable feelings during the process, which makes for both a defended participant and defended researcher. That is, they both have inner defences that protect them from feelings that may be too difficult to bear. This study draws on psychodynamic techniques in order to interpret these positions. For example, by recognising the phenomenological sensations I experienced during the research process, I can understand the hidden nuances of the stories told when using psychodynamic techniques such as transference and projection.

Transference is traditionally understood as the re-experiencing of early or transformative intra (and inter) psychic conflicts within the therapeutic relationship (Cabaniss et al., 2016). Transference can be communicated in numerous ways: from direct communication of conscious feelings and behaviours to re-enactments of

previous relationships (Grant & Crawley, 2002). This study is interested in the symbolism of what is transferred – that is the metaphors, stories or descriptions of events – within the research relationship. This interpretation is possible because of the understanding that transference and projection provide a reflection of the internal subjectivity of self. Projection is caused by transference (Grant & Crawley, 2002) and is the disowned aspects of the self that are split off and put onto or (more forcefully in the case of projective identification [PI]) put into (transferred) onto another person. In the clinical setting, there is an unconscious hope that the therapist will be able to bear, understand and give meaning to these otherwise unbearable feelings. My role as a researcher is different but nevertheless requires similar capacities to hear, feel, bear and understand what is, especially in the case of suicide bereavement, usually so unbearably painful.

Winnicot's concepts of holding (Winnicot, 1960) and Bion's theory of container/contained (Bion,1962) have often been used interchangeably in psychoanalytic literature (Ogden, 2004) and are therefore essential to define. This study refers to holding and containment relative to suicide loss, including: (a) where the holding environment can be provided (such as the relationships with other suicide-loss survivors) and (b) where containment can be achieved (such as the research itself where I processed more of my loss) and (c) where the mental container necessary for processing the loss has been affected and may be achieved (via many different forms of containment). The following section will show how mental containment may be affected by the strong historical context of suicide (a culturally specific construct held within the language, social discourses, and

behaviours of those around us) that will affect the type of holding environment and containers needed to process and integrate a loss by suicide into our subjectivity of self.

Methodolodgy

This study uses free associative narrative inquiry (FANI) in order to investigate defended subjects (Hollway and Jefferson, 2013). A crucial aspect of using FANI is a belief in researcher reflexivity, and as such the free association technique applies to both the defended subject of the participant and the defended subject of the researcher. Reflexivity and self-scrutiny are central to consider conscious and unconscious processes present for both the participant and researcher, also the dynamic they create. I achieved this by regularly using a reflective journal, supervision with two directors of studies (the first, a psychotherapist and member of the Psychoanalytic Council and the second, a qualified Counselling Psychologist), a recording of the interviews and data panels - all important parts of my data Gestalt.

The Gestalt principle is that the whole is greater than the sum of its parts. My use of Gestalt relates to the data set I used to develop a full understanding of my research topic. The data set included my memories of the meetings, the reflective journal, the data panel's observations, notes from the interviews, audio recordings and transcriptions from two interviews (totalling eight interviews). Data panels consist of a group of professionals interested in psychosocial and psychodynamic principles; who can provide different perspectives to uncover a researchers' unconscious blind spots or defences (Hollway & Volmerg, 2010). The data panels are a very important

aspect of working within the whole data set available when using FANI as a research tool. Particularly due to my positioning as an insider to the subject under scrutiny (Yardley, 2000) - having lost my brother to suicide in 2015. As Groos and Shakespeare-Finch (2013) argued, suicide-loss survivors feel more secure around those who have experienced suicide themselves. As such, this position enabled me to not only hear stories with emotional depth but also reduce the hierarchical power that can exist in the dynamic between interviewer and participant (Ellis, 2004).

Ethical Considerations

The research project was approved by the Ethics Committee of the Graduate School of the University of the West of England and adheres to the British Psychological Society Code of Practice. Participants were offered written and verbal information relating to the study. Following a decision to participate, written consent was gained from each individual. Confidentiality of participants was guaranteed with any identifying information being changed accordingly. Within this paper pseudonyms with regard to names and places were used.

Given that the sensitive nature of the topic and talking about past events could increase the potential for participants to experience psychological distress (Archard, 2020), I screened participants during an initial telephone conversation in which I gathered a brief history of their mental health and built rapport. This initial conversation helped me to determine whether their participation posed any risk to their mental health using a risk screening tool. As such I only included participants who self-defined as having already processed the death of their loved one.

Data Collection and Analysis

Adapted FANI was the most appropriate way to collect data for this study. The first interview used the life story method to open the consciously constructed story upheld by conventions of storytelling (Hollway & Jefferson, 2000). This was necessary to hear what narratives people used to defend against anxiety and to constitute their subjectivity (Archard, 2020). I asked participants to tell me their story about losing their loved one to suicide and I did not interject. After this first interview, I hypothesised the participants' unconscious processes by paying close attention to my feelings and any: contradictions, avoidances, inconsistencies, and changes of emotional tone. By following up with the reflective journal, I was able to highlight any countertransference, projection or transference I may have felt during the interview. I then used this information to produce questions for and during the second interview, where I followed emergent themes from the first interview.

The second interview used the free association method, which allowed access to the unconscious. Because this method assumes the participant and I are not always aware of or understand their own actions, feelings, and motivations, I was able to test my original hypotheses at the second interview. By questioning to clarify and gain further evidence, I checked on initial hunches and provisional hypotheses whilst giving the participants time to reflect (Hollway & Jefferson, 2000). I analysed out of the data after conducting the interviews, rather than offering in-depth analysis during the interviews themselves.

Although data production was based on free association, data analysis was based on psychosocial interpretation. There are no clear guidelines for conducting analysis with the FANI method. Hence, I broadly adhered to Hollway and Jefferson's

guidelines (2000, 2013), whist being open to interpretative accounts that emerged from the data based on a wide range of psychodynamic theories (e.g., containment, object relations and defences against anxiety) alongside socially constructed narratives – especially how these narratives are constitutive of their subjectivity of their selves when faced with suicide.

Recruitment, Sample and Participants

I used purposive sampling to recruit participants from a UK suicide bereavement support group network.

Table 1

Demographic Table

Participant	**Age**	**Ethnicity**	**Location**	**Relationship to deceased**	**Time since death**
Jim	63	White British	Wales	Father of Son	14 years
Chris	61	White British	Southeast England	Husband of Wife	2 years
Angela	43	White British	Southeast England	Daughter of Father	35 years
Macy	52	White British	Southwest England	Sister of Brother	8 years

Findings

The shared experiences from the Gestalt of the data set included one overarching theme, transforming pain into purpose, and three subthemes: (a) who am I? (b) the suicide construct – ours to own, (c) the healer narrative, holding and containment.

Who am I?

One integral theme across the cohort confirmed that suicide loss shook the survivor's assumptive worlds (Neimeyer et al., 2006) and highlighted the cognitive destabilisation of violent loss (Clark & Goldney, 2000). I found participants' identities were interwoven with their loved one and the suicide act, and after the suicide loss they had to rebuild their subjectivity of self – in other words, "who am I?" (Chris, Interview 2, 72). Angela described how much her father's suicide had affected her identity:

> [Suicide is] such an integral part of my story. That, yeah, like it's kind of, it really is who I am – I am, in so many ways – not a by-product of it but like, how I am so shaped by, not just the experience of suicide itself but then all the things that have come after. (Angela, Interview 2, 109)

Similarly, in Macy's case, her assumptive world broke down after her brother's death. Her caring-self broke down when she realised she had not been able to prevent Jack's death. She worked like a "mad thing" (Macy, Interview 1, 81) until that too fell apart and left her struggling to find a way to reconcile her identity with her brother's suicide. The dramatic, heavy language she used in her story made me and the data panel feel hopeless:

> I was bonkers, you know, absolutely bonkers and distraught in that first year definitely. Like completely off the Richter scale bonkers, you know, it's visceral, my trauma was just all over me. (Interview 2, 29)

Because her brother's suicide is hard to live with, Macy's investment in the suicide construct is still very painful and needs to be projected out. Across the sample, the

death of loved ones had become a part of who they were; in the context of cognitive destabilisation, it is evident how much painful effort it takes to integrate a suicide loss into a person's own subjectivity of self and provide the existential reconstruction needed.

The Suicide Construct: Ours to Own

All four participants had a meaning-making narrative, which I commented on in my journal during analysis:

> All of the stories spent over half the time of the first interview explaining why their loved one had done what they had done – they barely spoke about how they managed the bereavement. (Journal, 20/12/20)

The participants' stories were dominated by an explanation of why their loved ones had taken their own lives. This impulse indicates a kind of ownership:

> I feel like my dad's suicide is kind of mine, to own in a way. (Angela, Interview 2, 122)

Overall, the participants had to get to know suicide. Jim and Macy both invested in the suicide construct by leading SOBS groups and Jim completed counselling training to support other suicide loss survivors. All had to find significant ways to develop a relationship with suicide.

Identification is an integral component of grieving and after suicide loss is clearly complicated. For example, Angela's story illustrates how she both loved her father and felt he had been disruptive in the family home. Losing him at such a young age without emotional support to mourn, she defensively identified with him by doing activities he enjoyed (e.g. sailing) and was unable to mourn until she

recognised this melancholia and went on a long meditation retreat in order to make sense of who she was.

Klein suggested one form of manic defence was to control and obliterate any awareness of separateness, denying it has a life of its own (Klein, 1940) - that is, you have all the capabilities of the lost object so there is no need to deny it exists within your sense of self. This would explain the adoption of the suicide narrative and the development of a strong relationship with suicide - weakening the ego through the love/hate relationship with the internalised object so self-recrimination and self-hate ensued, adding to the felt responsibility, guilt and shame felt. Chris's anticipatory grief highlights this process well. Chris appeared to mourn after his wife's suicide because he had spent a long time in the melancholic position during the difficulties with her mental health. Because he did not have to introject 'suicide' into his identity once she had physically gone, he was able to slowly let-go of his wife without the pressure of suicide being something he had to continue to live with – he had done that whilst she was alive: "She wasn't the person, you know, that she used to be by a long way" (Interview 1, 39). "I couldn't see a way for her to get back to, I won't say normal but to usual, to, to the way she was" (Interview 2, 80).

This analysis has highlighted regular fluctuations between reflexivity, rational thinking, manic defences and defence mechanisms and in order to heal from the experience of suicide, as in my own story, we had to use safe ways to mourn and feel our grief whilst separating the act of suicide from our sense of

self – but only when we had mental containment or some other way to be held or contained in order to do so.

The Healer Narrative, Holding and Containment

Peters et al., 2016 found suicide-loss survivors can feel other people's discomfort when sharing their story. Jim felt he had to "protect" (Interview 1, 44) a bereavement counsellor:

> There is no point in having someone supporting you or counselling you if you feel you've got to protect them from how you're feeling. (Jim, Interview 1, 44)

The experiences of the data panel after hearing the stories may highlight why we take on this responsibility:

> DP1: [sigh] "Got really impacted by that one."
>
> DP2: "Yeah I just feel really sad for the mum. I was just like, She's really kind of, lost it hasn't she – she is lost in the world now isn't she. And similar age to me again – not that I'm 60 but… you know. Horrible."

This highlights how data panel member 2 felt she could relate to the age of the mother. This was found at other times in the data panel: relatability of the experiences was high. The hearing of stories also had a significant impact on the data panels thought processes:

> DP4: "It's really heavy. I found it really… I struggled to read it. Part of my brain refused to engage with it (DP: 49.36).

These data panel extracts illustrate the response people have to suicide stories and why the heaviness of the topic can leave suicide-loss survivors feeling the burden of

responsibility: reluctant to share their stories without the support or containment they need.

The wounded healer archetype (Jung, 1954) and healing narrative was present in three of the stories as well as my own reflexive account. Macy, Jim, and Angela found a way to be around others who have experienced suicide, which made it easier to share and heal from their stories. Chris's story did not contain the wounded healer (Jung, 1954) element, possibly because of anticipatory grief, which helped him to come to terms with losing Kate before her suicide.

The wounded healer archetype defensively impels some to help others because of their own immense pain. But when they do so, the identity of healer and wounded may split and the powerful healer may be identified within. in order to integrate the wounded and the healer, they must process their own pain whilst they support others, or their own pain and identity as wounded will be repressed and the other person may become the patient, needing fixing. This suggests that the capacity to hold the heavy pain of existential qualities of suicide grief can be obtained when the healer is reflective of their narrative constructions of suicide and grief. This was confirmed by Jim's account of personal growth as he integrated counselling training whilst working with support groups and my own account of healing during this research. Overall, this research has shown my transparency within the research relationship, gave me and my participants the capacity to hold space for each other and some of us gained some personal growth in the process. The wounded healer journey for suicide-loss survivors does not come without pain because we can be constantly activated by the anxiety we are defending against (Farber, 2017a). This

triggering process appears to also be a part of the healing process and allows survivors to integrate discrepancies of the experience in their own sense of self without projecting it outward or repressing it. These findings suggest that the wounded healer is a defensive position someone may adopt in order to work through melancholy. Due to the lack of appropriate support and feeling the burden of suicide within our identities, all but Chris were impelled to support others who had lost to suicide. The position of healer gave us permission to 'live out loud' and mourn – it gave us permission to feel our grief and be held by others whilst we processed it.

Concluding Theme: Transforming Pain into Purpose

Having a purpose after suicide loss offers containment and helped the participants to reconstruct their loss within their own assumptive worlds (Feigelman et al., 2009). For example, Chris honours his wife's mental health problems and her suicide by managing his own mental health:

> So I felt, well if she's done that - you know, to ease her own pain but also to, to, to relieve us of her suffering as well. Then the only true way to, to make value of that is - to honour her life and to be positive about her life and about her leaving and, and, to live my own. (Chris, Interview 2, 81)

Similarly, Jim feels his purpose (Jim, Interview 2, 92) has come from becoming a better person.

> It's been a massively constructive thing for me. I don't mean I'm glad he died - but I do think my life is better because he died…I'm more satisfied with who I am. (Jim, Interview 1, 54)

After Jim could not find appropriate support, he started his own suicide support group and reconstructed his own identity to one with more purpose. From a psychosocial perspective, this is likely to be because of his business-like personality and the containment he received from his wife that allowed him to make meaning of his son's death reflectively within a supportive group environment and training as a counsellor. However, helping for over ten years in support groups and bereavement counselling wasn't enough for it to be completely processed on an emotional level:

> I found that telling my story again. Which I've done many times. But probably not in a sort of, counselling environment where someone was really paying attention to me. When I tell it, I'm using telling it to a group. And it's often to sort of illustrate something, or to help them with something. Erm, whereas I actually did just tell it for myself the other day and erm, since then I've been more tearful. (Interview 2, 1)

My relationships with the participants demonstrated how shared experience can offer us informal holding and containment. Moving from pain to purpose is a helpful way to assimilate suicide into our life story, but the process is vulnerable and requires holding and containment to be able to reflect on our own feelings and succeed.

Discussion

These findings suggest mental health and suicide constructs affect how someone experiences suicide loss and their subjective sense of self. NHS suicide bereavement support is embedded within suicidology and suicide prevention discourse, which appears to add to the feelings of guilt felt by those bereaved.

The main theme of transforming pain into purpose, illustrates how the suicide-loss survivors were able to find formal and informal holding and containment (or support), for their complicated, heavy grief. To feel safe enough to process their grief, they found holding and containment through helping others within research, fundraising, and support groups whilst developing a relationship with suicide. My findings confirmed Bion's argument that containment is multi-layered. We all received containment in different ways depending on our unique biographies and the support easily accessible to us, and by creating our own purpose. Support is not always readily available and, as shown in this research, people have had to 'live out loud' in various ways to find their own support. Many who lose to suicide may go on to help others in their search for their own containment and support must include various options to understand suicide. Including support from other suicide-loss survivors and support to engage in telling their story, fundraising or campaigns when and if they are ready to do so. Containment is a dyadic process that needs to be considered when offering support to others. Those who oversee support groups need to be fully supported, where they can process and reflect on their own emotions, alongside the ones in the support group. Furthermore, professionals who go on to help others with suicide grief need to be specifically trained and supported fully through specialist supervision.

The findings from this research show defensive attitudes towards death and suicide may impact a health professional's relationship with someone bereaved through suicide. Health professionals must be prepared for the heavy effects of suicide grief to be projected into us during therapy and have adequate supervision.

Such specialist supervision is needed to provide the practitioner a container to reflect on any defensive attitudes towards death and suicide, and how they may be impacted by a client who is bringing the heavy story of suicide. Seeking support from professionals is hard for suicide-loss survivors (Wilson & Marshall, 2010) for reasons not fully known. This research offers one explanation: survivors may not feel as comfortable sharing their story with people who have not experienced this type of loss due to the evidence of the data panels: suicide grief is heavy, complex, relatable, difficult to mentally contain and may mean they take responsibility for the feelings of those they are sharing their story with.

Limitations of Research

While the present study provides a wealth of rich and detailed information, it is not without limitations. Firstly, the cohort was recruited through a support group network so it is likely they were those who had found containment through support groups. Secondly, there is a lack of inclusion of diverse ethnic and social classes due to homogenous enrolments of White, middle-class individuals. All participants were White, middle-class and living in the South of England/Wales. Social class will have an impact on stigma and availability of support.

Conclusion and Clinical Implications

This research has combined the situated accounts of narrative inquiry with psychosocial considerations of the complex psychological dynamics in the research relationship. The findings encourage health professionals, as both supervisee and supervisor, to deconstruct the historical medicalisation of suicide and suicide bereavement and consider how they may be affected when working with someone

bereaved through suicide. With the complexity of suicide grief, different levels of informal and formal holding and containment is needed long term as part of a well-integrated system of support.

This research has shown why suicide loss survivors are psychologically held by others who have lost to suicide due to historical discourses of shame and stigma surrounding suicide, which may impact how they are able to seek support and how easy it is to share their grief with others. Practitioners must provide opportunities for suicide-loss survivors to share their story in a safe way; however, they must also be proactively supported throughout this process. Anyone working with suicide grief needs to be adequately supervised with specialist formal supervision to ensure unconscious projections and transferences are processed safely. Specialist supervision is particularly important because many health professionals can enter the profession after their own trauma (Farber 2017b). Particularly after a suicide loss, where, illustrated by the main theme of this research, those who lose to suicide often go on to help others. As such, I argue specialist supervision training needs to be provided to supervisors working with suicide grief to be prepared to contain their supervisees.

Finally, we must be aware of the discourses within society on mental health, suicide, and suicide prevention. Practitioners must continue to deconstruct the social and historical stigma around suicide and suicide loss. One way to do so would be to offer specialist suicide grief services away from the rhetoric of suicide prevention, another would be changing the discourses through NHS services that are implicated by social policy and the medicalisation practices of postmodern society.