Title: Exploring Mental Health Nurses’ Experiences of a Patient Suicide in The Community

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EXPLORING MENTAL HEALTH NURSES’ EXPERIENCES OF A PATIENT SUICIDE IN THE COMMUNITY

by

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Ph.D.

A thesis submitted to the University of Bedfordshire, in fulfilment of the requirements for the degree of Doctor of Philosophy

May 2021
Exploring Mental Health Nurses’ Experiences of a Patient Suicide in The Community

Abstract

Aim:
The aim of this study was to explore the experiences of mental health nurses after a patient dies by suicide in a community setting within the context of UK mental health services.

Method:
It utilised the principles of Interpretative Phenomenological Analysis (IPA) to explore the experiences of ten community mental health nurses who had experienced a patient suicide between 2002 and 2018. The study was divided into two main types of fieldwork, a pilot study and a main study. Using IPA, the ten interviews were analysed descriptively, conceptually and linguistically, which produced rich narratives reflecting their lived experience of patient suicide.

Findings:
Findings from this study produced three superordinate themes which capture mental health nurses’ experiences after a patient suicide: The experiential significance of a therapeutic relationship ending unexpectedly for the mental health nurse; searching for meaning of the patient suicide in the face of public scrutiny; and, after the suicide, the experience of intense grieving, learning, growing and moving on. Their stories revealed that the experience of suicide-loss survivorship as a community mental health nurse creates conflict as well as ongoing tensions between existentialism and personal ontologies. The implications of the findings suggest that although the memory of the patient who has died by suicide never leaves their psychological caseload, the community mental health nurse can be secure in knowing that they fully lived up to their part in the therapeutic nurse-patient relationship.
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Academic Thesis: Declaration of Authorship

I, Melsina Makaza, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

- This work was done wholly or mainly while in candidature for a research degree at the University of Bedfordshire;
- Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- Where I have drawn on or cited the published work of others, this is always clearly attributed;
- Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- Where the thesis or any part of it is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- None of this work has been published before submission.

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Date: 12th May 2021
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List of acronyms and abbreviations

AAS  American Association of Suicidology
A&E  Accident and Emergency Department
APA  American Psychological Association
CMHT Community Mental Health Team
CRHT Crisis Resolution and Home Treatment Teams
DH  Department of Health in England
HEI  Higher Education Institution
GP  General Practitioner
IASP  International Association of Suicide Prevention
IEoS  Impact of Event Scale
IEoS-R Impact of Event Scale Revised
IPA  Interpretative Phenomenological Analysis
NHS  National Health Service in the United Kingdom
NMC  Nursing and Midwifery Council of the United Kingdom
NCISH  National Confidential Inquiry in the Suicides & Homicides by People with Mental Illness
NCISSMH The National Confidential Inquiry into Suicide & Safety in Mental Health
ONS  Office for National Statistics
PHE  Public Health England
UK  United Kingdom
UKCC  United Kingdom Central Council for Nursing Midwifery & Health Visiting
WHO  World Health Organisation
Chapter 1 ‘I’m sorry but the patient that you were working with has died by suicide.’

1.1. Introduction

On an annual basis, global statistics provided by the World Health Organisation (WHO) suggest that some 800,000 people die by suicide and it is estimated that, for each suicide, there are 20 suicide attempts (WHO, 2019). This means that, in the general population, suicide is the third leading cause of premature death in people aged between 15 and 44, making the prevention of suicide a global imperative (WHO, 2014a). In Europe, approximately 124,000 people die by suicide each year, with almost 80 per cent being men, which makes the average suicide prevalence rate 13.9 per 100 000 (WHO, 2014b). In the United Kingdom (UK), in 2015 the Office for National Statistics (ONS) registered some 4,820 suicides in England. This number of suicide deaths represents a suicide rate of 10.1 per 100,000 people. Overall, males made up 75 per cent of reported suicides in England, which makes men a significantly higher suicide risk compared with women (ONS, 2016). Collectively, global statistics show that one person dies by suicide every 40 seconds. Consequently, every 40 seconds there are people who have been affected by suicide and have to find ways of coping with the aftermath (WHO, 2019). Premature death by suicide is a complex and perplexing issue for those left behind. After a person has died by suicide, the bereaved may view the suicide as a perplexing, preventable death (Joiner, 2005; Jordan & McIntosh, 2011; De Leo & Postuvan, 2017).

Suicide statistics have prompted researchers to try to make sense of what happens to the people that are affected by or left behind after the suicide (Shniedman, 1996; Sween & Walby, 2008; Pompili et al., 2013). Understandably, some primary research studies have tended to focus on the consequences that a suicide may have on surviving family members, relatives,
friends and significant others (Fielden, 2003; Cerel et al., 2008; Jacob, 2008; Jordan & MacIntosh, 2011; Peters et al., 2016a; Peters et al., 2016b) whilst other research studies have investigated the effects of a suicide on people who were supporting somebody who was experiencing distress as a consequence of severe and enduring mental illness (Jacob, 2008; Sveen & Walby, 2008; Gaffney & Hannigan, 2010; Cerel, 2014). Research conducted by Hawton & van Heering (2009); Barker (2011) and Jones et al., (2012) confirms that it is common for people who have been clinically diagnosed with mental health problems to experience intense distress, to engage in suicide acts and therefore present with increased suicide risk, which sometimes culminates in death by suicide (Goldney, 2013; De Leo & Postuvan, 2017).

Whilst these studies have shown that suicide as a consequence of distressing mental illness is tragic, upsetting, and traumatic for family members left behind, (Gaffney & Hannigan, 2010; Peters at al, 2016a; Peters et al., 2016b) recent research has also shown that there are cognitive, behavioural, and emotional effects on mental health professionals\(^1\) after a patient who they have been caring for dies by suicide. At this point, it is important to acknowledge that not all people experiencing suicide thoughts and behaviours will experience mental illness but that people who experience mental illness are at an increased risk of experiencing suicide thoughts and behaviours during their course of treatment. Therefore, mental health professionals are keenly interested in researching the link between the experience of mental distress and the experience suicide thoughts and behaviours in their patients and how the death of a patient by suicide can affect mental health professionals who have cared for the deceased patient (Goldney, 2013; De Leo & Postuvan, 2017).

\(^1\) For this thesis, the term mental health professionals refers to psychiatrists, psychiatry trainees, psychologists, psychology trainees, registered mental health nurses, social workers, support workers and health care assistants.
Since the link between suicide and mental distress is well-established in clinical practice, as well as in evidence-based research (Goldney, 2013; De Leo & Postuvan, 2017), particularly as a consequence of the experience of affective disorders, psychotic illness, and alcohol misuse disorders (WHO, 2017), mental health professionals especially have to take care of people presenting with suicide on a more frequent basis, which increases the likelihood of their experiencing a patient suicide. The link between suicide and mental distress means that the patients' experience of mental distress adds another dimension to the mental health professionals' experience of responding to patients who present with fluctuating levels of experiencing suicide thoughts and behaviours which sometimes result in death by suicide. To confirm this, the National Confidential Inquiry in Suicides and Homicides by People with Mental Illness in the UK (NCISH, 2018) reported that, out of all reported suicides, 30 per cent of people who had died by suicide had experienced mental illness and had been in contact with mental health services during the twelve months prior to their suicide (Appleby et al., 2018; Public Health England (PHE), 2016). High-risk groups included male immigrants who had arrived in the UK for a period of five years before their suicide; people who were experiencing significant levels of distress due to being unemployed; the homeless; and people who were experiencing serious financial difficulties and also had a mental illness. Every patient suicide matters. It is crucial to acknowledge that, for each patient suicide, there are mental health professionals who may have been affected in some way by the suicide, and they matter too. However, their experiences of patient suicides are rarely reported on or reflected in inquiries such as the NCISH.

The UK provides a range of mental health services which are part of the National Health Service (NHS) which employs mental health professionals to work in services designed to deliver care that is free at the point of access (DH, 2015). Mental health service provision is in three tiers, namely primary mental health care, secondary and tertiary services (DH, 2015). Primary mental health care is provided by the General Practitioner (GP), whereas secondary
services refer to treatment provision in a mental health hospital or via community-based services. These secondary services offer more advanced mental health care to people within their own homes or in out-patient services such as a Community Day Hospital. Examples of community-based services include Community Mental Health Teams (CMHTs), Crisis Home Treatment and Resolution Teams (CRHTs), Child and Adolescent Community Mental Health Teams (CAMHS) as well as Assertive Outreach Teams (AOT)(DH, 2015). Tertiary mental health services refer to specialist in-patient services such as Forensic Mental Health Hospitals designed to provide highly secure services for people presenting with severe and enduring mental health problems as well as possibly having a criminal record (DH, 2015). In the context of secondary mental health services which provide care in the community, the NCISH (2018) also reported cases of mental health patients dying by suicide within a week of accessing community mental health services such as CRHTs or of being discharged from hospital. Patients presenting with high levels of distress may also have received short-term, acute care from the Crisis Resolution and Home Treatment Teams, due to a shortage of acute in-patient hospital beds (DH, 2014). There were three times as many deaths in the Crisis Teams as there were in in-patient care (Appleby et al., 2016; PHE, 2016).

These significant statistics provide mental health professionals with crucial information regarding the frequency, the actual number of mentally unwell people who die by suicide, and the distressing factors that contribute to these suicides. The information reported in the NCISH is used to inform the evidence-based psychosocial interventions that underpin mental health practice in response to the needs that distressed people experiencing suicide thoughts and behaviours may present with on a daily basis. However, the information does not delve into the effects of patient suicides on mental health professionals, nor does it shed light on how mental health professionals can carry on delivering high-quality care after their patient has died by suicide. Therefore, in order to address this issue, a growing number of researchers have begun to study what it is like for mental health professionals when someone they have cared
for dies by suicide.

In the context of mental health research, some researchers have studied the professional effects of patient suicide on psychiatrists, psychiatry trainees, psychologists, psychology trainees, and social workers (Chemtob et al., 1988a; Chemtob et al., 1988b; Midence, 1996; Dewar et al., 2000; Alexander et al., 2000; Linke et al., 2002; Thomyangkoon and Leenaars (2008) Ting et al., 2011; Darden & Rutter, 2011; Scocco et al., 2012; Draper et al., 2014; Finlayson and Simmonds, 2016; Gibbons et al., 2019) with only a few researchers focusing on the effects on mental health nurses (Valente, 2003; Bohan & Doyle, 2008; Takahashi et al., 2011; Shanley, 2012; Canning, 2014). The professional background of the clinician and the nature of the therapeutic relationship with any patient who chooses to die by suicide may have a strong influence on the understandings and interpretations of the deaths (Shanley, 2012; De Leo & Postuvan, 2017) which makes this an area worthy of further investigation. In a suicide loss survivorship study with consultant psychiatrists based in Scotland, findings from a nationwide survey revealed that patient suicide had a devastating effect on the participants. There was a significant threat to their professional identity as doctors. Some psychiatrists admitted that they had contemplated leaving psychiatry altogether after their patient had died by suicide, reporting that the suicide had had a negative bearing on their professional reputation as a psychiatrist (Alexander, 2000).

More recently, Gibbons et al. (2019) conducted a web-based survey that was similar to Alexander (2000) with 174 British psychiatrists. The survey investigated how having a patient who had died by suicide affected their emotional wellbeing and their psychiatric practice, as well as eliciting the support and resources that psychiatrists felt they might need. The survey highlighted that over 25 per cent of the psychiatrists considered a change of career as a consequence, which provides further confirmation that a patient suicide may significantly damage the professional reputation and identity of psychiatrists (Gibbons et al., 2019). It is
worth noting that research into the impact of patient suicide on psychiatrists reveals that psychiatrists continue to struggle on all levels long after their patient dies by suicide, despite the passing of time. Such an outcome is undesirable because the psychiatrist’s priority is to help individuals to regain their mental wellbeing. A patient dying by suicide, especially during treatment, achieves the opposite effect. However, psychiatrists are not the only professionals who struggle after a patient suicide. Similar effects were reported in Linke et al.’s 2002 survey which investigated how the suicide of a patient affected the clinical staff working within a community mental health service. This survey captured the views of community mental health nurses, psychologists and social workers who declared that they regretted ever working in psychiatry after failing to prevent patient suicides (Link et al., 2002). The study showed that psychologists, social workers, and mental health nurses also struggled after a patient suicide, experiencing strong emotional reactions after a patient suicide, to the extent of regretting their career choice. The inclusion of mental health nurses’ perspectives after a patient suicide is important as it acknowledges the clinical contribution that mental health nurses make when caring for patients experiencing suicide thoughts and behaviours and it begins to shed light on their struggles which also need to be empirically researched so that more can be known about mental health nurses’ experiences. Psychiatrists’ views tend to dominate the research literature but they do not have a monopoly over caring for patients experiencing suicide thoughts and behaviours. Mental health nurses also play a crucial role hence it is important for their experiences to be captured.

I examined the small body of research that focused on mental health nurses as survivors of a patient suicide and observed that researchers have predominantly studied mental health nurses’ experience after a patient dies by suicide in an acute mental health ward in a mental health hospital (Midence et al., 1996; Bohan & Doyle, 2008; Joyce & Wallbridge, 2003; Takahashi et al., 2011; Awenat et al., 2017). It has been suggested that in-patient suicides are more preventable due to the provision of a continuous 24-hour cycle of mental health nurse-
led suicide risk assessment and management interventions which focus on mitigating suicide distress and on promoting patients’ health and well-being (Bowers et al., 2007; Bowers et al., 2010). These in-patient or hospital-based studies tended to use mainly quantitative approaches, with very few studies using qualitative methodology. The use of predominantly quantitative methodology has been adopted by many suicidology researchers who have focused on explaining suicide using a hypothesis-deductive or an experimental method derived from natural sciences (Hjelmeland & Knizek, 2010). Some researchers have been driven to look for the reasons why people engage in suicide behaviours, using cause-and-effect terminology which has increased their bias towards using quantitative methodology. I observed that the trigger for the quantitative research was often an inpatient suicide with the researchers interested in investigating what had led to the occurrence of suicide and the causes of suicide behaviour within in-patient wards. The main objective was to study people as objects, thus reflecting the dominant biomedical model, in order for researchers to develop evidence-based interventions which ensured that psychiatric wards continued to be a place of safety for distressed patients (Midence et al., 1996; Bohan & Doyle, 2008; Joyce & Wallbridge, 2003; Takahashi et al., 2011). Other researchers use quantitative research methods such as epidemiological research, neurobiological research, and randomised controlled trials because they are interested in using numbers and statistically significant data to find explanations and cause-effect relationships in suicidology ((Hjelmeland & Knizek, 2010; Lester, 2010; Troya, 2019). There is also the tendency to duplicate research studies which have adopted a more positivist epistemological stance and have used research tools that were described as more valid and reliable. This can be seen in Takahashi et al.’s (2011) study with in-patient mental health nurses working in Japan. Takahashi et al. (2011) duplicated Chemtob’s (1988a) study which used the Impact of Event Scale-Revised (IoES-R) to measure the impact of patient suicides on psychiatrists in all 52 states of North America.

The results of this quantitative research confirm that suicide behaviour frequently occurs in in-
patient settings. It can range from thinking about suicide, attempting suicide through to suicide completion and it can have a significant impact on the mental health nurses who are left behind. After measuring the impact of a patient suicide, it is common for studies to report statistical figures and numbers which confirm that mental health nurses experience high levels of stress, distress, anxiety, hopelessness, and guilt (Midence et al., 1996; Joyce & Wallbridge, 2003; Takahashi et al., 2011). However, researchers need to use other research approaches to help us to understand and to make sense of the effects that suicide related behaviour can have on mental health nurses (Hjelmeland & Knizek, 2010; Lester, 2010; Troya, 2019). Researchers acknowledge that mental health nurses expend much emotional labour and may become emotionally attached (Bowlby, 1998) as part of their work with patients who experience suicide thoughts and behaviours who then choose to die by suicide whilst being cared for in an in-patient hospital ward. However, emotional labour cannot be measured using quantitative research methods, hence it would be more appropriate to adopt a more qualitative approach as evidenced in studies undertaken by Bohan and Doyle (2008); Carlen and Bengtsson (2007); Bowers et al., (2007) and Awenat et al. (2017). More recently, Murphy et al. (2019) undertook a mixed methods study using a questionnaire that was sent to 508 people investigating the personal and professional impact of service user suicides on mental health professionals in the West of Ireland. 179 mental health professionals participated, a response rate of 35.2 per cent. Quantitative findings from this study help to explain that 79.5 per cent of mental health professionals experienced sadness; 68.7 per cent were in shock and 68.7 per cent were surprised after a patient suicide. The qualitative findings from a thematic analysis give us an understanding of the human experience of patient suicide (Hjelmeland & Knizek, 2010; Lester, 2010; Troya, 2019). They revealed that some mental health professionals had developed more expertise when dealing with suicide related incidents and in supporting colleagues who had been bereaved by suicide in both community and in-patient settings (Murphy et al., 2019).
I discovered that there are very few studies which have investigated how community mental health nurses are affected when a patient dies by suicide while receiving care in their homes and other non-hospital-based environments (Valente, 2003; Linke et al., 2002; Shanley, 2012; Canning & Gournay, 2014). My observation of the literature further intensified my curiosity and interest to discover the available evidence-based research about community mental health nurses’ experiences after a patient dies by suicide.

1.2. The role of mental health nurses in the assessment and management of suicide risk

The existing Nursing and Midwifery Council (NMC) standards (NMC 2010; NMC 2018), indicate that mental health nurses have the added professional responsibility of preventing patient suicide as part of their job description (NMC, 2010; NMC, 2018), hence their lived experience of a patient suicide is the main focus of this research study. This expectation is set at the start of each mental health nurse’s career, during their preliminary education. The NMC standards for pre-registration nursing in the UK state that all graduate mental health nurses must be able to minimise risk of harm, including attempted suicide, as a core clinical skill before they are admitted on to the NMC professional register (NMC, 2010; NMC; 2018). However, the education standards do not address what mental health nurses can and need to do after a patient dies by suicide. It is worth noting that the core competency of minimising the risk of self-harm and suicide is currently not part of the pre-registration nursing standards for other fields of nursing such as adult, child and learning disabilities. This is a cause for concern as it may serve to perpetuate the idea that suicide is exclusively associated with people experiencing mental illness when, in reality, suicide statistics confirm that adults, children, and people with learning disabilities can also experience suicide thoughts and behaviours (NCISH, 2018). That being the case, the Royal College of Nursing (RCN) has highlighted that to expect only mental health nurses to minimise risk of self-harm and suicide leaves a dangerous
knowledge and skills gap for adult, child and learning disabilities nurses who also work with people who experience suicide thoughts and behaviours in their clinical nursing roles (RCN, 2016).

Members of the RCN also confirmed their skills deficits as reported in a survey that was conducted by Rebair and Hulatt (2016). The purpose of the survey was to investigate nurses’ insights into their levels of knowledge about suicide prevention and to elicit their levels of confidence to talk to distressed patients about suicide. 415 RCN members from adult, child and learning disabilities nursing participated in the survey and their responses indicated that they lacked the skills, training, and knowledge to be able to engage in this important work within their field of nursing. Barriers to having challenging and difficult conversations with distressed patients experiencing suicide thoughts and behaviours included time deficits, lack of suicide awareness training, and lack of structured supervision and debriefs after a suicide attempt or a patient death by suicide in a non-mental health setting. Whilst this important work of raising suicide awareness with nurses from other fields of nursing practice is developing (Rebair and Hulatt, 2016), it further justifies the need to investigate how mental health nurses are affected by a patient suicide, especially within their role as community care coordinators.

Within the Care Programme Approach (CPA) process (DH, 1999; 2008) community mental health nurses tend to assume the Care Coordinator role, which means that they carefully coordinate care for their patients and they frequently enlist the help of other mental health professionals as and when the need arises (DH, 1999; 2008; Norman & Ryrie, 2013). During the nursing assessment, mental health nurses will connect with the patient in a compassionate manner to conceptualise the presenting problem, how it is currently impacting on the person, any background mental health history, and if there is any evidence of experiencing suicide thoughts and behaviours. Undertaking this work involves a major investment in emotional labour as nurses engage in the therapeutic use of the self as they develop therapeutic
relationships with the patient experiencing suicide thoughts and behaviours (Peplau, 1952; Peplau, 1997; DH, 2002; Jones et al., 2012) and take on the caregiving role as indicated in Bowlby’s Attachment Theory (1998). According to Bowlby (1998) caregiving behaviour is:

“complementary to attachment behaviour and it serves a complementary function, that of protecting the attached individual. This is commonly shown by…one adult towards another, especially in times of ill health, stress or old age.” (pp 40-41).

When Attachment Theory is applied to the therapeutic work of mental health nurses, it shows that they tend to work very hard to form, engage in, and sustain therapeutic relationships with patients experiencing suicide thoughts and behaviours, to mitigate their distress and reduce the risk of the patient dying by suicide (Spencer, 2007; Cole-King et al., 2013; Kayman & Goldstein, 2016). It is understandable that when a patient suicide happens, a disturbance of the attachment takes place, resulting in anxious detachment or separation anxiety (Bowlby, 1998). I felt that it made sense, therefore, for me to find out how mental health nurses may be affected after a patient with whom they have formed an attachment (Bowlby, 1998) and worked very closely with dies by suicide.

In Britain, the National Patient Safety Agency (NPSA) describes a patient suicide as a 'never event'. Patient suicide is regarded as a death that can and should be prevented (Clark, 2018; NHS Improvement, 2012). As discussed above, mental health nurses are expected to do all that they can to keep the patients in their care safe. The practice of maintaining patient safety is underpinned by mental health policy and government strategy which stress the importance of addressing and responding to suicide risk as part of suicide prevention and interventions which are mostly led by mental health nurses working with other members of the mental health multidisciplinary team (DH, 2012; NHS England, 2016). More recently, the belief that suicide deaths by people with mental health problems are both predictable and preventable
contributed to the British government's focus on 'zero suicide'. The 'zero suicide' movement has triggered increased and, to a certain extent, unrealistic expectations that the psychiatric community can achieve 'zero suicide' (Gibbons et al., 2019). This heightened expectation produces pressure for mental health nurses and other professionals expected to deter people from dying by suicide as part of their role even though they know that some patients will choose to die by suicide (Goldney, 2013; Rebair and Hullett, 2016; Gibbons et al., 2019). It may also explain why mental health professionals can experience high levels of distress after they perceive that they have failed to deter people from dying by suicide.

With regard to the clinical work of suicide prevention, it is important for all involved to recognise that it is not an exact science and it is not without its challenges. Anecdotally, mental health nurses know that suicide prevention is very hard work, but there is a dearth of empirical research investigating the practice of suicide prevention from their perspective, including what it is like for them when a patient dies by suicide. In other words, research into the effectiveness of preventing suicide among people with distress is very challenging because it is almost impossible to say exactly when mental health nurses have successfully prevented a suicide, unless someone tells them directly. Crompton & Walmsley (2004) argue that mental health nurses only tend to know when they have failed to prevent suicide, a phenomenon which can have significant implications for them and their future clinical practice.

When a patient suicide happens, current clinical practice is for teams to undertake an inquest into the death (Shanley, 2012; NHS Improvement, 2018) and to prioritise their attention on assessing suicide risk in the families, relatives, friends and significant others who have been bereaved (DH, 2002; DH 2015; Crowley; 2015; PHE, 2018). However, they do not necessarily assess how the death of a patient affects mental health nurses and the broader clinical team, nor do they consistently assess their clinical performance in the aftermath of the suicide. The
practice of establishing and confirming that a patient has died by suicide is extremely important. It supports future suicide prevention because it is known that having a relative or a family history of suicide significantly increases the likelihood of the bereaved person dying by suicide and it is important to prevent suicides among this high-risk group (Cooper & Kapur, 2004; Peters et al., 2016a; Peters et al., 2016b; WHO, 2017; Andriessen et al., 2017).

While working with bereaved relatives is a very important aspect of suicide prevention, it does not take into account the emotional labour that mental health nurses expend when working with distressed people experiencing suicide thoughts and behaviours, whilst they support the families bereaved by suicide as well as trying to deal with the devastating effects that a patient suicide can have on their personal wellbeing. As much as there is a duty of care towards the bereaved families, relatives and significant others, there needs to be a duty of care shown towards the mental health nurses who have likewise been bereaved by the suicide of their patient (Crowley, 2015; De Leo et al., 2014). In my capacity as a mental health nurse, experience of patient suicide loss has affected me personally on several occasions and I have captured this in the form of a narrative which I present in the section below.

1.3. My interest in suicide loss survivorship research

During the course of my clinical practice as a mental health nurse who is registered and governed by the Nursing and Midwifery Council for England (NMC) in the UK, I have cared for mental health patients who have died by suicide. My lived experience is the main reason why I have developed an interest in suicide survivorship, and I have chosen to pursue experience of suicide survivorship\(^2\) among registered mental health nurses as a topic for empirical

\(^2\) The term ‘suicide survivor’ has wide use in the suicide literature. However, researchers such as Cerel et al. (2014); Andriessen et al. (2017) acknowledge the meaning of the term needs to be refined. For example, the term does not differentiate between people who have survived a suicide attempt from people who have been left behind after a suicide. In order to provide a clearer nomenclature, the term ‘suicide attempt survivor’ is used to describe people who attempted suicide and lived while the term
research.

‘I am sorry…. I have bad news…. the patient that you were working with on your previous placement as a student nurse… has died by suicide.’

I could not believe these words as they were articulated to me by the registered mental health nurse that I had worked with on a clinical placement as a novice clinician. She had called me in for a debriefing session because she was interested in my well-being after the patient suicide. It was April 1997. I was a pre-registration mental health nursing student from an African background and I was undertaking the second year of a three-year Project 2000 pre-registration nursing course at a School of Nursing located in the Thames Valley Region in England. Growing up in my home country Zimbabwe, I had heard about suicide and suicide attempts but I had never met anyone who had attempted suicide, nor had I come across the relatives of someone who had tried to die by suicide or had died by suicide. I was a novice; I was on a steep ontological, existential, cultural, and sociological learning curve, experiencing the complex problem of in-patient suicide on six occasions during the process of my pre-registration nurse education. All the patients who had died were white British people and I felt that this experience triggered my interest in suicide loss survivorship, existentialism and suicidology within the context of the Western World.

I was on my clinical placement experience on an acute admissions ward with twenty-one beds for adults aged between sixteen and sixty-four who were experiencing high levels of distress as a consequence of living with mental illness. At that point, I was on practice placement for nine weeks working under the mentorship and supervision of a registered mental health nurse with the United Kingdom Clearing Council (UKCC), now known as the Nursing and Midwifery

‘suicide loss survivor’ is used to describe a person who has been left behind after someone has died by suicide (Cerel et al., 2014). For clarity, in this thesis I have chosen to use the term ‘suicide loss survivor’ to describe a person who has been left behind after suicide. I refer to mental health professionals who have lost a patient to suicide as ‘suicide loss survivors’.
Council (NMC). My practice placement mentor at the time had been practising for fifteen years as a nurse and used her expertise to guide and direct my practice experience of working with people who were experiencing suicide thoughts and behaviours. Consequently, I developed a clinical interest in working with and caring for distressed people with schizoaffective disorders such as severe clinical depression and depression with psychotic symptoms as well as bipolar affective disorder.

Although I was an undergraduate student nurse working in a supernumerary role, with support from my mentor and other mental health professionals within that in-patient unit, I became actively involved in the care of a small caseload of patients who were distressed, struggling with experiencing suicide thoughts and behaviours, and were presenting with high levels of intent to die by suicide. I observed that the clinical team was made up of women and men who were psychiatrists, psychologists, social workers, occupational therapists, and mental health nurses. The nursing team was made up of unregistered health care assistants (HCAs) and registered mental health nurses. They had different levels of experience and they represented a diversity of races, cultures, and ethnic groups. In many instances, I observed that when some in-patients became distressed they self-harmed by engaging in self-mutilating behaviours such as cutting and scratching. In an attempt to mitigate their distress, other patients had engaged in self-destructive behaviours such as taking overdoses of prescribed medication, over-the-counter medication or illicit street drugs smuggled onto the ward. In response to these distress behaviours, my mentor and the clinical team taught me how to assess and manage suicide risk. This work allowed me to apply the suicide risk theory that I learned at the School of Nursing. I learned that, for some people, the experience of mental illness and distress can have serious implications for their safety, resulting in the weakening or even the erosion of their desire to keep living.

At this novice stage of studentship as a nurse, I worked intimately and developed deep
emotional connections with distressed people who were actively expressing their experience of suicide thoughts and behaviours in a way that I had never done before. This experience left me feeling perplexed. I did not know how to cope with such high levels of distress or how to help other people deal with their distress. Therefore, I sought support from my mentor and the ward manager. The manager had the responsibility of taking the lead in providing support and care for the wellbeing of the nursing team. I observed that the registered nurses and the HCAs working on that ward received clinical supervision regularly as an intervention to mitigate against the distress that was sometimes caused by working with in-patients experiencing suicide thoughts and behaviours. Even though my status in the team was supernumerary, I was grateful that my mentor provided me with regular clinical supervision as a student nurse.

As a consequence of one clinical supervision session, where we were discussing the skills required when nursing distressed people, my mentor arranged for me to have a one-to-one session with the charge nurse who was managing the ward. During our meeting, the charge nurse explained that I would experience being part of a team that was highly-skilled at assessing and managing the risks presented by mentally distressed people who were experiencing psychiatric emergencies that required in-patient admission as an intervention to maintain their safety and, in some cases, as a way of keeping them alive. This conversation with that ward manager made a real impression on me because it helped me to learn about the complexities and challenges that came with the task of suicide prevention.

As a student nurse, I embraced the opportunity to engage in assessing risk and coming up with interventions to manage that risk within the context of suicide prevention and intervention in an in-patient setting. Although this was a very challenging and anxiety-provoking time for me, I was determined to work intensively and collaboratively with six patients who were actively experiencing suicide thoughts and behaviours, three males and three females. They articulated the wish to die, they described the means that they would use if they had the chance
and they openly voiced that life in this world would be a much better place if they were no longer alive. In order to develop my knowledge about the clinical presentation of suicide risk, to understand the aetiology of suicide distress and to develop the clinical skills of working with people experiencing suicide thoughts and behaviours, I had permission to work closely with these patients. As my mentor was already their named nurse, she encouraged me to take on more of a lead role under her direct supervision. In other words, I established, developed, and maintained close therapeutic relationships with these distressed patients.

Looking back, I can vividly remember working with a man in his thirties, who had battled with distressing thoughts of suicide and had openly disclosed his wish to end his life through asphyxiation. While the content of his narrative about his existential distress was very difficult for me to hear, I felt quite privileged that he had trusted me enough to disclose this important information about his desire to end his life. I interpreted that his engagement in an open and honest narrative with me regarding his suicide intentions meant that he wanted something to be done to reduce his mental distress. However, I felt very concerned that the content of his disclosure revealed worryingly high levels of suicide intent, with specific details about his plans and how he would access the means to die by suicide. He seemed quite determined to end his life and I was concerned about the potential implications for the people who were members of his family, especially for his spouse and young offspring. However, I never really thought about how his death by suicide would have an effect on the clinical team that was looking after him at the time. As far as I was concerned, there was only one possible eventuality. I strongly believed that the clinical team could prevent him from dying by suicide. Consequently, my lived experience of listening to his story gave me the determination to learn about how to work with people who may be acutely distressed by their adverse life circumstances to the point of desiring to die at their own hand. The mentorship that I received from the multi-professional team on this clinical placement taught me how to facilitate person-centred care, which aimed to keep people who may experience suicide thoughts and behaviours safe by endeavouring to
instil in them the desire to carry on living despite their experience of mental illness or psychological distress because of severe clinical depression or psychosis. In other words, I was determined to help distressed patients and to instil in them the hope to keep living.

A few weeks after the completion of my placement on this ward, I received a series of telephone calls from my mentor on my previous ward placement, inviting me to attend urgent face-to-face meetings. During the first meeting, I was dismayed as she announced that one patient had died by suicide while he was out of the ward environment on unescorted home leave. Clinically, he had been progressing towards being discharged from the ward back into the community but had died by suicide before his hospital discharge. I could not believe that I was hearing this tragic and distressing news. Looking back, I recognise that this was my first experience of the debriefing process, which allowed me to process this shocking and upsetting news. It was the same man in his thirties who had told me about his wish to die by asphyxiation. My mentor reported that he had gone home on weekend leave and had died by carbon monoxide asphyxiation while sitting in his motor vehicle in the garage at his family home. He had done exactly what he said he desired to do. We had failed to stop the suicide that we had worked hard to prevent. Instead, the opposite had happened. I was very traumatised and distressed by this shocking news.

Shortly after this meeting, on separate occasions, I was invited to attend further urgent debriefing sessions where my mentor told me that five other patients that I had worked intensively with while I was a student nurse on placement had also died by suicide. They had died within what seemed like weeks of each other, in the same ward setting, which was intended to be a place of safety for 24 hours a day and supposed to provide protection from the identified suicide risks. The methods of suicide which the five patients had used were drowning in a bathtub, strangulation, overdose of prescribed medication and two died by hanging. My mentor had described these events as "copycat suicides" that all took place on
that one ward. The therapeutic alliances and relationships which I had formed with all six patients had ended tragically and made me question the notion of suicide prevention and what it meant for me in my clinical practice as a student mental health nurse.

My automatic negative thoughts were:

“I am a failure! If I can’t even save people from dying by suicide in my capacity as a student nurse, how on earth am I going to achieve this when I become a registered nurse?”

I felt a strong, overwhelming sense of shame and interpreted this experience at the start of my mental health nursing career to mean that I had somehow failed to do something I had been taught to do. I had failed to prevent a preventable death. I began to ask an existential question:

“How come all that effort that the team and I had put into working with these patients had not made a difference?”

I was an early career mental health nurse in my early 20’s and my lived experience significantly shaped my professional identity development as a suicide loss survivor. Although I had received theoretical training about the concept of distress, risk, risk assessment and risk management on my nursing course, the curriculum had never prepared me for the possibility that, despite everyone’s best efforts, including my own, some patients would choose to die by suicide. It had not occurred to me that some patients would choose to die by suicide. I had naively assumed that, with the right therapeutic interventions, help and support, the clinical team could prevent mentally distressed people from hurting themselves or dying by suicide. So when the suicides did happen I did not know what I was meant to think, feel, do or say. I remember experiencing a strong sense of shame, vulnerability and inadequacy. On reflection, I now recognise that, with limited experience and knowledge, I was trying to interpret this loss
after suicide on my own at this early stage in my career as a mental health student because I did not know what else to think, feel, say or do.

1.3.1. Suicide loss on a personal and professional level

In 1997, I experienced suicide loss survivorship in my personal life. Until that point, in my capacity as a student nurse, I experienced suicide loss-survivorship in the context of an in-patient setting. I had never experienced the suicide of a friend or a relative. That all changed in the winter of 1997 when a close family friend died by suicide. He was found hanging from the loft in his apartment after a traumatic relationship break-up. This suicide was very disturbing for me as he was in his thirties and had become a father to a son at the time that the relationship was ending. This suicide was my first experience of losing someone very close to me and it was not an easy situation to deal with. Naturally, his family were devastated. I did not see the signs, yet I was learning all about them at the School of Nursing. From my perspective, my friend was not showing any outward signs of mental distress nor was he expressing suicide ideas. However, that is not to say that he was not experiencing any distress at the time. From my standpoint, I was delighted that he had become a father and, from the outside looking in, it appeared that he was happy with his life and that he had a lot going for him. After he had died by suicide, I wondered about what would happen to his son, growing up without his father. I contemplated how his son’s mother would answer questions regarding how his father had died and the implications of this tragic death on this young person’s life. Consequently, I had more unanswered questions about why people die by suicide when, in my philosophical view, life was and is worth living and celebrating.

I noticed that my personal experience of suicide loss survivorship continued to affect my philosophical views after I completed my undergraduate nursing course. When I was working
as a registered mental health nurse between the years 2001 and 2002, I became a suicide loss survivor again. I still found it very distressing. This time, two male mental health patients that I had cared for within the context of a CMHT for Adults experiencing severe mental illness had died after drowning themselves. One patient had been a successful businessman who had developed severe clinical depression after a traumatic road traffic accident left him paralysed from the waist down. At an initial risk assessment interview, he disclosed that he had a strong desire to die by suicide and he explicitly stated that he would drown himself. As soon as he was discharged from a general hospital setting, he drowned himself in the swimming pool at his home just as he had disclosed during the suicide risk assessment interview. His suicide attracted much media attention and the CMHT that I was working with came under intense professional scrutiny from the local NHS Trusts involved in providing the services that he accessed, the coroner’s court, the local media, and the police. This suicide traumatised all the members of the CMHT and it severely disrupted the service that was being delivered to the other patients on the team caseload.

Approximately one month later, another male patient, who had a long history of paranoid schizophrenia characterised by fluctuating moods, delusions, persecutory auditory and visual hallucinations, drowned himself in a lake that was near to his home. He had been single, not in an intimate romantic relationship with anyone and had not been in paid employment for many years. He lived with his mother in their family home and his father had died when he was a teenager. He left a suicide note addressed to his mother. This suicide note gave his mother some insight into his distressed mental state at the time of his death. As part of her grieving process, his mother shared this letter with me, and I was able to learn about his thought processes before he died by suicide. Even though I was a registered nurse working with a highly skilled multi-professional team at that point in my career, my feelings of shame, guilt, vulnerability, failure, and incompetence resurfaced:
“I have failed again! Maybe I am just not good enough to do this work of managing risk and preventing people from dying by suicide.”

I started to wonder if other community mental health nurses were also attempting to make sense of this experience of losing a patient to suicide. I asked myself the question:

“Were other mental health nurses trying to interpret this phenomenon in the same way? Did they come to the same conclusions that I had? Or was it just me?”

This thinking prompted deep personal reflection and it motivated me to pursue this area of research at postgraduate level.

As I reflect on this catalogue of difficult experiences which started in 1996, I realise that these experiences have been problematic and difficult to cope with. These lived experiences still affect me, leaving me traumatised and grief-stricken. The passing of time makes it no easier to deal with losing someone to suicide. This is what has motivated me to research this very important subject with the aim of exploring and interpreting what it means for registered mental health nurses to have the lived experience of being left behind after a mental health patient dies by suicide as part of their daily clinical practice and not just in response to a critical incident.

1.4. My experience of suicide loss survivorship as a mental health nurse is not unique

Although there is little research that has investigated how mental health nurses can be affected after a patient dies by suicide, the available empirical evidence that I have studied shows that
what I experienced as described in my narrative so far is not unique. Many mental health nurses have gone through the same experiences as evidenced in empirical studies carried out by Bohan & Doyle (2002); Valente (2003); Takahashi et al. (2011); Shanley (2012); Canning & Gournay (2014) and Awenat et al. (2017), mostly in in-patient settings. Community mental health nursing is the specific focus of this thesis because nurses are pivotal to providing mental health care in community neighbourhoods and they are experts in the work that they do. They work as autonomous practitioners who have a strong presence. They frequently carry heavy clinical caseloads of between thirty-five and forty patients. Additionally, community mental health nurses have the challenging responsibility of being a CPA Care Coordinator whilst working therapeutically, mainly in the homes of the patients (DH, 1999; DH, 2002; NHS England, 2016). Therefore, they have a unique opportunity of entering into the lifeworld of the patients. I aimed to undertake a primary research study that would help me to find out what it means to lose a patient to suicide after having entered into the patient’s lifeworld as part of providing care in the community.

As mentioned in Section 1.1, the primary research studies that do exist have tended to use quantitative methodology to investigate and measure how mental health nurses are affected and impacted after a patient dies by suicide, mainly in inpatient settings. There are fewer studies that use qualitative approaches and even fewer studies which focus on community mental health nurses’ experiences of patient suicide, even though the NCISH (2018) reports an increase in the number of patient suicides in community mental health settings, especially among patients who may have received care from a Crisis Home Resolution Team.

I aimed to address this gap in knowledge and research by designing a research study which would use a qualitative phenomenological lifeworld approach to explore the lived experiences of community mental health nurses after a patient dies by suicide as a consequence of distressing mental illness. As a doctoral researcher, I was influenced by phenomenological
philosophy underpinning life world approaches (Crotty, 1998) inspired by Gadamer, Husserl and Sartre (Finlay, 2011; Hefferon and Gil-Rodriguez, 2014). The term ‘life world’ is defined as:

“the taken for granted world as experienced; it is how our body and relationships are lived in time and space”. (Finlay, 2011, p. 125).

In our lives, we move, act and experience life as it happens. Most of the time, we do not reflect on what that life experience means to us, we take it for granted. The focus of lifeworld research is to explore life experiences as they happen. The concept of the life world influences phenomenological research as the researcher seeks to explore the lived experience. It points us to the intentional relationship between conscious meaning making humans subjects and their relationship with the external, often taken for granted meaning-giving world in which they live (Finlay, 2011). When applied to my research journey, I was interested in the way that community mental health nurses connect with the world after a patient dies by suicide and I wanted to know how they try to make sense of what happened to them with a view to finding the meaning behind that experience. Although the concept of the life world influences phenomenological research overall, there are differing ways in which phenomenological researchers carry out the research. Dahlberg’s Reflective Lifeworld Research (Dahlberg et al, 2008) is an approach which aims to reveal the lived world in a way that expands our understanding of human being and human experience. The researcher needs to approach the phenomenon under investigation with an open attitude and a willingness to see that phenomenon in new ways. An alternative approach is proposed in Ashworth’s Heuristic Lifeworld Dimensions (Ashworth, 2006) which provides a structured approach to life world research to give an idiographic heuristic, practical and discovery-oriented approach to see and describe the particulars of an individuals’ experience (Finlay, 2011). Whilst these two approaches focus primarily on the individual experience, they do not necessarily include the
human experience of the physical environment that humans inhabit. Therefore, Seamon’s Hermeneutic Geography of the Life World (Seamon, 1993) offers an approach which focuses on everyday taken for granted environmental space experience, that is, people’s first-hand experience and involvement with the physical geographical world. In other words, the central aim of his Seamon’s approach is to explore and interpret the mutual relationship between human beings and their material social world by examining behaviour, experience and meaning in a descriptive, interpretative manner (Finlay, 2011). Within the context of undertaking sensitive suicide postvention research, my thinking was guided primarily by the life world approaches as developed by Dahlberg’s Reflective Lifeworld Research (Dahlberg et al, 2008) and Ashworth’s Heuristic Lifeworld Dimensions (Ashworth, 2006). The life world concept is further discussed in Chapter 4, section 4.

After developing an insight into the concept of life world research, I was curious about existing research and I carried out a literature review which helped me to situate current research about suicide in relation to mental illness. I also completed a scoping review which helped me to examine and critically appraise research studies which investigated the effect that a patient suicide in both in-patient and community settings had on mental health nurses. Findings from the scoping review guided the design of this research study, which used qualitative research methodology to interview community mental health nurses, whose stories and lived experiences of patient suicide are often untold. It is against this background that the next section will present the aim and the structure of this thesis.

1.5. The aim and structure of the thesis

Research Question:
• What are the experiences of mental health nurses after a patient dies by suicide in the community?

Aim:
• To explore mental health nurses’ experiences of a patient suicide within community-based mental health services.

Objectives:
• To examine the research studies which investigated the effect that a patient suicide had on mental health nurses by means of a scoping review.
• To explore the experiences of mental health nurses as survivors of a patient suicide whilst working in the community.
• To explore mental health nurses' views about the support they received at the time of the suicide.

1.6. Outline of chapters in the thesis

Chapter 2 will explore the concept of death by suicide among people experiencing distress as a consequence of mental illness. A brief consideration of suicide statistics in Chapter 1 sheds light on the fact that not all people who experience suicide thoughts and behaviours will experience mental illness but that people who experience mental illness are at an increased risk of experiencing suicide thoughts and behaviours and of dying by suicide during their course of treatment. This chapter provides an overview of how the clinical practice of working with people experiencing suicide thoughts and behaviours came to be associated with psychiatry and later with mental health nursing practice. It will begin by defining 'suicide', and it will present the Western World’s historical perspectives of suicide in relation to mental ill-
health. It will identify and critically analyse key theoretical frameworks that can help mental health professionals to understand the reasons why people may experience suicide related distress whilst they are receiving care from mental health services. It will discuss the prevalence of suicide by people with mental illness and the implications that patient suicides have on the clinical practice. It will conclude by presenting the implications of a patient suicide on the personal and professional lives of mental health professionals that are left behind.

Chapter 3 will discuss the concept of *suicide loss survivorship* and how it may be applied to mental health nurses and not just relatives who have been bereaved by suicide. It will present historical perspectives and factors that have influenced the idea of *suicide loss survivorship*, with a focus on the terms and definitions that are currently being used in the field of suicidology. It will present theoretical approaches which underpin the conceptualisation of *suicide loss survivorship*, and it will discuss the application of *The Continuum of Suicide Survivorship Model* to include mental health nurses who are the main focus of this study. It will critically analyse general research that has investigated multi-professional mental health practitioners as *suicide loss survivors* to establish what we currently know about this phenomenon and how this knowledge can be used to underpin future developments in mental health nursing practice. This chapter will conclude by presenting evidence-based research that supports the idea that mental health nurses can legitimately be described as *suicide loss survivors* after a patient suicide.

Chapter 4 will present a critical analysis of the philosophical underpinnings for this study. It will discuss the underpinning epistemological and ontological ideas that influenced the research study presented in this thesis. This study adopts a contextual constructivist epistemological position and employs a qualitative approach using Interpretative Phenomenological Analysis (IPA) as the chosen methodology. This chapter will conclude by outlining how these philosophical underpinnings contributed to the development of the overall
qualitative study design.

Chapter 5 will discuss the research methods which were used in this study. It will justify the use of semi-structured interviews as a lifeworld research method which aligns with my constructivist interpretivist epistemological stance and my ontological position which has resulted in my use of qualitative lifeworld research methodology. It will give an overview of the purposive sampling methods, the ethical considerations and the data collection that were used in this study. It will discuss how I applied the principles of Patient and Public Involvement (PPI) as proposed by the National Institute for Health Research (NIHR) (NIHR, 2018) to develop two phases of fieldwork, namely a pilot study and a main study. It will discuss how I planned to conduct a pilot study as a way of establishing the feasibility of undertaking the main study in a sensitive manner which ensured the safety and well-being of the mental health nurses who willingly volunteered to be participants.

Chapter 6 will present a scoping review of the literature which asks the question: “How do mental health nurses react to a patient suicide?”. The scoping review was designed in response to the research objective to examine the research studies which investigated the effect that a patient suicide had on mental health nurses as stated in Chapter 1. In order to address this objective, this chapter reports on a scoping review of the reactions experienced by mental health nurses, by identifying the nature and the extent of the research evidence using the framework developed by Arksey, O’Malley & Levac (2005). It establishes what we know about this topic, it identifies gaps in the literature which helped me to justify the need to undertake a qualitative lifeworld study focusing mainly on community mental health nurses. It will present a critical appraisal of findings from the scoping review and discuss how these key findings influenced the design of the main study.

Chapter 7 will discuss the Pilot Study, which was Phase One of the fieldwork. The Pilot Study
was designed using the principles of Patient and Public Involvement (PPI) as suggested by the National Institute for Health Research (NIHR) (2018). The pilot study aims, objectives and findings will be presented. It will explain the ethical considerations, target population, eligibility criteria, sampling strategy, data collection, transcription, and analysis of the semi-structured interviews that I conducted with six community mental health nurses who volunteered to participate in the pilot study. This chapter will conclude by discussing how the lessons learned influenced the design and development of the main study.

Chapter 8 will discuss the Main Study, which was Phase Two of the fieldwork. The Main Study was also designed using the principles of PPI as applied in the Pilot Study. It will discuss the lifeworld experiences of ten community mental health nurses who responded to the Main Study recruitment advertisement and willingly volunteered to be interviewed about their lived experiences as suicide loss survivors after a patient suicide. In the tradition of IPA methodology, this chapter will discuss my researcher development regarding research rigour and the use of reflexivity as I conducted lifeworld research interviews. This chapter will conclude by briefly mentioning the findings from the Main Study, which will form the basis for Chapter 9.

Chapter 9 will focus on the findings from this lifeworld qualitative IPA study. It will discuss how I engaged in idiographic data analysis, one transcript at a time, by noting the description and the content of the semi-structured interview transcript and the linguistic or language use and conceptual coding in relation to what each participant is revealing about their lifeworld experience of losing a patient to suicide. It will discuss the process of interpretation, using double hermeneutics, which resulted in the synergy and development of divergent and convergent themes across the ten cases, which is a common feature of IPA research. This chapter will conclude by discussing how community mental health nurses make sense of the experience of losing a patient to suicide.
Chapter 10 will present a discussion of the findings from this study within suicide-loss survivorship research and it will consider the extent to which the research question that was set in Chapter 1 has been answered. It will present the convergent themes which were derived from the idiographic participant narratives to form the ordinate and superordinate themes. Furthermore, Chapter 10 will present a comprehensive discussion based on the discoveries which were presented within Chapter 9.

Chapter 11 will present conclusions and recommendations from this study. It will present what is new and novel about this study and will discuss what this study has contributed to the suicide loss survivorship literature, highlighting the unique contribution it makes. It will present recommendations for mental health nursing policy and practice and for UK pre-registration and post-registration mental health nurse education. The limitations of the study will be highlighted, and this chapter will present a reflective statement which will link back to the trigger for the research as discussed in Chapter 1. It will discuss how I, as a doctoral researcher, have engaged in personal and professional development as a patient suicide loss survivor. Finally, it will highlight recommendations for future research regarding the experiences of mental health nurses after a patient dies by suicide.

1.7. Conclusion

This chapter has presented a narrative which has highlighted the significant events which triggered my interest in this research. It has set the scene for the research study by constructing a case of need to empirically study suicide loss survivorship for mental health nurses after a consultation of empirical evidence revealed that this is an area worthy of further research. It has provided an overview of the prevalence of suicide among the general population and, more specifically, among people presenting with mental distress as a
consequence of experiencing mental illness. The death of a patient by suicide within the context of mental health practice will affect families, relatives, friends and significant others, including mental health professionals. The effects of patient suicide on families and psychiatrists are well researched, while the effects on mental health nurses have been less researched. Therefore, my novelty aspiration was to empirically research the qualitative stories of community mental health nurses who experience patient deaths by suicide, as they work under pressure as autonomous practitioners, to prevent and respond to suicide among distressed in the community as experts in their field. To set the scene, Chapter 2 will provide a historical overview of how suicide came to be so closely associated with mental illness and subsequently with mental health nursing.
Chapter 2: Suicide within the context of mental health practice – A historical overview

2.1. Introduction

In current mental health service delivery, it is generally accepted that mental health professionals, including mental health nurses, will provide psychosocial interventions to people experiencing complex suicide thoughts and behaviours (Jones, 2012; Norman and Ryrie, 2013). With the advent of social inclusion and the development of recovery-oriented mental health practice, effort has been put into opening up social discourse about suicide prevention with a view to reducing the taboo and stigma surrounding it (Barker, 2011). However, such acceptance of and tolerance towards suicide have not always been in evidence, and I was interested in investigating how the stigma around suicide has developed. As a way of setting the scene for this study about the experiences of community mental health nurses, my aspiration was to find out how working with people experiencing suicide thoughts and behaviours came to be such an integral part of the mental health nurses’ role within the context of Western mental health care. As mentioned in Chapter 1, it is known that dying by suicide is not always associated with mental illness. More people who do not have a history of mental illness die by suicide in comparison to those who are in contact with mental health services. However, people with mental illness are at higher risk of experiencing suicide thoughts and behaviours and of dying by suicide (Appleby et al., 2018) and this has serious implications for mental health practice. Therefore, I began to explore the concept of death by suicide and the associated stigma as experienced by mental health patients who were receiving care from mental health services. It is against this background that this chapter will provide an overview of how the clinical practice of working with people who experience suicide thoughts and behaviours came to be strongly associated with psychiatry and, later on, with mental health nursing practice.
The development of stigma around suicide is complicated and it partially originates from the way it has historically been viewed by religion and the law (Witte et al., 2010). Globally, suicide is still a taboo and stigmatised subject which causes much distress for people who experience suicide thoughts and behaviours and those who are left behind after a person has died by suicide (Pridmore et al., 2006; Barker, 2011). Generally, it is an act that is viewed with shame and disgrace and is often perceived as abnormal behaviour, which further perpetuates the negative stigma surrounding death by suicide. Research studies which focus on people who have had a spouse, relative or a friend die by suicide confirm that people bereaved by suicide have been shunned, avoided or treated differently after the suicide (Sveen & Walby, 2008; Cerel et al., 2009; McKinnon and Chonody, 2014; Hanschmidt et al., 2016; Sheehan et al., 2017). Findings from these research studies reveal that participants are stigmatised for being suicide loss survivors, even though this has not been by choice. The negative opinion that people who die by suicide are weak, selfish, and cowardly is commonly held by society. Many participants have shared their stories which give a first-hand account of how they were held responsible, how they felt humiliated, were criticised, and looked down on by others who had not experienced the suicide of a loved one (Cvinar, 2005; Peters et al., 2016a; Peters et al., 2016b).

More recently, researchers have also included the perspectives of suicide attempt survivors. Researchers use this term to describe people who have tried to die by suicide but have not died and have consequently experienced distress, self-stigma, and stigma from others in the aftermath of their suicide attempt (Dodemaide and Crisp, 2013; Hines, 2013; Hines, Cole-King & Blaustein, 2013; Sheehan et al., 2017). Many who attempt to die by suicide are negatively labelled as being attention seekers and, in many cases, they are not taken seriously and some experience malignant alienation, which increases their risk of dying by suicide (Jordan and McIntosh, 2011; Olson, 2013). A qualitative study investigating the suicide stigma as
experienced by those affected by suicide which was conducted by Sheehan et al. (2017) confirms that participants experienced negative stereotypes, prejudice and discrimination after a patient suicide or a suicide attempt. The participants were grouped into suicide loss survivors, suicide attempt survivors and service providers and they engaged in focus group interviews which were designed to facilitate a discussion about their personal experience of stigma after a suicide attempt and/or a suicide loss (Sheehan et al., 2017). The inclusion of service providers shed some light on the experience of suicide-related stigma as experienced by mental health professionals after their patient died. The notion that having a patient die by suicide is a form of ‘therapeutic failure’ is not new. In the late 1890s, when Sigmund Freud was developing his practice of psychotherapy, he disclosed feelings of failure after one of his patients died by suicide, to the point that he ended up refusing to treat patients experiencing suicide thoughts and behaviours (Hawgood and De Leo, 2015). As discussed in my narrative in Chapter 1, I too felt this therapeutic failure and it made me wonder if this may be another element of therapist induced self-stigma which can be triggered after experiencing a patient suicide. This was also reported on in Takahashi et al.’s (2011) study with Japanese mental health nurses who reported experiencing stigma that they did not feel they could openly discuss because mental health nurses are often seen as the suppliers, rather than the recipients, of care and support after a patient suicide. Many participants called for suicide awareness training and support to help them to cope after an in-patient suicide, as it was not readily available at the time (Takahashi et al., 2011).

This information helped me to establish the background for this novel thesis about exploring the experiences of community-based mental health nurses. I started to find out how negative views and stigma about suicide towards the suicide attempt survivor, the person who died by suicide and the suicide loss survivor, as well as therapist induced self-stigma have been a part of human history for many centuries. I was curious to find out why suicide-related negative thinking stigmas still exist and how such negative attitudes and beliefs may manifest
themselves in the aftermath of a patient suicide within mental health nursing practice. By reflecting on these ideas, my curiosity increased, which prompted me to ask more questions and begin to find answers regarding the origins of negative attitudes towards suicide.

In order to satisfy my curiosity, I undertook a literature review which explored historical perspectives about the stigma associated with suicide in relation to mental illness. I wanted to develop insight into some of the factors that influenced the early developments of western societal views regarding suicide (Marsh, 2010; Goldney, 2013; Eghigian, 2018). These historic views shed light on how currently held views about suicide have developed over time, and how they can have an adverse impact on how people are affected after a suicide. Key theoretical frameworks developed by researchers such as Shniedman (1967), Williams (2001), Joiner (2005), Johnson, Gooding, and Tarrier (2008), O’Connor (2011), and O’Connor and Kirtley (2018) can help mental health nurses explain why and how suicide occurs when people experience mental distress which requires psychosocial interventions as provided by mental health nurses.

My review of the literature presenting historical perspectives of suicide started when I became a student member of the American Association of Suicidology (AAS) and subscribed to the Journal of Suicide and Life-Threatening Behaviour. The network exposed me to the work of leading suicidologists who were researching the field. The work of Goldney (2013) helped me to appreciate that there were other thinkers who had documented suicide before Durkheim, a concept which was quite new to me. This review signposted me to references which I was able to follow up using databases such as Academic Search Elite, PubMed, Medline, CINAHL with Full Text, CINAHL Plus with full text, PsychArticle, Google Scholar and Psych INFO.

The search terms that had been used from January 1995 to the present day included: 'suicid*', 'suicide history', 'historical perspectives', 'sociological perspectives', 'suicide and psychiatry',
'suicide postvention', and 'suicide before Durkheim'. In addition to searching the databases, reference lists of retrieved articles were manually searched, and they yielded further results. There were textbooks which have been written by leading suicidologists who addressed the historical perspectives of suicide within the context of psychiatry. The next section presents the results of the literature review.

2.2. Historical perspectives of stigma against suicide

In the Western world, as far back as the ancient Greek and Roman empires, philosophers such as Socrates (470–399 BCE) and Cato The Younger (95–46 BCE) regularly had deliberations and debates which reflected a tolerant ontological position, as well as a stoic attitude about the ethics or rightfulness of dying by suicide. Suicide researchers have reported that both philosophers died by suicide themselves and up to this day they have a good reputation and are well respected in the academic world despite their dying by suicide (Quinett, 2012; Eghigian, 2018). In the Greco-Roman empires, death by suicide was tolerated and not generally viewed negatively (Farberow, 2005; Pridmore et al., 2006). For centuries, the debate about whether it was acceptable to die by suicide or not was generally viewed as an existential matter for Greek philosophers, clerics, clergymen, and theologians to ponder on from a moralistic perspective and it influenced the dominant discourse at that time. While this was the pervasive view among the Greeks and the Romans, such views were not shared but were criticised and, in many cases, opposed by philosophers from Europe and other Western nations (Pridmore et al., 2006; Khan and Mian, 2010; Quinett, 2012) thereby creating differing views which challenged the moral discourse dominant at the time.

In Europe, Christian thinkers articulated a less tolerant attitude towards self-inflicted death with many sharing the revulsion to suicide that was expressed by St Augustine of Hippo (354-430
BCE), whose views influenced Western Christianity and philosophy. He shunned the tolerant stoic views from the Roman Empire, which conceptualised suicide as a matter of heroism and virtue when, for example, the person died for political reasons, to protect their chastity or to avoid personal difficulties (Khan and Mian, 2010; Quinett, 2012; Mower, 2015). St Augustine promoted a religious view which branded the act of suicide an arrogant refusal to submit to God’s will and challenged the deeply-held view of the principle of the value of life. It was widely accepted that only God in heaven, the Giver of Life, and God alone could decide when an individual’s life should come to an end (Khan and Mian, 2010; Quinett, 2012; Eghigian, 2018). Augustine’s negative view of suicide influenced virtually the entire Christian religious tradition, especially within the then-dominant Roman Catholic Church. It became an established belief that suicide is a worse sin than any that can be avoided by it and could not be called a shortcut to eternal life in heaven (Mower, 2015). Not only did this belief influence religious thinking, but it also influenced the political, legal, and social systems of the time. Consequently, there were legal implications to suicide, which was deemed to be a crime. The bodies of people who died by suicide were desecrated. Socially, the surviving families of people who had died by suicide were shunned and their possessions were confiscated and used by the state as form of punishment for breaking the law (Goldney, 2013; Eghigian, 2018).

Early English common law, religion, and folk beliefs were adamantly opposed to suicide and promoted public humiliation of the deceased by giving people who died by suicide a shameful burial. Some suicide victims had a stake pierced through their hearts and were buried at crossroads. Such burials would typically take place at night, at locations kept secret by the authorities, with no mourners or clergy present (Pridmore et al., 2006; Goldney, 2013; Marsh, 2010). This meant that bereaved families and others affected by the suicide loss did not have the opportunity to engage in public grief rituals but were forced to grieve privately in secret and feel ashamed. With suicide being viewed in such a negative way, it is highly likely that the families, relatives, and significant others who were left behind after the suicide may have been
negatively stigmatised in the same way as the person who had died by suicide, resulting in much suffering (Marsh, 2010).

Shifting attitudes and thinking about suicide began to take place between the 1500s and the 1800s, mainly due to the development of the Enlightenment and other significant advances in sociological research and understanding. Against a background of strong religious opposition to suicide, there arose some Enlightenment scholars such as Voltaire (1694-1788) and David Hume (1711-1776) who presented the argument that, under certain circumstances, suicide can indeed be legitimate or valid. Hume’s work was published posthumously in 1783 (Hume, 1783; Morgan, 2015; Goldney, 2013; Eghigian, 2018) and paved the way for the movement towards decriminalising suicide in Europe. Many local authorities adopted the view that penalties imposed on the corpses and the estate of those who had died by suicide were unreasonably harsh and posed an unjustifiable burden on the family members of the deceased. A shift in attitudes took place and people began to attribute suicide not to moral failings or the devil, but to the deep emotions of grief, melancholia, and sadness (Marsh, 2010). Leading up to the 1700s, reform-minded thinkers paved the way for understanding suicide as an expression of melancholy, or clinical depression as it is known today (Pridmore et al., 2006; Khan and Mian, 2010; Pridmore, 2011). A critical review of this development shows how suicide came to be medicalised to the point that it became strongly associated with the distress associated with mental illness (Khan and Mian, 2010; Goldney, 2013). The next section will present a historical account of how suicide came to be associated with mental illness.

2.3. History of suicide in relation to mental illness

Clinical observers and researchers began to take up the subject of suicide and to link the experience of suicide thoughts and behaviours with mental illness by describing it as the decision of an unsound mind. The earliest writing about suicide, its prevention, and its
association with mental and physical illness in Western countries was first documented in 1637 by an English physician and Calvinist minister called John Sym (1518c-1638). His “Life's Preservative Against Self-Killing” focused exclusively on a discussion about suicide as an atrocious sin greater than the murder of another person. In other words, he believed that the destruction of self is far worse than the destruction of the life of another human. Alongside his strongly-held views against death by suicide, he argued that suicide can and should be prevented. He believed that it was possible for people to overcome suicide despair, paving the way for the practice of suicide prevention as it is known today (Sym & MacDonald, 1988; Goldney, 2013).

The next notable research contribution following John Sym’s was presented in 1790 by Charles Moore (1743-1811), who published two volumes titled, ‘A Full Inquiry into the Subject of Suicide’. These volumes postulated that to die by suicide was a sort of ‘madness’, even though it was often difficult to make a clear distinction between what was meant by sane and insane suicides. Although Moore was not a physician, he was quite an influential rector and vicar of the powerful Church of England. His notable work reflected St Augustine's strong religious opinions because Moore also described suicide as being morally wrong and an insult to God in heaven (Goldney, 2013). Likewise, Moore’s work greatly influenced the attitudes towards suicide in the eighteenth century and he silenced the voices of Enlightenment authors such as Hume, who, in his ‘Essay on Suicide’ (1783), presented stoic and epicurean views of suicide (Lo Sardo, 2017). Moore’s view of death by suicide as a manifestation of ‘a sort of madness’ made a significant contribution to the way in which suicide was viewed among people presenting with mental health problems. In 1807, a Danish physician, Heinrich Callisen (1740-1824), based on his own clinical practice and not on empirical evidence, anecdotally described suicide as a form of illness and other physicians followed suit (Pridmore et al., 2006; Goldney et al., 2008). Progress in shedding light on the causes of suicide continued to develop in the eighteenth century, resulting in significant fluctuation in social attitudes, views, and beliefs.
about the act of dying by suicide. It also resulted in the development of the nosology of suicide, a process of classification of diseases and disorders, which significantly influenced the clinical practices of the psychiatrists who were treating individuals presenting with mental health problems and experience suicide thoughts and behaviours in response to mental distress (Khan and Mian, 2010; Goldney; 2013).

In England, a key change in societal and legal views was associated with the suicide of an influential English politician called Lord Castlereagh in 1822, who died by suicide after experiencing melancholia at the age of 53. It may have been due to his status as a public figure that Lord Castlereagh was not considered ‘felo de se’, a Latin expression for ‘felon of himself’, an archaic legal term that denoted the illegal act of suicide. Additionally, Lord Castlereagh was not denied a burial as should have been the case at the time but was given a full and proper burial, leading to considerable public debate at the time (Marsh, 2010). This shift in attitudes led in 1823 to a 22-year-old law student Albert Griffiths becoming the last recorded person to ever be buried at a crossroads in England (Pridmore et al., 2006; Goldney, 2013). Attitudes towards suicide were beginning to shift and society was beginning to adopt new perspectives.

Esquirol (1772-1840), a Frenchman hailed as one of the founders of modern psychiatry, has been credited with developing the first medical model of suicide in 1805. Esquirol’s clinical practice was greatly influenced by his contemporary colleague and friend, French psychiatrist Philippe Pinel (1742-1826) who held compassionate views towards the treatment of mentally ill people presenting with suicide risk (Pridmore, 2011). Esquirol particularly acknowledged the role of social factors such as alcohol abuse, gambling, and the breakdown of interpersonal relationships in the development of suicide thoughts and behaviours and proposed humane methods of treating mental health patients who were incarcerated in asylums (Marsh, 2010). In the 1800s, there were other physicians such as Burrows (1828) who noted that a key clinical
feature of suicide was melancholia and insanity; Bucknille & Tuke (1858) produced a textbook of psychiatry which included the classification of suicide with monomania, and Savage (1892) categorised suicide as either deliberate or impulsive (Marsh, 2010; Goldney, 2013). This paved the way for the modern practice of psychiatrists classifying mental disorders in manuals such as the International Classification of Diseases (ICD-11) published by the World Health Organisation (WHO, 2018) and the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) published by the American Psychiatric Association (APA, 2013). Whilst mental health nurses do not currently diagnose mental illness, they do refer to the ICD-11 and the DSM-5 when working with people experiencing suicide thoughts and behaviours after they have been diagnosed with a mental illness.

In the 1900s, the debate within psychiatry about the causes of suicide coincided with the widespread anecdotal perception that the incidence of suicide was increasing. To verify such claims, many governments in Europe started to make concerted efforts in the collection of suicide statistics as part of a wider effort aimed at developing more empirically informed public policy. This led to developments in suicide research in psychiatry and sociology. Psychiatrists became fascinated with knowing the number of people who had died by suicide and their presenting psychopathology, whilst sociologists were drawn to identifying and analysing factors influencing suicide patterns and statistics (Eghigian, 2018). This paved the way for the modern practice of collating international suicide statistics that are currently published by the World Health Organisation (WHO, 2018) which aims to spearhead the global suicide prevention agenda by encouraging member nations to have suicide prevention strategies for their respective countries. In England, this agenda is reflected in the National Suicide Prevention Strategy (DH, 2012). The outcome measures of the effectiveness of the suicide prevention strategy are reported by the Office of National Statistics (ONS, 2016) as well as the annual National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (Appleby et al., 2018) which has recently been renamed the National Confidential Inquiry into
Suicide and Safety in Mental Health (NCISSMH)(Appleby et al., 2019).

White et al. (2016) argue that although this early work as described above has contributed to the development of the field of suicidology as it is known today, it has also been criticised for being too focused on the positivist biomedical paradigm and obscuring other paradigms. De Leo and Postuvan (2017) have contributed to this debate by suggesting the need for perspectives of suicide to be included from other disciplines such as psychology, sociology and, to a certain extent, mental health nursing. This view is reflected in current mental health practice, which has now developed a more constructivist, multi-professional approach to understanding suicide and its impact when it occurs in modern-day mental health services (Murphy et al., 2019). Additionally, the shifting attitudes towards suicide have also influenced how it is currently defined and understood by members of the public as well as among mental health and social care professionals, including mental health nurses (Pridmore et al., 2006; Khan and Mian, 2010; Barker, 2011).

In the English language, various dictionary definitions have been constructed in an attempt to help us to understand what suicide is. Three key definitions have been selected for discussion in this thesis and their main purpose is to explain what this complex act literally means in general terms that are accessible to lay members of society.

Table 1: Three English Language Definitions of Suicide

<table>
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<tr>
<th>Definition</th>
<th>Source</th>
<th>Date</th>
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<td>3 “The act of killing yourself deliberately”</td>
<td>Oxford Learner’s</td>
<td>2018</td>
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The origin of the word suicide comes can be traced back to circa 17th Century, and it is derived from the Latin word: “suicidium”. ‘Su’ meaning “of oneself” and “cidium” from “caedere”, meaning “to kill”.


It is interesting to note (Table 1) that these definitions primarily focus on the act of dying by suicide and they highlight the intentionality and deliberate nature of such an act. The reasons why someone would choose to die by suicide are not included in such definitions. This may well reflect past negative views and stigma that was perpetuated by the Roman Catholic Church and the state, which tended to focus on the act of dying by suicide with little consideration for the anecdotal reasons why people might elect to die by suicide. The definitions may also reflect the very important view that not all people who die by suicide will have a mental illness, but they may be experiencing distress caused by other biopsychosocial and socioeconomic factors not linked with mental illness. On the other hand, having such definitions that are available for members of the public to access is an indication of the gradual demystification of what suicide is, as it becomes a subject increasingly in the public domain and in public discourse.

Various professional definitions of suicide have been proposed with a view to explaining suicide within the context of mental health practice. Three key definitions are presented below, and they also reflect the shifting attitudes that have been increasingly adopted in the field of suicidology, psychiatry, psychology, and mental health nursing practice.

“Suicide is the act of killing oneself, now no longer a crime [in England] with the passing of the Suicide Act in 1961. It refers to a person who has voluntarily or deliberately taken his or her own life.”
Suicide is a devastating consequence of a mental illness, usually but not always depression. All mental disorders are associated with an elevated risk of suicide. “It is a self-inflicted act resulting in death, albeit with varying levels of intent.”

(Goldney, 2013, p.9.)

“Suicide is the act of killing yourself, most often because of depression or other mental illness.” (American Psychological Association (APA), 2018)

These definitions all refer to the deliberate act of taking one’s own life, but they also reflect a change in legal and ethical frameworks that indicates an acceptance of the strong link between increased suicide risk and mental illness. The awareness that a person who is distressed by mental illness may choose to die by suicide understandably creates a profound sense of unease among mental health professionals, who are primarily interested in helping people who are disadvantaged by distressing and adverse life events. Ontologically, this choice to die by suicide challenges some of our most deeply-held beliefs about the value and sacredness of life and places a question mark over the taboos against the taking of life (Wertheimer, 2001), even if the reasons for developing high levels of suicide risk are understandable. For mental health nurses, suicide also challenges the therapeutic work that is based on developing interpersonal relationships with people experiencing suicide thoughts and behaviours, a therapeutic process that has been shaped by frameworks developed by early influential mental health nursing theorists such as Peplau (1952, 1997) and Travelbee (1979). Their early theoretical work significantly influenced the therapeutic nurse-patient relationship as the foundation of working with people presenting with suicide distress and this will be discussed further in Chapter 6. Whilst the development of therapeutic relationships with patients is encouraged both theoretically and practically as a direct attempt to reduce patient suicide risk.
in mental health nursing, it does bring with it an increased sense of responsibility, or failure if the therapeutic relationship ends prematurely after a patient dies by suicide (Spencer, 2007; Barker, 2011). Therefore, in the next section, it is appropriate to consider theoretical frameworks which inform current mental health nursing practice.

2.4. Theoretical frameworks of suicide in mental health practice

Theoretical frameworks that explain suicide in the context of mental illness are helpful because they inform current mental health nursing practice and provide mental health nurses with various explanations for why people with high levels of distress may choose to die by suicide. Although suicide tends to be a solitary event, it has far-reaching consequences for those left behind, both laypersons and mental health professionals. The act of suicide is often carried out in secret, hidden from the gaze of others, yet it becomes the subject of public scrutiny as the people left behind become involved with the police, emergency services, coroners and even the media (Wertheimer, 2001; Shanley, 2012) in an attempt to understand why such a tragedy has happened.

The research carried out by Emile Durkheim, a world-renowned French sociologist (1858-1917) resulted in widely-used theoretical frameworks that underpin our understanding of both the medical and the social factors influencing suicide (Durkheim, 1952). Durkheim skilfully used a positivist epidemiological approach to suicide based on the statistical data which highlighted that suicide rates tended to increase when socio-political norms were deteriorating (Durkheim, 1952; Eghigian, 2018). His work is like that of social researchers such as Morselli (1879), Westcott (1885), and Savage (1892). They all made significant contributions to the classifications of suicide by providing the reasons for suicide, statistics, prevalence, and frequency of suicide. Durkheim’s work of classifying suicide into egoistic, altruistic, anomic and fatalistic categories still influences current approaches to suicidology and mental health
practice. It helps us to understand the multiple factors which may increase people’s vulnerability to suicide (Durkheim, 1952; Eghigian, 2018).

Suicide clinicians and researchers have developed The Stress Diathesis Model which connects suicide with increased vulnerability to stress and distress by formulating a conceptual framework of clinical utility for mental health nurses (Mann et al., 1999). The word diathesis means that a person has the tendency or disposition to experience a medical condition or emotional reaction such as stress and distress. The Stress Diathesis Model suggests that predisposition to longitudinal factors, which either raise or lower the threshold to suicide behaviour, is influenced by triggers or distressful conditions which precipitate that suicide behaviour (Mann et al., 1999). Longitudinal factors which contribute to diatheses may include inherited or developmental factors, the presence of distress, mental disorders, personality traits, the presence or absence of psychosocial support systems, societal attitudes and stigma towards mental illness, alcohol and substance misuse, and the presence of physical illness. Triggers or stressors include factors which contribute to the manifestation and exacerbation of mental distress and illness such as acute intoxication or impulsivity. A number of these predisposing stressors can result in increased suicide risk which may result in the act of death by suicide (Mann et al., 1999; Goldney, 2013).

Although the Stress Diathesis Model identifies longitudinal factors which can contribute to stress, it has some limitations because it does not acknowledge short-term factors such as impulsivity, which may precede suicide behaviours. It is not uncommon for mental health nurses to work with people who choose to die by suicide after showing signs of recovery from mental illness. Evidence of recovery may come from the person who may disclose that they are feeling better, which leads to them being discharged from mental health services. It often comes as a shock to the mental health nurse when the discharged patient dies by suicide after showing signs of recovery. In addition to this, diathesis leans heavily towards the medical
model which focuses on a person’s tendency to experience medical conditions without taking into consideration the idiographic experiences (Lester, 2010) of the person who may be experiencing suicide feelings, which is a key aspect of the mental health nurses’ engagement and investment in the therapeutic relationship. It is against this background that I felt that it was important to include the Williams (2001) Cry of Pain Model which has clinical utility for mental health nurses, as it considers suicide as a way that a person uses to express otherwise inexpressible pain and it can be applied to the idiographic nurse-patient therapeutic relationship (Williams, 2001; Peplau, 1952).

The Cry of Pain Model (Williams, 2001) was developed in order to explain suicide behaviour from a biopsychosocial perspective in relation to the human experience of depression, whilst drawing heavily from ethology and comparing it to human behaviours. In other words, Williams (2001) used lessons learned from observing certain behavioural manifestations of animals in nature and he compared these to the behaviours of humans after they had experienced certain significant life events which may have triggered an episode of clinical depression. He noted that there are similar ways in which animals and humans respond to losses, threats, failure, and entrapment, and he used this as another way of explaining the mind that is thinking about suicide. The Cry of Pain Model moves away from the traditional view that the experience suicide thoughts and behaviours is a “cry for help” and it presents the notion that suicide is a behavioural reaction to three key interacting factors which have been observed to increase suicide risk. These factors have been described as being the presence of defeat, the feeling that there is entrapment and no escape, and the belief that there is no rescue (Williams, 2001; Allely, 2011). This Model has been empirically tested by researchers such as O’Connor (2003), Johnson, Gooding and Tarrier’s (2008) appraisal of suicide thoughts and behaviours in people with schizophrenia, and Rasmussen et al.’s (2010) study with patients who engage in self-harm for the first time and those who repeatedly self-harm. Findings from such research studies provide strong empirical support for the Cry of Pain Model and they inform research
and practice that people who engage in suicide behaviours do not just do it to get attention.

The Model also explains both suicide behaviour and death by presenting suicide on a continuum. In the initial phases of experiencing suicide thoughts, a person may be feeling defeated by their life circumstances and they may begin to engage in suicide behaviours as a way to demonstrate that they feel defeated and unable to escape from a distressing situation. Such suicide behaviours may be a way of regaining control. However, if the feelings of entrapment and defeat increase, the person may feel hopeless and trapped and may resort to dying by suicide as a form of escape from a situation that they are no longer able to tolerate.

As with any model, there are some limitations. Whilst the model is strongly underpinned by ethology, from the observation of animals who may be trapped, it makes it difficult to relate the uniquely human experience of suicide feelings to the behaviours of animals who do not have a human way of thinking (Rasmussen et al., 2010). In other words, humans are endowed with the amazing ability to articulate their thoughts and make sense of their lived experience of suicide thoughts and behaviours and to attribute meaning to that experience in a way that animals cannot. We can learn lessons from the animal world but animal behaviours, although similar in some situations, cannot define our experience of suicide thoughts and behaviours as humans. Therefore, while this model provides a theoretically driven approach to suicide prevention which can be applied to mental health nursing practice, it is important to look at another model which proposes a different explanation regarding why humans may choose to die by suicide, especially when they experience psychotic illness such as schizophrenia.

Johnson, Gooding and Tarrier (2008) developed The Schematic Appraisal Model of Suicide (SAMS) for psychosis after they engaged in a critical evaluation of the Cry of Pain Model of Suicidal Behaviour in depressed people (Williams, 2001) and they identified that although people with schizophrenia can be depressed, they do not necessarily experience suicide thoughts and behaviours because of that depression. Therefore, the SAMS Model has three
main components which are: negative information processing biases, the presence of suicide schema, and an appraisal system (Johnson, Gooding and Tarrier, 2008). Firstly, the model suggests that the triggers for suicide thoughts and behaviours in psychotic people tend to be associated with negative information processing biases. This refers to the negative way that people with psychosis experience the world as they struggle with symptoms such as misattribution, catastrophising, and misperception of threat as they experience delusions or hallucinations as well as selective attention (Bolton et al., 2007; Johnson, Gooding and Tarrier; 2008). Secondly, the model proposes that people living with psychosis have negative internal suicide scripts and schema. It acknowledges that suicide behaviour is a cry of pain, and it is an escape from an intolerable situation. The schema refers to the connection between “stimulus, response and emotional stored information which when activated at any point...will trigger suicide as an escape strategy” (Johnson, Gooding and Tarrier, 2008, page 65). Thirdly, the model suggests that the presence of negative appraisal systems are closely related to the lived experience of psychosis. For example, people with psychosis may hold certain values, beliefs and attitudes which may have a strong influence on the way they make sense of their past experiences, their current lived experience and also their future experiences (Johnson, Gooding and Tarrier, 2008). For mental health nursing practice, the SAMS has clinical utility because it addresses the serious but poorly understood clinical and social problem of suicide thoughts and behaviours in people living with psychotic illness. It helps mental health nurses to increase their knowledge and understanding of why people with schizophrenia may die by suicide not out on impulse but in response to schema activation. Knowing about the SAMS Model and the evidence-based clinical guidelines which underpin Cognitive Behavioural Suicide Prevention for Psychosis as a psychosocial intervention (Johnson, Gooding and Tarrier, 2008) can equip mental health nurses to have a better understanding of the experience of suicide thoughts and behaviours for people with psychosis.

Another theoretical framework of clinical utility and applicability to mental health nursing is the
Interpersonal-Psychological Theory of Suicidal Behaviour which was developed by Thomas E. Joiner (2005). Joiner proposes that a person will not die by suicide unless they have developed the desire to die and have acquired the aptitude to be able to carry out the act. According to this theory, when a person develops two psychological states of mind, namely “perceived burdensomeness” and “a sense of low belongingness or social alienation” (Joiner, 2005, p48), they develop a desire for death. In other words, the person will develop a fearlessness of pain, injury and death, which then gives them the fearlessness to take their own lives (Joiner, 2005).

According to Joiner (2005), perceived burdensomeness is the view that one’s existence is a major problem for family, friends and other members of society at large. As illustrated in Figure 1, Joiner (2005) explains that acquired ability to engage in serious self-mutilation is regarded as a dynamic continuous construct which may manifest itself in a history of self-harm using self-destructive or self-mutilating behaviours as a response to high levels of distress. Additionally, acquiring the capacity for suicide is not necessarily limited to previous suicide behaviours, it can also be developed after a person repeatedly experiences other painful, distress-inducing behaviours such as self-mutilation, self-starvation, exposure to another’s pain and physical abuse (Joiner, 2005; Van Orden et al., 2010). These experiences serve to desensitise the person from fearing suicide and result in high suicide rates, despite what might appear to be protective factors (Van Orden et al., 2010).

Joiner’s Model (2005) provides a useful visual representation which combines three key concepts in an attempt to explain why people may die by suicide. It is a person-centred model, which can help researchers and clinicians to understand why people die by suicide from an interpersonal perspective. However, Hjelmeland & Knizek (2019) present a critical analysis of Joiner’s Theory and they criticise it for coming across as being paternalistic in its presentation of assumptions regarding some of the reasons that lead people to choose to die by suicide. Hjelmeland & Knizek (2019) point out that Joiner’s Theory does not consider some of the real
contextual factors which may be contributing to a person’s experience of thwarted belongingness and perceived burdensomeness. For example, people with suicide feelings may be going through an existential crisis which will trigger real feelings of thwarted belongingness, social isolation, and loneliness. This may happen if a long-term relationship breaks down or if they experience the death of a spouse or a partner. Hjelmeland & Knizek (2019) suggest that such significant life events are not simply perceived but are quite real and will result in real, attributable feelings of distress. The person experiencing suicide thoughts and behaviours, who is going through a contextual life problem, may also experience real feelings of burdensomeness if they have lost their employment due to ill-health, redundancy, or dismissal from work and are therefore without a regular source of income. For example, in the UK, the economic recession and resultant austerity measures have resulted in unemployed people having restricted access to social welfare. This is confirmed in the most recent edition of the NCISSH (Appleby et al., 2019) which reports that males over the age of 45 are at an increased risk of suicide if they have a history of clinical depression and financial problems. With this in mind, a person experiencing suicide thoughts and behaviours may feel that they are a real burden on society each time they have to access public funds. Therefore, contextual factors and intra-personal relationships also need to be taken into consideration when considering why people choose to die by suicide.
The Integrated Motivational-Volitional Model of Suicide (IMVM) developed by Rory O’Connor (2011, updated 2018) is another useful model which helps mental health nurses to understand why people may choose to die by suicide. It is a three-phase model which conceptualises suicide and self-harm as unique behaviours and gives the context where suicide thoughts may emerge, not simply as by-products or symptoms of mental illness or disorder. Instead, it charts the relationship between background factors and trigger events as well as the development of suicide ideas and intent through to the engagement in suicide behaviour on a continuum (O’Connor, 2018). In other words, it suggests that suicide behaviour is the consequence of a complex interaction of factors, diatheses, environmental factors, with the main predictor being a person’s intention to engage in suicide behaviour which is seen as a solution to life’s circumstances in the context of disadvantage or distress (O’Connor, 2011).
Whilst this model incorporates aspects of Joiner’s (2005) Model, such as the person’s experience of thwarted belongingness and perceived burdensomeness, it also includes a description of the motivational phase, which helps to explain the development of suicide ideation, which then progresses into suicide thoughts, intention, and is finally followed by suicide actions. Therefore, like the Cry of Pain Model (Williams, 2001), this Model also presents suicide on a continuum ranging from suicide ideation, thoughts, and feelings through to suicide attempts and subsequently death by suicide. The volitional or the action phase helps to explain how people might engage in behavioural manifestations of suicide through impulsivity, capability, intentions or planning, access to means, implementation, imitation or by contagion (other suicides). In other words, this phase suggests the view that people can move from thinking about suicide to attempting suicide and then dying by suicide, commonly referred to as the ideation to action model (O’Connor, 2018).

![Figure 2: The Integrated Motivational-Volitional Model of Suicidal Behaviour (O’Connor & Kirley, 2018). Image reproduced with permission from Professor O’Connor (2019)](image)

Although this model was originally presented in 2011 diagrammatically as a linear process (as
depicted in Figure 2,) recent studies by O’Connor and Kirtley (2018) have revealed that the lived experience of thinking about suicide and attempting suicide follows a more cyclical process, taking place over a period of time. This makes sense because the human experience of experiencing suicide thoughts and behaviours is complex, multifaceted and cannot take place in a linear fashion. The model has now been updated to reflect this notion and a further eight volitional factors have been added which explain how a person may make the shift from thinking about suicide to engaging in suicide behaviour, as depicted in Figure 3. These factors include the person having access to means, preparation, exposure to suicide behaviour, giving in to feelings of impulsivity, physical pain sensitivity/endurance, not being afraid of dying, mental imagery, and a previous history of attempting to die by suicide (O’Connor and Kirtley, 2018).

![Figure 3. Eight Volitional Factors developed by O’Connor & Kirtley (2018). Image reproduced with permission from Professor Rory O'Connor (2019).](image)

These eight volitional factors had been explored previously in the field of suicidology but not been presented as composite factors until the model was refined in 2018. This model has
contributed a broader and biosocial context for explaining why people die by suicide, with a view to informing the current practice of suicide prevention and intervention activities that are carried about by mental health nurses who work with patients experiencing suicide thoughts and behaviours.

While these theoretical frameworks highlight the reasons why people die by suicide, it is important to remember the human side and the human stories that are told by people who are left behind after a suicide and by people who have tried to die by suicide (Hines, 2013; Hines, Cole-King & Blaustein, 2013; Benjamin & Pfluger, 2018). From the perspective of the person living with distress as a consequence of mental illness, to experience suicide thoughts and behaviours might mean that they are experiencing high levels of that distress, resulting in the experience of suicide ambivalence or mixed feelings of wishing to live and wishing to die. When engaging in conversations with mental health professionals, some patients may utter expressions of wanting to escape from intolerable emotional pain or an inexplicable situation with little thoughts of actual death by suicide (Williams, 2001). Conversely, other patients may express feelings of relief after they have decided to choose death by suicide as an option (Goldney, 2013). Rhimer (2011) argues that psychological autopsy studies have demonstrated that sixty-six per cent of people who die by suicide will have had an episode of severe depression at the time of their suicide. For mental health nurses, the information presented above has major implications for them when they are left behind after a patient suicide.

2.5. Conclusion

This chapter has discussed how the practice of working with suicide has ended up being the core work of mental health professionals, especially mental health nurses. It presented a historical perspective which gives some insight into how suicide was viewed in the past, and
how religious, political, sociological, and psychological opinions and attitudes towards suicide have changed over time. These key developments have informed our understanding of why people die by suicide and have influenced clinical practice and research as indicated by the key theoretical frameworks discussed in this chapter. There have been shifting landscapes in the field of suicidology which have shaped current views of suicide as a consequence of mental illness such as depression and psychotic illness, when in the past it was a subject of discussion for clergy, theologians, and philosophers. The next chapter will consider how these historical factors contributed to the development of the concept of suicide loss survivorship after a patient has died by suicide.
Chapter 3 – Suicide Loss Survivorship – A review of the literature

3.1. Introduction to the concept of suicide loss survivorship

The development of suicide research against a background of shifting religious, legal and sociocultural attitudes has resulted in the development of evidence-based approaches to support the people left behind after a suicide, a phenomenon which has been described as ‘suicide loss survivorship’. As stated in Chapter 1, there is more research which has resulted in our increased knowledge and understanding about suicide and its implications for all those who are affected by it (Jordan & McIntosh, 2011; Goldney, 2013; Zalsman et al., 2017; Postuvan, 2017). Researchers have become increasingly interested in researching the experience of loss and bereavement after suicide in comparison to being bereaved by non-suicide-related deaths (Sveen and Walby, 2008; Jordan & McIntosh, 2011). Some researchers have estimated that for every person who dies by suicide, there may be as many as four people who will be affected by that suicide and that one in six or more people are left behind after a suicide, an estimate that was first suggested in the 1960s by Shniedman, known as the father of modern suicidology in North America (Pompilli et al., 2013; Andriessen et al., 2017).

To begin the process of finding out what has already been published, I accessed the ‘Clinicians as Survivors of Suicide: Bibliography’ which is published by the ‘Clinician Survivor Task Force’, a professional forum that has been developed by the American Association of Suicidology (AAS, 2012). This database contains research studies, opinion papers, discussion papers which address suicide loss survivorship, suicide postvention and suicide bereavement loss among mental health and social care professionals. A careful search of this bibliography flagged up some relevant and interesting references which I was able to follow up using electronic databases such as Academic Search Elite, PubMed, Medline, CINAHL with Full
Text, CINAHL Plus with full text, PsychArticle, Psychology and Behavioural Sciences Collection, Elsevier, SocIndex, Google Scholar and Psych INFO. I also searched Ethos for published PhD theses and my colleagues in a local UK based Suicide Prevention and Intervention Network (SPIN) which is affiliated to the International Association of Suicide Prevention (IASP) (WHO, 2012) shared articles of interest, which have been included in this review.

Search terms which were used were ‘suicide’ AND (‘emotion’ OR ‘responses’ OR ‘reaction’ OR ‘experience’ OR ‘impact’ OR ‘coping’) AND (‘social workers’ OR ‘occupational therapist’) OR ‘psychiatrist’ OR ‘clinical psychologist’ OR ‘psychiatric nurse’ OR ‘therapist’). Additional search terms were ‘mental health nurse’ AND ‘patient suicide’ AND ‘reactions’ NOT ‘assisted suicide’. The time frame was from January 1995 to the present day, which meant that I would continually explore the literature as I was undertaking the research. The search helped me to retrieve literature which will be presented from section 3.2 onwards.

My initial observation of the empirical evidence indicated that the suicide of a loved one has an obvious traumatic impact, with grief being identified as the most common emotional reaction. Sveen and Walby (2008) identified grief variables among suicide loss survivors. In comparison to other forms of grief, individuals who have been affected by suicide reported feeling higher levels of abandonment, disgrace, dishonour, and feelings of blame. They felt embarrassed and felt a strong urge to hide the fact that the person who had died had died by suicide (Sveen and Walby, 2008; Goldney, 2013). Consequently, this knowledge has contributed a noticeable shift in legal and sociocultural attitudes towards those who have been left behind after suicide.

An example of such a change in legal and sociocultural attitudes can be seen in the toleration of suicide in many countries around the world, especially in the Western world (Goldney, 2013).
The enactment of the 1961 Suicide Act in the UK contributed to a significant change in attitudes towards those who attempt, die, or are left behind after a suicide. This legislation decriminalised the act of suicide, meaning that suicide was no longer illegal, and it ended the legal prosecution of people who attempted suicide, whilst opening the way for people who are bereaved by suicide to begin to be supported (Andriessen et al., 2017). Consequently, evidence-based research is being completed to address and respond to suicide in a more sensitive and compassionate way.

Even with the noteworthy legislative changes brought on by the 1961 Suicide Act, there are remnants of negative attitudes and stigma towards death by suicide that still exist. Such negative attitudes are often reflected in the language that is still used in every day colloquial speech when people talk about a person ‘committing suicide’, which gives the impression that suicide may still be viewed as a crime, in the same way that people who commit murder have committed a crime. An observation of the language in the suicidology literature also reveals the prevalence of the use of the term ‘committed suicide’ over ‘died by suicide’, which appears to be rarely challenged in the literature. To address this issue regarding terminology, this thesis will use the most sensitive language to discuss suicide by adopting the term “death by suicide” or “dying by suicide” as opposed to “committing suicide” as it focuses on what happens to survivors of suicide within the context of suicide prevention, intervention and postvention research.

### 3.2. The scope of suicide research – prevention, intervention and postvention

A consideration of the scope of suicide research and practice in this thesis will position the concept of suicide loss survivorship as it is currently known. Suicide research is generally divided into 3 areas, namely suicide prevention (what needs to be reasonably done to prevent people from dying by suicide) (WHO, 2014), suicide intervention (what needs to be done when
people are experiencing suicide thoughts and behaviours) and suicide postvention (what needs to be done after people have attempted to take their own lives, have died by suicide including assessing the impact of suicide on those left behind) (Gaffney & Hannigan, 2010; Andriessen et al., 2017).

Regarding suicide prevention, the World Health Organisation (WHO, 2014) provides international guidance that recommends the adoption of a public health policy approach and healthcare strategies as effective evidence-based strategies. This is because there is a strong link between the presence of distress as a consequence of mental illness, particularly in relation to clinical depression and increased levels of suicide risk. There is also evidence that highlights that anyone who has been bereaved by suicide is more likely to experience distress in the form of a grief reaction, which may increase their risk of developing depression and of experiencing suicide thoughts and behaviours (Peters et al., 2016a; Peters et al., 2016b). Therefore, any resulting experiences of depression after being bereaved by suicide tends to be treated clinically with the aim of managing and ameliorating levels of suicide risk. However, there is very little research that examines how suicide prevention strategies support the clinicians who work with people experiencing suicide thoughts and behaviours as they invest emotional labour into this aspect of their clinical practice. Other suicide prevention initiatives include limiting the access that people have to lethal means, ensuring a chain of care which provides follow-up for people who experience suicide thoughts and behaviours as well the provision of suicide prevention education in schools (Zalsman et al., 2017; De Leo & Postuvan, 2017). Therefore, mental health professionals have a crucial role in preventing suicides and they are well-placed to be involved in suicide prevention activities as part of establishing therapeutic alliances with the patients that they work with every day (Andriessen et al., 2017).

In terms of suicide intervention, evidence-based research has been shaping the suicide intervention activities that are implemented when mental health patients present with suicide
thoughts or engage in suicide behaviours (Andriessen et al., 2017). One of the most effective interventions used to engage with the person experiencing suicide thoughts and behaviours is the development of a therapeutic relationship whilst exploring some of the factors that may be contributing to the distress associated with their increased levels of suicide risk. It has been recognised that factors such as having mental health problems, being unemployed, having sexual identity concerns, being homeless, and engaging in alcohol and substance misuse can all have a significant impact on the person’s experience of suicide thoughts and behaviours (Joiner, 2005; Goldney, 2013, Appleby et al., 2016). Whilst the act of responding to such complex stress-inducing issues can be problematic for mental health professionals, there is no option but to intervene, to mitigate some of the factors with a view to saving lives. However, despite the best intentions, interventions and plans, there are times when patients make the existential decision and choose to die by suicide. Consequently, this action leaves mental health professionals with the task of addressing the complex issues that arise after a patient dies by suicide, by addressing many problems that suicide inadvertently triggers for bereaved relatives, family, friends, carers and significant others. This is a process which is now commonly referred to as suicide postvention (Andriessen, 2017).

The field of suicide postvention has advanced significantly over the last 50 years, notably in North America, with ideas spreading internationally as researchers become more interested in this under-researched subject (Farberow, 2005; Andriessen, 2017). It started from a grassroots level, when general laypeople who had been left behind after a relative had died by suicide started to provide peer support for each other. The peer support system developed after they rejected the psychological services that were offering therapeutic interventions in an attempt to address suicide loss when what the bereaved were really looking for was suicide bereavement support and not psychological therapy (Farberow, 2005; Cerel et al., 2008). With the emergence of peer support groups, psychologists recognised the need to develop alternative professional support mechanisms which could complement the peer support groups
that had initially been set up for those bereaved by suicide. This key development prompted the development of various policies, protocols and research activity around the effects and impact of suicide on the bereaved (Andriessen et al., 2017). While there is empirical evidence which confirms that families must receive essential assistance after a suicide (Cerel, et al. 2008; Jordan and McIntosh, 2011; Peters et al., 2016a; Peters et al., 2016b), the idea that mental health professionals also need support as part of the process of suicide postvention has also received increased attention (Chemtob et al. 1989; Young & Oliver, 1997; Weiner, 2005; Jordan & McIntosh, 2011; Andriessen et al., 2017). This is reflected in the development of the concept of suicide loss survivorship.

3.3. Suicide loss survivorship – a historical overview

The suicide loss survivor movement was started in 1972 in North America by Albert. C. Cain when he published the volume, ‘Survivors of Suicide’. According to Cerel (2014), Cain provided a ground-breaking collection of theoretical writings which focused on how suicide had a significant effect on members of the family left behind, including the children. Cain’s contribution to the field of suicide postvention encouraged researchers to conceptualise what happens after someone dies by suicide and how such a significant life event will affect those left behind. It also encouraged debates about the implications of suicide postvention for people who had attempted to die by suicide and were living with the consequences of their actions (Cerel, 2014). In the literature, there are many different words that have been used to describe a person who has been left behind after a suicide, such as “survivor”, “suicide survivor”, “survivor after suicide”, “suicide loss survivor”, “survivor of suicide loss”, “bereaved by suicide” and “bereaved through suicide” (Andriessen et al., 2017). This can be very confusing for the family, relatives, friends, health and social care professionals and significant others left behind suicide, including suicide researchers. In response to this need, researchers started to work
towards the development of a more united and easily understood nomenclature that could be adopted in the emerging field of suicide postvention especially (Cerel et al., 2014).

In due time, the terms “suicide survivor” or “survivors of suicide” became well-established in the field of suicidology (Cerel et al., 2014). Jobes et al. (2000) explained that suicide survivors are self-defined: they include anyone who experiences hurt after suicide and acknowledges that the death has affected them in sometimes painful and profound ways. The people bereaved by suicide began to adopt this terminology and apply it to themselves as they felt that it expressed what they were experiencing, and they could use it if they needed to access support from established mental health services (Jordan & McIntosh, 2011). While the adoption of such terminology was beginning to meet the needs of people who were bereaved after a suicide, it did not address the experiences of people who had attempted suicide and it was not clear if it could be applied to professionals who had been bereaved by suicide in the course of their clinical duties.

In their study of suicide bereavement, Jordan & McIntosh (2011) acknowledged the need for a more comprehensive definition of suicide survivorship that was more inclusive of other people, besides the relatives of the person who had died by suicide. In their comprehensive text, ‘Grief After Suicide’, they included this definition of a “suicide survivor”,

“Someone who experiences high levels of self-perceived psychological, physical and/or social distress after the suicide regardless of the social relationship with the person” (Gutin et al., 2011) (page 7).

This definition suggests that anyone who was in any type of relationship, not just kinship with the person who died by suicide, can be regarded as a “suicide survivor”. This would allow for the inclusion of friends, neighbours, members of the community and clinicians. Following on
from this, Cerel teamed up with McIntosh (2014) and they developed a Continuum of Suicide Survivorship Model, which further expanded the definition of suicide survivorship, to include those “exposed to, affected by and bereaved by suicide” (Cerel et al., 2014). A closer examination of suicide survivorship reveals that the term “survivor” could legitimately include people who attempted to die by suicide but lived to tell the tale.

In the field of suicide postvention, it is crucial that the voices of nonfatal suicide attempt survivors are heard and that important lifesaving lessons are learned from their life-transforming experiences. The experience of the mental health activist, storyteller and filmmaker Kevin Hines provides a powerful example of a nonfatal suicide attempt survivor whose life was totally transformed by his experience (Hines, 2013). In September 2000, 19-year-old Kevin leapt off the Golden Gate Bridge in San Francisco, North America. This major tourist attraction is a renowned suicide hotspot that has resulted in the death of almost 2000 people since it was first constructed in 1937. Kevin is one of 36 people who survived the fatal jump and he now actively engages in suicide postvention activities all around the world (Hines, 2013). Another inspirational example is that of Johnny Benjamin, an English mental health activist and author who attempted to jump off the Waterloo Bridge in London in 2008. His life was saved by a kind stranger who came to his side and had a compassionate developmental conversation with him which resulted in Johnny being guided to safety (Benjamin & Pfluger, 2018). Whilst Kevin and Johnny’s stories of suicide attempt survivorship feature very strongly in the media, in everyday encounters there are many other stories that mental health nurses hear about whenever they encounter a patient who may be experiencing mental distress. During the assessment phase of an admission to any mental service, mental health nurses engage in suicide risk assessment by having a conversation which allows for the exploration of past episodes where people have tried to take their own lives. The use of the term “suicide attempt survivor” (Cerel, 2014) is useful in the clear identification of this important group of patients, who can help mental health nurses to learn about some of the fundamental and
existential reasons why people engage in suicide behaviour as a behavioural manifestation of their psychological distress.

To acknowledge such life-transforming experiences and create a consensus of meaning, in the year 2014, the American Association of Suicidology formally introduced the expression “suicide attempt survivors” to designate people who had engaged in nonfatal suicide behaviour whilst the term “suicide loss survivors” is currently used to describe those left behind after a suicide, including mental health professionals (Cerel et al., 2014). As introduced in Chapter 1, within the United Kingdom care in the community is currently guided by the Care Programme Approach (DH, 1999; 2008). It is a formal arrangement that provides all patients presenting to community-based mental health services the chance to have a comprehensive assessment of their presenting problems, including any risks of suicide or self-harm, using self-mutilating or self-destructive behaviours. Such a comprehensive assessment feeds into the creation of a holistic plan of care which is patient-centred, in collaboration with an identified care coordinator, a role that is often taken up by mental health nurses. It is important to acknowledge that, in view of the multi-professional nature of community-based mental health services, the role of the care coordinator can also be taken on by social workers, occupational therapists and psychologists (DH, 2008).

As care coordinators, mental health nurses often take the lead responsibility in managing a clinical case and providing clinical continuity. They arrange input from members of the multi-professional team, regular reviews of the care delivered, develop safe discharge plans, and create realistic after-care packages designed to help the patient to stay as well as possible after being discharged from the mental health services. With the advent of recovery-oriented practice, as pioneered by Mary Ellen Copeland’s (2006) Wellness Recovery Action Plan (WRAP) and Phil Barker’s (2005) Tidal Model, mental health nurses work collaboratively with patients to identify early warning signs of suicide relapse, relapse signatures, action plans to
address relapse, safety plans and crisis plans. When a patient attempts suicide or if a patient were to die by suicide, all of these mental health nurses can be significantly affected. Therefore, for clarity, the term *suicide attempt survivors* is used to describe those who engage in nonfatal suicide behaviour. The term *suicide loss survivors* is used to describe mental health professionals, including mental health nurses as *professional suicide loss* or *clinician* survivors (Andriessen et al., 2017), definitions which are helpful and very important for this study.

### 3.4. Suicide loss survivorship – current evidence

In many ways, mental health professionals respond to a patient suicide in a way that is similar to the way relatives, family or close friends respond (Gutin et al., 2011); however, their reactions as professionals are not always acknowledged. The initial reactions to the suicide of a patient who was actively recovering on their caseload, or one who had recently been discharged, may include shock, disbelief, confusion, denial, numbness and anger. This is understandable because of the attachment (Bowlby, 1998) and interpersonal nature of the psychosocial interventions which mental health professionals use when engaging with distressed patients experiencing suicide thoughts and behaviours. The professional has the duty of care to do no harm to the patient, to promote recovery and they also have the responsibility of engaging in suicide prevention with their patient. This therapeutic work, whilst it can be rewarding, can also be very challenging, especially when the professionals have invested a significant amount of emotional energy, whilst truly believing that they are facilitating change and making a difference in people’s lives. Therefore, when the patient dies by suicide, it is common for professionals to feel a deep sense of anger as part of the emotional manifestation of suicide grief and bereavement. Anger may be directed towards the deceased, to the self, at the family, police, media or anyone who may have been involved in
or affected by the case. Subsequently, such feelings may be quickly accompanied by sadness, loss, rejection, anxiety, fear, shame and grief in varying proportions (Farberow, 2005). Both groups may publicly or privately express grief, which at times can be complicated or abnormal, traumatic, pathological, chronic, prolonged, persistent or complex, depending on the duration and the intensity of the grief reaction (Andriessen et al., 2017).

It is also common for people to feel or express sorrow for the person who has died by suicide, to feel overwhelmed by complex emotions such as guilt, rage, and feeling deserted and rejected by the deceased (Jordan and McIntosh, 2011). There may be changes in the behaviour within the social networks as they experience grief after suicide. Some have reported feeling rejected, isolated, ashamed, a fear of being blamed, ostracised and stigmatised as a direct result of the taboo surrounding suicide (Peters et al., 2016a; Sheehan et al., 2017). Others have engaged in self-stigmatising behaviour after experiencing suicide loss by suffering their loss in silence, which has made it hard for them to seek or accept help when offered, whilst others have struggled to deal with the social ineptitude of people in their social network who genuinely do not know what to do or how to react to those grieving after a suicide (Peters et al., 2016a; Peters et al., 2016b). Still others may be comforted by knowing that their patient is not distressed anymore, with the sincere hope that the patient has found peace from their existential distress. For all groups, regardless of their ontological views after the suicide, the patient suicide is generally considered to be a traumatic loss, which may have a long-lasting effect on those bereaved by the death (Gutin et al., 2011).

To be bereaved means “to be deprived or robbed of something” or someone and the term bereavement has been defined as “the state of having suffered the loss of a loved one by death” (Blackwell's Dictionary of Nursing, 1994, p. 87). Additionally, Martin and Law (2014, p. 56) define bereavement as:
“the feelings that arise as the result of being deprived, especially of a relative, friend or other loved one through death but also previous good health.”

The sudden and unexpected nature of death by suicide may trigger strong feelings of being “robbed of someone” in the people that are left behind. It is known that there is a process that may take place once a suicide happens and no time limit can be put on the period of bereavement (Andriessen et al., 2017). During this time, people may go through a process of acknowledging or expressing their grief as a solitary endeavour or they may seek survivorship support from family, friends, peer support groups or mental health clinicians (McKinnon & Chonody, 2014; Andriessen et al., 2017). Therefore, regardless of the type of affiliation with the individual who died by suicide, there is evidence-based research that supports the notion that people will be bereaved and will identify with the experience of being a suicide-loss survivor. People who try to die by suicide and survive also receive acknowledgement in empirical literature and their experience is adding to the growing research that is being carried out with people who attempt suicide and live. With the purpose of conceptualising the experience of suicide loss survivorship, the next section will now consider how the work of Cerel et al. (2014) resulted in the construction of a theoretical framework which underpins current suicide postvention research, policy and clinical practice.

3.5. A theoretical approach to the conceptualisation of suicide loss survivorship

A theoretical framework that helps us to further understand the concept of suicide loss survivorship was proposed and constructed by Cerel et al. (2014) in the form of The Continuum of Suicide Loss Survivorship Model. This model was developed over time and it aims to provide a theoretical framework that underpins suicide postvention research, public health and clinical interventions for people left behind after a suicide. This model adopts a multi-dimensional
approach to the aftermath of a suicide as a continuum on which people would be considered as “suicide exposed”, “suicide affected”, “suicide bereaved in the short term”, or “suicide bereaved in the long term” (Cerel et al., 2014). As part of their discussion around the four groups of people, Cerel et al. (2014) provide a clear and helpful description of what these terms actually mean.

'Suicide exposed' refers to:

“anyone who knows or identifies with someone who dies by suicide.... This would include those who ‘know of’ someone who died by suicide but did not experience the severity of and/or the longer-term effects associated with the loss of someone with a closer or more intimate relationship’ (Cerel et al., 2014, p. 595) with the person who has died by suicide.

In everyday life, people may be exposed to suicide when they hear of the suicide of a famous international celebrity, the suicide of a national hero or heroine, or the suicide of someone well known in their local county, city, town, village, community or even at a school. For example, in England, it is common for passengers using overground rail services or the London Underground tube services to be “suicide exposed” when there is a public announcement regarding train delays after a person has died by suicide after throwing themselves or jumping in front of a moving train. While working within mental health services, members of clinical and supporting staff without clinical responsibilities, not directly involved in direct patient care, may also be “suicide exposed” when news of a death by suicide spreads across a certain clinical directorate or service. For those “suicide exposed”, emotional and psychological reactions may be fleeting but they do exist, which results in the theoretical recognition and consideration of people’s experiences in a way that has not been done previously.

Next on the continuum are the “suicide affected”, described by Cerel et al. (2014) as people
who experience:

“significant psychological distress…. which includes those bereaved by the suicide of a significant other and those whose relationship to the deceased would have previously excluded them from being bereaved in the usual sense, as in people who witness the suicide and subsequently experience post-traumatic symptomatology.” (Cerel et al., 2014, p. 595)

In research by Troy Tranah (1992) entitled “Suicide on the London Underground”, seventy-six London Underground Train Drivers were interviewed one month after a person had jumped or fallen in front of a train. The data generated by these interviews revealed that thirteen out of seventy-six drivers (17.11%) showed signs of Post-Traumatic Stress Disorder (PTSD). He noted that the levels of distress decreased after three, six and nine-month intervals, with no drivers showing symptoms of PTSD after twelve months. According to Cerel et al.’s model (2014), these train drivers would fit the definition of those who have been “suicide affected”, in view of the fact that they did not have a relationship with the person who jumped in front of the train but were significantly affected by the suicide of the person. Similarly, within the context of mental health practice, a member of staff who did not directly know the patient who died may become very upset upon hearing about often violent modes of death used during the suicide, even though they did not personally know or have a relationship with the patient who had died by suicide.

By building on attachment theory presented by Bowlby (1956, 1998), which posits that, as humans, we exhibit certain behaviours, thoughts and feelings when we are trying to form, establish, maintain and sustain close connections with others, Cerel et al. (2014) developed the next level of the continuum. According to Bowlby (1956, 1998), there are four attachment styles which can be developed in childhood in response to parenting methods and behaviours. These styles can shape the way in which we live, love and respond to detachment or loss as adults. To illustrate, the secure attachment style is more likely to develop when children feel a
strong sense of connection, consistency and responsiveness from their parents, whilst the avoidant attachment style may develop after a child’s needs for closeness, comfort and intimacy are dismissed by the parent. When parents reject or fail to provide consistency for their children and their love for their children blows hot and cold, the child may learn to anxiously observe their parent’s moods, which may result in their experience of the anxious attachment style. The disorganised attachment style occurs when parents are unable to emotionally regulate and self-soothe due to their own unresolved experiences of trauma-based shame, loss, abuse or exploitation. Bowlby recognised that the manner in which a child feels frantically upset if they cannot find their mother if they get lost or they are separated is somehow duplicated or played out in adults after they have been separated from a loved one by death. In other words, it was as if the same feelings were triggered and experienced in adults after someone they loved dies (Bowlby, 1956, 1998). Cerel et al. (2014) incorporated this important theory into the development of the next phase of the suicide loss survivorship continuum which identified people who have been bereaved by suicide depending on the level of attachment that they had with the deceased over a certain period of time.

The next point on the continuum represents people who have been “bereaved by suicide in the short-term” due to the close nature of the relationship that they had with the deceased which is of:

“relevance for the survivor’s sense of felt security. This group of people may include partners, family members, close friends and associates for whom the loss carries personal and usually profound implications”. (Cerel et al., 2014; p. 595).

By giving this description, Cerel et al., (2014) argue that, in distinguishing between people who are suicide bereaved in the short-term vs the long-term, they are acknowledging that, as identified by Bowlby (1998), people will experience a wave of initial complex feelings and thoughts immediately after the suicide loss. This group of people may include family
members, mental health professionals, friends and close work colleagues or school friends. Continuing with the illustration about suicides on the London Underground, those “bereaved by suicide in the short-term” would include the partners, family, relatives and close intimate friends of the person who has jumped or fallen in front of the moving underground train. Within the context of mental health practice, mental health professionals who may have participated in facilitation of direct care to the patient would also meet the criteria of those “bereaved by suicide - short-term”. For some people, the intensity of these feelings of bereavement may subside, whilst others bereaved by suicide may continue to experience distressing and protracted feelings, justifying a classification of ‘suicide bereaved, long-term’.

In the final layer of the nested model of suicide loss survivorship, Cerel et al. (2014) provide a description of what is meant when they use the term “suicide bereaved, long-term”. This refers to “those with close personal relationships to someone deceased by suicide who struggle across a protracted period of time with clinically significant responses to the loss.” (Cerel et al., 2014; p. 595). Significant responses may include distress, complicated grief (Jordan and McIntosh, 2011); difficulties with grief and the challenge of making sense of the loss (Niemeyer and Sands, 2011); as well as post-traumatic stress, prolonged depression and generalised anxiety (Dyregrov et al., 2012; De Leo et al., 2014; Andriessen et al., 2017). To add to this list of people described as being “suicide bereaved, long-term” (Cerel et al., 2014) are mental health nurses who will have had sustained or intensive therapeutic relationships with the patient who died by suicide (Spencer, 2007).

This model is the first one to provide helpful ways of understanding and making sense of the complex process of being left behind after a person dies by suicide and it helps to justify the reasons for choosing to focus on the experiences of mental health nurses. Cerel et al., (2014) acknowledge that their model is not perfect; however, it does provide researchers with a useful theoretical framework which helps to demystify and clarify the concept of suicide loss.
survivorship. Not only will this model benefit researchers but it will be of good use to mental health nurses as they engage in their daily practice of suicide prevention, intervention and postvention with people experiencing mental distress. Cerel et al. (2014) also believe that this shared vocabulary will bring some clarity to the relationships that connect different groups of people with each other whilst allowing them to be recognised as being capable of experiencing different forms of suicide survivorship on the continuum of suicide loss. In other words, this model can apply to anyone who may be affected by a suicide, regardless of how they were connected with the person who died by suicide. Therefore, it is against this background that I have chosen to adopt this model for this study as it allows for the inclusion of community mental health nurses as suicide loss survivors who may shift along any part of the suicide loss survivorship continuum after the death of a patient.

Cerel et al. (2014) provided some examples that illustrate who might be included in the four categories of suicide loss survivorship. Table 2 below provides a visual representation of the examples provided in the original research paper. The descriptors which I have chosen to highlight, using bold italicised letters, indicate the various roles which mental health nurses can be in at the time when a patient suicide takes place. The model also allows for the inclusion of mental health nurses who work in in-patient hospitals or within community-based services. From the time that the suicide loss survivorship continuum was first published, more empirical research has been published to further explain the terms ‘suicide exposed’ and ‘suicide affected’ (Maple et al., 2017; Cerel et al., 2017; Andriessen, 2017; Weisenhorn et al., 2017; Cerel et al., 2018).
I have chosen to apply this model to this research because it includes mental health nurses who can fall under the category of therapist, health care worker, first aider or the person who discovers the body after a patient has died by suicide (Cerel et al., 2014). The therapeutic nature of mental health nursing was widely publicised by Hildegard Peplau (1952), fondly known as one of the founders of modern mental health nursing practice, when she promoted the use of interpersonal relationship in the practice of mental health nursing (Jones et al., 2012). Peplau was heavily influenced by the work of Harry Stack Sullivan (1892 – 1949), a proponent of interpersonal psychoanalysis, who described people in distress as having ‘problems in living’ and suggested that, by interacting with others in a meaningful way, such
levels of distress could be understood and ameliorated. Based on Sullivan’s philosophical influence, Peplau began to teach mental health nurses about the therapeutic use of self, through active listening and embracing the world view of the patient presenting in distress. This process would create a therapeutic milieu in which the distressed patient experiencing suicide thoughts and behaviours could begin to talk about how they view themselves, other people and the world in which they are experiencing ‘problems with living’. Peplau’s work later influenced modern mental health nursing philosophers such as Phil Barker (2011), who explained the humanistic nature of mental health nursing where people are interested in helping other people who are experiencing significant life problems.

In today’s practice, mental health nurses are able to evaluate and respond to suicide risk by talking and listening to the patient, whilst expressing genuine compassion, kindness and empathy. It is not surprising that, in the course of deeply engaging with people experiencing suicide thoughts and behaviours, mental health nurses may develop deeply collaborative and interconnected relationships with the patients that they are looking after, as described by Bowlby (1998). Frosh (2012) explained that the use of psychodynamic psychotherapy, and other related interpersonal therapy approaches, has led to the extensive development of a tradition of therapeutic approaches in which meaning is placed at the centre of understanding mental distress. In other words, the role of mental health nurses is varied and the scope of their lived experience as they engage in the work of suicide prevention within a community mental health setting can be far-reaching. Therefore, this model allows for the inclusion of mental health nurses as suicide loss survivors on all four points of the continuum.

3.6. Mental health practitioners as suicide loss survivors – the reality

Having shown that suicide loss survivorship affects all mental health professionals, including
mental health nurses, the next section will present a review of the literature which presents findings that illustrate what mental health professionals go through after a patient died by suicide. As a starting point, after he lost a patient to suicide in the 1980s, a Clinical Psychologist called Dr. Claude Chemtob, with a special interest in trauma, was motivated to conduct ground-breaking primary research aimed at determining how frequently the loss of a patient to suicide occurred for psychiatrists and psychologists across North America (Chemtob et al., 1988a; Chemtob et al., 1988b). This work was ground-breaking because, at the time, there were no large-scale studies on the impact of patient suicide on psychiatrists.

Early studies by researchers such as Kahne (1968), Holden (1978), and Lapp (1986) had investigated the impact of suicide on psychiatrists but had been carried out on a very small scale, with some significant sampling issues, including, in one instance, the sourcing of participants from a single hospital. For example, Kahne (1968) surveyed psychiatrists who had experienced the suicide of an inpatient at a hospital in Boston and his findings indicated that the participating psychiatrists had experienced acute grief reactions. At a later date, Holden (1978) studied 28 clinicians made up of psychiatrists and psychologists working in private practice. 40 per cent of Holden’s participants reported that they had lost a patient who was in long-term therapy to suicide, an experience which had also triggered grief reactions.

Most papers published from the early 1960s onwards consisted of single case reports, interviews or surveys of small groups of psychiatrists. The findings suggested that, in the aftermath of a patient suicide, psychiatrists were affected both personally and professionally. Whilst these early findings provided Chemtob et al. (1988) with information and insight, they offered relatively broad-brush impressions of psychiatrists’ reactions to a patient suicide with little specificity. These methodological problems severely limited the reliability and generalisability of the research findings from these early studies. Consequently, this prompted Chemtob and his colleagues to undertake their study, which aimed to address the identified
methodological limitations in the empirical evidence available at the time. This decision prompted Chemtob et al. (1988) to significantly expand the scope of earlier work and to produce findings which would result in the publication of some ground-breaking survey research.

Using a large and representative national sample of 269 psychiatrists out of 643 who had been invited to participate, Chemtob et al. (1988a) obtained a reliable and generalisable estimate of how frequently patients died by suicide and how this affected them. In his capacity as the principal investigator, Chemtob formulated an empirical study which aimed to assess, in much greater detail, the impact of such an event on the private and professional lives of psychiatrists. Based on his clinical interest in post-traumatic stress disorder (PTSD), his practice as a trauma specialist, and his positivist epistemological stance, he used a structured and well validated instrument – the Impact of Event Scale (IoES) – to measure the impact of patient suicide on psychiatrists (Chemtob et al., 1988a). The IoES was grounded in the Stress Diathesis Model, which, as discussed in Chapter 2, is a theoretical framework widely used to conceptualise suicide behaviours. It contains statements reflecting the experiences of intrusion and avoidance that are directly related to the stressful event that has occurred (Chemtob et al., 1988a). For example, participants reported on intrusive thoughts about patients who had died by suicide, whilst others reported staying away from anything that reminded them of the trauma, also known as avoidance.

The IoES is a self-reporting tool, which has a pre-set questionnaire designed with measurement in mind. Its reliability and validity as a tool have already been tested (Sundin and Horowitz, 2002) and it is widely accepted in the research community. This formed the basis of Chemtob’s survey, which asked psychiatrists to provide demographic information, to state the number of patient suicides that they had experienced, and to describe the effects of suicide on their clinical practice as well as their personal lives. For the sake of clarity, Chemtob
excluded any psychiatrists who had had a patient attempt suicide during therapy, those who had experienced the suicide of a former patient who had been discharged from the system, and the suicides of in-patients. Such aspects of suicide survivorship were to be investigated by other researchers after Chemtob et al. (1988a).

Findings from the study by Chemtob and his colleagues confirmed that a significant number of psychiatrists had experienced a patient suicide during their clinical practice, with many of them reporting emotional reactions such as stress and distress. 259 psychiatrists had had at least one patient suicide during treatment and it was estimated that there was a 55 per cent chance that they would lose another patient at some point in the future. Impacts that were reported by psychiatrists included their increased attention to legal aspects of practice, a fear of being sued, a tendency to hospitalise distressed patients and a more conservative approach to the selection of patients that they would agree to treat. There were also reports of increased focus on suicide cues during consultations, increased concerns with the issue of death and frequent use of collegial consultation, as well as peer supervision. Other effects were more conservative record-keeping and disturbed relationships with colleagues, friends and family. Many psychiatrists reported feelings of loss, low self-esteem, guilt, anger, intrusive thoughts of suicide, social withdrawal, emotional numbness and distressing dreams relating to suicide (Chemtob et al. 1988a).

The most significant finding was that the intrusive and avoidance scores in the two weeks after a patient suicide revealed distress levels that were comparable to the ones that had been reported by Horowitz et al. (2002) in a study of the experience of people who had been bereaved by the death of a parent. Such a well-executed research study shed light on the severity of impact of patient suicide on psychiatrists and has been hailed as gold standard research which has greatly shaped the thinking of suicide researchers from other disciplines (Andriessen et al., 2017).
Not only has this work prompted other mental health researchers to investigate the frequency of this phenomenon, using surveys that explore the stress and distress element as a reaction to patient suicide by various professional groups (Alexander et al., 2000; Dewar et al., 2000; Courtenay and Stephens, 2001; Linke et al., 2002; Pilkington and Etkin, 2003; Jacobson et al., 2004; Wurst et al., 2010; Landers et al.; 2010; Heeb et al.; 2011; Wurst et al., 2011; Draper et al., 2014; Dransart et al.; 2014; Finlayson and Simmonds, 2016), it has also laid the foundation for clinician suicide survivor research. A notable longitudinal research study by Sanders et al. (2005) investigated the impact of patient suicides on social workers over time. This ranged from seven days after the patient suicide to one year, two years, three years, four years, five to ten years, ten to fifteen years and finally fifteen to twenty years. The findings confirmed that there was a lessening of grief reactions in response to the patient suicide with the passing of time. In 2010, Wurst and colleagues followed suit and investigated the reactions of psychiatrists and psychologists in Switzerland through the use of a postal survey. It measured the impact of patient suicide on the well-being of the clinicians immediately after the death of the patient, two weeks later and then six months later. Other surveys were conducted in Switzerland by Dransart et al. (2014; 2015). These were both large surveys undertaken in inpatient hospital settings, using the IoES-Revised, to measure the grief reactions of multi-professional mental health professionals after a patient suicide.

Survey studies by Alexander et al. (2000), Dewar et al. (2000), LaFayette & Stern (2004), Landers (2010); Rothes et al. (2013) and Gibbons et al., (2019) confirm that patient suicide can have a profound emotional and professional impact on both trainees and qualified psychiatrists. Some participants reported feelings of shock, disbelief, sadness and anxiety, whilst others disclosed that they felt regret about entering psychiatry as a profession. A case study was undertaken by Veilleux (2011), using the Area Model of Adaptation and focusing on how therapists cope after a patient suicide, to help identify coping strategies that could be
adopted by bereaved therapists. Whilst this is an interesting approach to use, it is not clear if such an approach could be adapted to the support of other clinicians such as mental health nurses.

In addition to studying the effects of a patient suicide on psychiatrists (Alexander et al., 2000; Dewar et al.; 2000; Gibbons et al., 2019), survey studies were also used to investigate the attitudes of staff towards patient suicide (Pilkington and Etkin, 2003). Scocco et al. (2012) surveyed 34 psychiatrists in Italy and discovered that they too experienced acute grief reactions. It is also important to note that early researchers chose to study participants who had lost a patient to suicide, whilst they were in the process of receiving psychiatric treatment. This has its own implications because, from the perspective of the psychiatrist, the purpose of treating a patient is to support them to work towards recovery and to help them to reach an optimum level of functioning by learning to live well with their mental illness.

The paradoxical nature of losing a patient who is in treatment has been described as an occupational hazard not only by Chemtob et al., (1988a) but also by other mental health professionals from other disciplines (Chemtob et al., 1988b; Foley and Kelly, 2007; Dransart et al., 2015). Evidence from surveys indicates that, among the participants in various studies, between 51 per cent to 82 per cent of psychiatrists (Chemtob et al., 1988a; Alexander et al., 2000; Landers et al., 2010; Gibbons, 2019), 22 per cent to 39 per cent of psychologists (Chemtob et al., 1988b; Trimble et al., 2000; Finlayson and Simmonds, 2016), 33 per cent of social workers (Jacobson et al., 2004), and 55 per cent of nurses (Takahashi et al., 2011) have experienced a patient suicide during the course of their clinical practice. Evidence presented in studies undertaken by Ting et al. (2008), Ting et al. (2011) and Gulfi et al. (2010) also confirm the experience of distress in the form of anger, shame and worry among social workers. Whilst the death of a patient has been described as a traumatic event, there is a growing body of evidence that suggests that some clinicians may experience post-traumatic growth as a way
of moving on from the suicide (Tedeschi and Calhoun, 2008).

With regards to the actual impact of a patient suicide on mental health professionals, Chemtob et al.’s research specifically investigated the characteristics and impact of such a loss using the structured, well-validated instrument the Impact of Event Scale (IES) (Chemtob et al., 1988a. Chemtob et al., 1988b, Farberow, 2005). Studies prior to this had been small in scale, tended to focus on a small sample of psychiatrists or psychologists from one organisation unrepresentative of the larger population of psychiatrists and psychologists. By targeting such a large population of mental health professionals, Chemtob et al. (1988a) were able to assess in much greater detail how the death of a patient affected the professional and personal lives of those who chose to participate. Consequently, other researchers have since duplicated aspects of Chemtob et al.’s original 1988 study, through the use of survey questionnaires, the IES, and later the Impact of Events Scale-Revised (IoES-R), to investigate the impact of a patient suicide in other countries such as Ireland (Cryan and McCaffrey 1995; Landers et, 2010); England (Yousaf et al., 2002) and Switzerland (Heeb et al., 2011; Dransart et al., 2015).

As a result of using the Impact of Events Scale (IES), findings that were reported by Chemtob et al. (1988a) and other researchers confirm that patient suicides do trigger clinical stress reactions in mental health professionals, which can have a significant impact on their personal and professional lives. The experience of emotional turmoil, disruption, and stress reactions that range from acute stress to post-traumatic stress disorder, complicated grief and bereavement have been reported by mental health professionals (Chemtob et al., 1988a; Chemtob et al. 1988b; Jordan & McIntosh, 2011; Finlayson and Simmonds, 2016). Stress reactions ranging from the experience of intense distress, acute stress to experiencing symptoms of Post-Traumatic Stress Disorder (PTSD) such as invasive thoughts and avoidance behaviours have also been widely reported. Interestingly, almost 50 per cent of the participants reported post-trauma symptoms that also continued to manifest themselves for at
least 6 months after the event. Consequently, these psychologists adapted their clinical practice with patients experiencing suicide thoughts and behaviours by becoming increasingly aware of suicide cues, by accessing more clinical support from colleagues and teams, as well as becoming increasingly hyper-vigilant with clinical record-keeping.

The nature of mental health practice is such that clinicians tend to work in teams or departments. Therefore, when a patient dies by suicide, it is highly likely that many members of the clinical team will know about it and will feel the ripple effects in the aftermath of that patient suicide (Linke et al., 2002; Spencer, 2007; Canning & Gournay, 2014). This factor was taken into consideration by researchers using survey research as an approach to investigate the impact of patient suicide on teams. Research participants were asked if they had knowledge of another professional who had lost a patient to suicide and how this knowledge had impacted on them. In Chemtob et al.’s (2008a) study, many participants indicated that they knew of someone who had lost a patient to suicide. Such responses revealed the increased likelihood that mental health professionals may experience more than one suicide in the course of their professional lives, and it is reported in other surveys by Alexander et al., (2000), Trimble et al., (2000), Hendin et al., (2000), and Dransart et al., (2015). The suicide of a patient may have had a significant impact on career choices and, in some cases, led professionals to contemplate leaving the mental health profession (Alexander et al., 2000). However, such research about the impact of experiencing multiple patient suicides is still in its infancy and more work needs to be done to address this very important issue. Having determined how frequently mental health professionals experience a patient suicide, other studies have provided detailed descriptions of the characteristics of the suicide and its profound impact on their professional lives (Gutin et al., 2011; Andriessen et al., 2017).

On a professional level, it is recognised that mental health professionals may react with strong negative emotions that specifically stem from their professional role or position (Farberow,
2005; Gibbons et al., 2019). In other words, the emotional reactions from professionals may be bound up with strong feelings of uncertainty about their accountability, competence, fitness to practice, professional knowledge and clinical skills in the assessment and management of suicide risk (Foley and Kelly, 2007; Gibbons et al., 2019). Such feelings may also be accompanied by feelings of failed responsibility, reduced confidence and low self-esteem (Alexander et al., 2000; Gibbons et al., 2019). In addition to this, professionals may begin to doubt the reliability of their professional judgement, levels of knowledge, competence, suicide risk assessment and management skills, as well as experiencing increased levels of fear of legal consequences and professional investigations (Dransart et al., 2017). Furthermore, professionals may experience disenfranchised grief (Doka, 1989), a form of grief that is not permitted to exist or be expressed because professionals are expected to maintain their professional boundaries by repressing and concealing their personal reactions to any traumatic loss, including suicide (Takahashi et al., 2011; Dransart, 2017).

All the studies that have been included in this literature review have largely been influenced by the ground-breaking work of Chemtob et al. (1988a; 1988b). Based on his professional background and interest in post-traumatic stress, he used a recognised IoES to measure the impact of patient suicides on psychiatrists and psychologists. His study produced valid and reliable results, which many other researchers have been able to duplicate in order to explore the reactions of other mental health professionals to a patient suicide. Within this body of research, a small number of studies use this same approach to investigate the effects of patient suicide on mental health nurses, in an attempt to capture what it is like for this large professional group. To illustrate this point, with regards to the nursing workforce within the context of the UK, at the end of September 2018 there were 693,618 nurses and midwives professionally registered by the Nursing and Midwifery Council (NMC) to work in the UK (NMC, 2018). This included 525,810 Adult Nurses, 88,821 Mental Health Nurses, 50,565 Children’s Nurses, and 17,142 Learning Disabilities Nurses (NMC, 2018). Mental health nurses are the
second largest group of nurses in the nursing workforce and they make a significant contribution to mental health practice, which includes the emotional work of engaging with distressed people experiencing suicide thoughts and behaviours. Their numbers can be compared with those of the psychiatrist workforce. The UK based Royal College of Psychiatrists (RCP) ‘Summary of Workforce Census 2017’ revealed that 7,068 psychiatrists were professionally registered to work as consultants, specialists and associate specialists in NHS and non-NHS organisations (RCP, 2019). Of this number, 5,395 were registered as consultant psychiatrists and 1,673 were registered as speciality doctors (RCP, 2019). These figures show that mental health nurses significantly outnumber psychiatrists, yet the views of psychiatrists are widely represented in the research literature whilst there is little research which reports on the experiences of nurses after a patient dies by suicide. In an attempt to address this imbalance, some nurse researchers have embarked on studies which are designed to capture the experiences of mental health nurses, regardless of the clinical setting in which they work.

Takahashi’s (2011) survey study on the impact of in-patient suicides on 531 mental health nurses in Japan revealed that mental health nurses experienced distress in the same way that the psychiatrists in Chemtob et al.’s (1988a) study had reported. Whilst there is some research that recognises that mental health nurses as suicide loss survivors (Joyce and Wallbridge, 2003; Valente, 2003; Bohan and Doyle, 2008: Shanley, 2012), there is little qualitative research that explores the meaning of that lived experience for community mental health nurses after a patient dies by suicide. There may be the expectation that mental health nurses will carry on delivering high quality evidence-based care after a patient suicide loss regardless of what this experience might mean to them on a professional and personal level (Linke et al., 2002; Talseth and Gilje, 2008; Gournay and Canning, 2015).

This review has highlighted that there is a well-established body of research which confirms
that clinicians, predominantly psychiatrists, do experience emotional distress after a patient suicide. Survey research has been widely used to measure the impact of the patient suicide predominantly in psychiatrists, due to the dominant medical model which is influenced by positivist epistemology. Whilst this sets the scene for suicide postvention research in mental health professionals, it also highlights a gap in knowledge about the effects of a patient suicide on mental health nurses as a professional group.

3.7. Conclusion

This chapter confirms that the experience of suicide loss survivorship in relation to mental health professionals is a harsh reality. There is evidence to suggest that mental health staff are at a high risk of experiencing at least one patient suicide in their career (Gulfi et al., 2010; Gibbons et al., 2019), an experience which has been described as a work-related risk (Chemtob et al., 1988a; Chemtob et al., 1988b; Gulfi et al. 2010) which evokes strong emotional reactions. A conceptual framework proposed by Cerel et al. (2014) has helped to provide common nomenclature regarding who can be described a suicide loss survivor and it adds clarity to the concept of suicide loss survivorship which allows for the inclusion of mental health nurses. The literature review has established that there is a growing body of evidence which uses quantitative survey research based on the early work of Chemtob et al. (1988a). However, there is a lack of research which investigates the experiences of mental health nurses as suicide loss survivors, particularly using qualitative methods. This thesis will address this by undertaking a scoping review of literature relating specifically to mental health nurses, which will be discussed in more detail in Chapter 6.
Chapter 4 – Philosophical Considerations

4.1. Introduction

Before embarking on the study of a particular topic and to answer research questions, researchers need to select a research approach which will help them to contemplate the best way to go about doing the work. Each researcher’s approach will depend on several philosophical factors, such as how the researcher contemplates the problem, how it has and can be studied in a way that ensures that findings from the research can be credible to the researcher and to others in their discipline (Wagner et al., 2012). Each researcher will have their own philosophical view of what they think is true and how they believe knowledge is created. Such opinions will direct their rationale, principles and the assumptions that they hold about society and themselves. Consequently, these views will also frame or shape how we view the world around us, a concept which, according to social scientists is referred to as a paradigm (Wagner et al., 2012).

Quantitative and qualitative research paradigms have traditionally been considered as being polar opposites because they have distinctive belief systems which carry with them clear philosophical assumptions about what reality is (ontology), how we come to know things (epistemology), ethics and value systems (axiology), and the appropriate approaches to systematic inquiry (methodology) (Robson, 2013; Wagner et al., 2012; Robson and McCartan, 2016). It is important for researchers to develop an understanding of philosophical considerations which have a significant influence on the design of their study, and it will influence the way researchers undertake their study. The purpose of this chapter is to give the reader clear insight into the philosophical considerations that shaped how I designed my qualitative study as presented in this thesis.
In the research literature, it is well documented that there are certain methodologies associated with certain paradigms. A positivist approach tends to employ a quantitative methodology whilst a constructivist interpretative paradigm characteristically uses qualitative research methodology (Robson, 2011; Denzin and Lincoln, 2011; Creswell, 2012; Denscombe; 2014; Robson and McCartan, 2016). To say that there are only two paradigms would be simplistic and not a true reflection of what is known about research paradigms. Generally, the positivist paradigm forms one end of a spectrum and it is followed by other paradigms such as post-positivism, constructivism, interpretivism, transformative, emancipatory, post-colonial and indigenous paradigms (Wagner et al., 2012). This is by no means an exhaustive list, but it is one the reflects the diversity in the belief systems, cultural, political and scientific human experiences that influence the way in which we create knowledge and seek to acquire understanding of the world that we live in. For this thesis, I have chosen to focus on the most commonly known paradigms with a view to giving an overview of what they are and how they are commonly applied in social research.

It is important to acknowledge that the main reason for doing research using a positivist paradigm is to discover laws that are generalisable and govern the universe (Wagner et al., 2012) and to investigate causal relationships and test hypotheses with the aim of scientifically proving or disproving such hypotheses (Finlay, 2011). This paradigm also applies the natural science model of research to answer questions about the social world, where researchers treat social reality in the same way that they would treat physical reality, as something that is independently ‘out there’. Their focus is on facts and figures relating to the cause and consequences of phenomena in the social world (Denscombe, 2014). This way of working is underpinned by realist ontology, which is interested in how facts co-relate and focuses on statistical logic and verification of such knowledge (Crotty, 1998). As discussed in Chapter 2, early researchers influenced by positivist epistemology such as John Sym (1637) and Charles Moore (1790), through to Durkheim (1897), made significant contributions to the facts that we
know about suicide, its frequency and prevalence. In the field of suicide research, there is a place for the use of positivism, because it is important to know how many people die by suicide. For researchers using a constructivist, interpretative paradigm, the main reason for doing the research is to understand and describe the human condition with a view to explaining experiences and meanings created in the social world (Denzin and Lincoln, 2011; Wagner et al., 2012; Finlay, 2011). Thus, when applied to suicide loss survivorship research, using a constructivist, interpretivist approach allows researchers to have conversations with people who have been left behind after a suicide with a view to understanding what that explanation of suicide bereavement might mean to them in their lives.

The positivist paradigm is also philosophically-informed by idealism and critical realism whilst the constructivist interpretivist paradigm is informed by phenomenology and hermeneutics (Crotty, 1998; Finlay and Evans, 2009; Denzin and Lincoln, 2011; Finlay, 2011). Phenomenology involves researchers engaging with participants in conversations which are designed to elicit the subjective meaning of their personal, everyday experiences. Some of those experiences may be ‘taken for granted experiences’, such as the meaning of loss, while other experiences, such as suicide loss survivorship, may challenge a person’s sense of existence or gestalt, in the here and now, as well as in their view of other, their future and the world around them (Finlay, 2011). Using a phenomenological approach in research helps the researcher to develop an insider’s perspective after listening subjectively to the personal account of a suicide loss survivor as they tell their truth about their experience of suicide bereavement. The ontological assumptions of positivism suggest there is only one reality knowable via data and statistics, whereas the interpretivist paradigm acknowledges that there are multiple realities which are socially constructed (Crotty, 1998; Denzin and Lincoln, 2011; Creswell, 2013; Denscombe, 2014). In relation to researching mental health nurses’ experiences of patient suicide, I was interested in finding out how the participants experience the reality of the same phenomenon, the death of a patient by suicide, from the point of view
of their individual lifeworld and subjective reality. Researchers who adopt a positivist stance often posit that science is value-free and values have no place except when choosing a topic. However, constructivist interpretivists argue that values are an integral part of life and that there are no groups with values that are wrong, just different (Wagner et al., 2012). They aim to develop insights into the values that shape people’s beliefs, their lived experiences and how they make sense of that experience. Using such an approach would allow for a deeper investigation into the lived experiences of community mental health nurses.

As has already been mentioned, there are certain methodologies associated with certain paradigms and we see that positivist approaches favour quantitative methodology using random sampling, experiments, quasi-experiments, correlations, comparatives, causal comparatives and surveys. Constructivist interpretivist approaches often employ qualitative methodology, which uses methods such as phenomenology, ethnography, symbolic interactionism and naturalism (Finlay, 2011; Wagner et al., 2012; Denscombe, 2014). With regards to the actual collection of quantitative data, the positivist paradigm uses mainly questionnaires, observations, tests and experiments. Findings are reported using numbers and statistics. Researchers influenced by the constructivist interpretivist paradigm will typically use data-gathering techniques such as interviews, participant observation, pictures, photographs, diaries and document analysis. Their findings are reported using words, images and creative arts (Finlay and Evans. 2009; Finlay, 2011; Wagner, 2012; Denscombe, 2014).

Wagner et al. (2012) argue that there is no one model or theoretic framework that is right but, rather, it is the researcher’s choice to determine their own paradigmatic view and to decide how that view will inform the research design in a way that best answers the research question under consideration. This is not a simple process and it requires that the researcher develops a good understanding of the paradigms, with a view to making sure that they choose the most
appropriate approach to answer their research question. As a novice researcher, the works of authors such as Crotty (1998), Denzin and Lincoln (2011), Wagner et al. (2012), Creswell (2013), and Silverman (2014) made a significant impact on how I was able to identify my views of what is real, what I know, how I know it, and what I value, along with the theoretical perspectives that I have about my research topic. This mattered to me because, although I was a novice researcher at the start of the PhD process, I was also a very experienced registered mental health nurse with many years of working in both in-patient and community mental health services and I had also experienced the suicide loss of patients I had been caring for. Therefore, as described by Denscombe (2014), my assumptions about the nature of reality and knowledge, my value systems and my understanding of theories, research literature and my clinical practice significantly influenced my choice of using the qualitative research paradigm (Wagner et al., 2012).

After careful consideration of both quantitative and qualitative research paradigms, I chose a qualitative approach to help me to address my research questions. A major reason why I chose to use a qualitative approach was that I understood this would be the best way to address the research objectives I had set at the start of the research process. I understood that for me to address my main research objective, that of exploring the experiences of mental health nurses as survivors of the suicide loss of a patient, I needed to use a qualitative approach as this would be the best way to find out about the lived experiences from the participants’ point of view. This approach would also allow me to apply qualitative research methods in my exploration of factors that may have influenced how community mental health nurses experienced the death of their patient as well as exploring their views about the support that they may have received at the time of suicide.

4.2. Epistemology
I have chosen to adopt a constructivist interpretivist epistemological stance for this research study. These are related concepts which I believe address my understanding of the world as others experience or live it. According to Wagner et al. (2012), in comparison with positivists, constructivists hold different assumptions about the nature of reality, about what constitutes knowledge, what sources are credible and what values underpin the research process. The constructivist approach can be credited back to the German philosopher Edmund Husserl (1859 – 1938) who established the school of phenomenology, which is the study of human knowledge, self-awareness and consciousness. The interpretivist approach was developed by German philosopher Wilhlem Dilthey (1833 – 1911) who studied hermeneutics, which is defined as the study of interpretation and was later developed by contemporary philosophers such as Martin Heidegger (1889 – 1976) and Max Weber (1864 – 1920), the latter one of the founding fathers of the field of sociology commonly associated with Durkheim (1858 – 1917) and Karl Marx (1818 – 1883) (Denzin and Lincoln; 2011; Creswell, 2013; Denscombe, 2014).

The literature review in Chapter 3 has identified many quantitative studies which explored the experience of a patient suicide from a positivist epistemological stance. These findings have been useful in establishing facts about the impact of suicide on the professionals left behind. They measure the severity of the impact resulting in the production of empirical evidence which has laid the foundation for suicide postvention research. For the novice researcher, this is invaluable, and it sets the scene for the exploration of other aspects of the aftermath of patient suicide, including the lived experience, which can be achieved using an interpretivist approach.

An interpretivist approach arises from a critique of the natural sciences — such as biology, physics and chemistry — as the only model to be followed when undertaking research about common lived experiences. Whilst it is true that some social research adopts positivist approaches through the use of both qualitative and quantitative methodology, or a mixed method approach, there cannot be just one way of investigating topics. The interpretivist
approach, which aims to generate subjective knowledge about a range of human experiences that simply cannot be quantified, is recognised as way of studying lived experiences. This approach is underpinned mainly by subjective ontology which acknowledges that people are people, they are not objects, they have their thoughts, feelings and motivations which are influenced by different factors. These include age, gender, race, ethnicity, culture, social class, education and life experiences. Interpretivism is about understanding the how and why things happen, providing layers of meaning or engaging in meaning making. Typical approaches that are used are ethnographic study, in-depth interviews and analytic approaches, such as IPA and discourse analysis.

4.3. Ontology

My ontological perspective has been influenced by my lived experience of suicide loss survivorship on several occasions, as discussed in my narrative in Chapter 1. I believe that there is no single reality, the there are multiple realities and there are different ways in which life experiences can be understood and interpreted (Denzin and Lincoln, 2011). My ontological perspective has also been affected by my clinical experience of twenty-one years as a registered mental health nurse who has practised as a community mental health nurse and developed a specialist interest of working with people who experience suicide thoughts and behaviours. I am aware that my passion to do this research will be fuelled by my lived experience of helping people experiencing suicide thoughts and behaviours with their problems, but also with the lived experience of suicide survivorship loss on a personal and professional level. My ontological stance has also been influenced by my role as a nursing academic, a senior lecturer in mental health nursing, delivering undergraduate, postgraduate and post-registration education to mental health nursing students within the context of a higher education institution, as well as within clinical practice.
I am responsible for educating mental health student nurses about suicide prevention strategies such as suicide risk assessment and management, as well as teaching them about the various psychosocial interventions which they can use as tools as they create, develop, maintain and sustain therapeutic relationships with people experiencing mental distress as a consequence of problems in living. I have had the privilege of working collaboratively with a suicide prevention nurse consultant in facilitating suicide loss workshops for community-based mental health professionals after they have experienced suicide loss survivorship. This experience has enriched my lived experience as a researcher. I am interested in real lifeworld (Ashworth, 2003) research, underpinned by the principles of relationship-centred research, as described by Finlay and Evans (2009). This process has been a voyage of discovery where I have learned about the workings of key research relationships, the dynamic processes in qualitative research and explored my own personal development as a suicide loss survivor turned researcher.

I have also experienced suicide loss of family members, friends and even one of my undergraduate nursing students. The epistemological stance that I have chosen to adopt falls within the interpretivist constructivist paradigm and allows me to engage in more exploratory research about the effects of patient suicides on mental health nurses working within a community setting. The word *effect* means a change which is the result or a consequence of an action or another cause. In other words, I am interested in finding out the consequences of suicide on the personal and professional lives of mental health nurses.

I am interested in storytelling and hearing stories which reveal meanings about suicide-loss experiences that are common but, due to the stigma associated with suicide, are not always openly expressed or shared. The lived experience of the same event will differ from one person to another, so the use of an interpretivist model or framework will help me to make sense of
this phenomenon of suicide loss survivorship from the perspective of each individual nurse with a view to identifying themes, ideas, realities, vulnerabilities and strengths that can contribute to what is known about suicide loss survivorship. Therefore, my epistemological and ontological positions have influenced me to select qualitative methodology in the form of IPA, which will be discussed in more detail in the next section.

4.4. Methodology of choice

As a starting point, I chose IPA as a research methodology because it is an approach to the lifeworld (Ashworth, 2003) and because it considers the intricate relations between human beings and the complex world that we exist and live in. (Dahlberg, Drew and Nystrom, 2001; Ashworth, 2003). IPA is concerned with what it means for us all to be human and as stated by Dahlberg, Drew and Nystrom (2011),

“What it means to be human cannot be totally captured in language, and by no means by numbers, but is understood in fullness only through experience of it.” (p. 17).

As mentioned in Section 4.3., the focus of this research is the experience of suicide loss survivorship, the clinician’s experience of losing a patient to suicide and the subsequent process of meaning making and readjustment to living in the world after a patient has died by suicide. We live our lives knowing that at some point we will die, but when a death does occur, especially by suicide, we struggle to make sense of what has happened. As described in Chapter 1, I have experienced patient suicide in my own life, so I was interested in IPA because it allowed for the exploration of the lifeworld of the participants, at the same time giving some expression to my lifeworld as an IPA researcher who shares the experience of suicide loss
survivorship. From the interpretative hermeneutic phenomenological school of thought, Heidegger proposed that our ‘being’ in the world means that we cannot completely separate ourselves from the world that we inhabit (Heidegger, 1962; Dahlberg, Drew and Nystrom, 2001; Finlay, 2011). Therefore, when researching the lived world, the researcher has some investment and interest in the lived world. I recognise that my lived experience of patient suicide loss influences the direction of my research and that this informed the way in which I made sense and interpreted the experiences of my participants (Finlay, 2011). IPA acknowledges that I, as a researcher, am also a human being and am embedded in the world that I am trying to research. As IPA researchers, we are interested in knowing about how we negotiate our relationship in the world, the everyday experiences which may challenge us and challenge who we are in the world. In essence, IPA helps us to explore our lifeworld (Ashworth, 2003) as we exist in the world, as we face existential challenges with a view to making sense of our human experiences (Finlay and Evans, 2009; Finlay, 2011).

IPA is concerned with the detailed examination of human experience in its own terms rather than according to predefined categories. As IPA researchers we gather stories about the lived experience, which are often very detailed and reflective first-hand accounts and we engage in an analytical process with a view to interpret these lifeworld accounts (Ashworth, 2003) and give voice to the participants’ lifeworld (Smith et al., 2009). IPA, as an approach, takes into consideration the reality that human beings are meaning makers, in the sense that the meaning bestowed by the participant on their lived experience can be said to represent the experience itself (Langridge, 2007; Smith et al., 2009). Within the lifeworld paradigm, there is an acknowledgement that people will experience multiple realities. The realist view posits that every human being’s experience is valued and that it is the truth for that person (Willig, 2013). So it is crucial for IPA researchers to focus on the meaning and processes attached to the existential lifeworld experience (Ashworth, 2003) that the participants have shared with us.
based on their reality. We are keenly interested in finding out how they got to where they are in their lives. By following the principles of IPA, researchers are able to engage in meaning making whilst working hard to maintain a balance of giving voice to the participants and making sense of what they say (Smith et al., 2009).

The participants for this study were community mental health nurses who have experienced a patient suicide and are therefore experts in that experience. IPA focuses on the idiographic experience versus a nomothetic approach, giving emphasising to that particular individual and their lived experience (Smith et al., 2009). As applied to this thesis, it is an approach which helped me to meet the objectives of this study, which seeks to understand how these community mental health nurses make sense of this experience of a patient suicide from their own point of view. As a qualitative research approach, IPA is intended to transfer knowledge about an experience that matters to the participant. In other words, what the participants say will be directly related to their experience, which is what this study is interested in unfurling as a way of answering the research question about mental health nurses’ experiences of a patient suicide.

As a research method, IPA connects with core ideas from several phenomenological philosophers and it is a complementary approach rather than a competing one (Smith et al., 2009; Finlay, 2011). In 1986, Professor Jonathan Smith developed a qualitative research framework which aimed to focus on an in-depth experiential view of the lifeworld of the participants, by focusing on their inner drivers and how they make sense of their reality in relation to a particular lived experience. (Smith et al., 2009). IPA is situated within the continuum of phenomenological methodologies such as Husserl’s descriptive phenomenology and Heidegger, Merleau-Ponty, Sartre and Gadamer’s hermeneutic or interpretive phenomenology (Dahlberg, Drew and Nystrom, 2001; Finlay, 2011). When we engage in
hermeneutics, we are able to access lived experiences through interpretation and give voice to the participants, helping to sense of what they say. This results in IPA researchers engaging in the hermeneutic circle where they work to understand the whole of the experience and parts of it, from the description of an experience through to analysing the meaning of that experience for the participant (Smith et al., 2009; Finlay and Evans, 2009). The principles which underpin the hermeneutic circle will be discussed in further detail later in this chapter.

In order to make this process of hermeneutics take place, Smith et al. (2009) developed a flexible set of guidelines which are situated somewhere in the middle of Husserl’s descriptive phenomenology and Heidegger, Merleau-Ponty, Sartre and Gadamer’s hermeneutics which focus on lifeworld approaches (Ashworth, 2003; Smith et al., 2009). The experience of the death of another human being can have a significant effect on how human beings make sense of the world. With reference to mental health nursing research undertaken by Bowers et al. (2010), it is interesting to note that, on average, a mental health nurse working full-time within in-patient mental health services in the UK can expect to be exposed to a patient suicide approximately every three years. Within a community setting, Appleby et al. (2016) confirm that the likelihood of experiencing a patient suicide in Crisis Resolution and Home Treatment is also high due to the nature of patients presenting in these services. In the context of this study, the experience of the premature death of a patient by suicide is seen as the ‘real lifeworld experience’ that is under consideration using a qualitative approach (Ashworth, 2003).

As mentioned above, IPA emphasises a Heideggerian approach to reflexivity that engages with the concept of the hermeneutic circle (Dahlberg, Drew and Nystrom, 2001; Finlay, 2011). The term hermeneutics is used to describe the theory of interpretation which meets with phenomenology through the work of hermeneutic phenomenologists such as Heidegger,
Gadamer and Schleiermacher (Smith et al., 2009). When compared with IPA, descriptive phenomenology also focuses on individual experiences and the lived world, but does not include an interpretive element (Finlay, 2011), which is why it was not selected as a qualitative method for this study. The hermeneutic circle provides the researcher with the opportunity to see the dynamic relationship between the part and the whole. It is iterative and allows the researcher to develop a deep relationship with the qualitative data (Smith et al., 2009), also referred to as the double hermeneutic, which means that the researcher spends time making sense of the participant making sense of something (Smith et al., 2009; Finlay, 2011).

The work of Hursssel, as incorporated in IPA, encourages researchers to develop a phenomenological method, where we use bracketing to put to one side the taken-for-granted world that we are researching, and we concentrate our perception of that world. The process of bracketing allows the researcher to look at who they are, their ontology and epistemology, as well as their own assumptions and biases in relation to what they are researching. The researcher can engage in bracketing when conversing with the participant, when interviewing the participant, when interpreting the data and when engaging in and presenting the final analysis. In IPA, the best way to engage in bracketing is to engage in reflexive practices which are commonly used in qualitative research (Smith et al., 2009; Finlay, 2011).

Within the context of this study, during my fieldwork, starting with advertising the study, recruiting, and selecting participants who met the inclusion criteria, communication with the participants through to interviewing them and analysing the data, I intentionally and actively engaged in bracketing. With specific reference to my data collection activities, I chose to engage in reflexivity by keeping audio diaries after each interview with a participant. The main reason for doing this was to record my personal beliefs, assumptions, biases, and thoughts about each interview with a view to identifying where they are on the hermeneutic circle. When I listened back to the audio recording, I was able to gain some insights into my lifeworld and my lived experience as I was carrying out this research. This is considered to be good research.
practice, as it acknowledges that my personal world view and my experiences may have a significant effect on the research process (Smith et al., 2009; Finlay, 2011). This is especially important because my interest in this research topic was triggered by my own lifeworld (Ashworth, 2003) experiences of patient suicide loss at the start of my career as a student mental health nurse during the second year of my undergraduate studies, making it even more crucial for me to engage in bracketing. IPA actively encourages reflexivity because this is designed to help novice researchers like me to be aware of my personal relationship with and my overall investment in the outcome of the research.

Although IPA focuses on developing themes in the same way that Thematic Analysis does, Thematic Analysis puts less emphasis on reflexivity than IPA does. Due to larger sample sizes that are used in Thematic Analysis, there is more room to generalise to similar populations, whereas IPA focuses more on knowledge transferability (Finlay, 2011) in relatively small sample sizes. I favoured IPA over Thematic Analysis because IPA lends itself more to human life, due to its use of reflexivity and the hermeneutic circle. IPA gives the researcher a deep insight into the experience, which they might not get from thematic analysis. Therefore, reflexivity was the key activity that I engaged in right from the start of the research process in order to record my ideas, reflections, observations, questions, and decisions that came up during the study whilst engaging with double hermeneutics (Finlay, 2011).

Another distinctive feature of IPA is the notion of idiography, which is concerned with the particular and with understanding the meaning of the individual lifeworld (Ashworth, 2003) rather than attempting to establish universal and causative laws. In other words, the value of IPA as a qualitative approach is to offer some in-depth “nuanced analyses of particular instances of lived experience” (Smith et al., 2009, p. 37). This helped me to understand that,
as the researcher, I would engage in a thorough and systematic analysis of interviews. Doing so would demonstrate that I have a strong commitment to the analysis of each single case in its own right, by examining it in such detail as if it were the only case. In order for me to do this successfully, I recognised and appreciated the need to recruit and talk to a relatively small number of participants for the study. This process will be discussed in more detail in Chapter 6. A qualitative method that focuses on the use of language through discourse is Discourse Analysis, which views talking as a medium for conveying information and knowledge. It differs from IPA in that meaning can be made from text-based data, so interviews with people are not always necessary. Although both methods focus on linguistics, IPA was chosen as an appropriate methodology because it also utilises cognitive, behavioural, and affective reactions that may be played out in an embodied way during a face-to-face semi-structured interview. During the analysis phase, IPA then utilises linguistics to understand how participants make sense of their real-life experiences (Finlay, 2011).

Grounded Theory Methodology was considered as an approach that could be used for this study. When compared with IPA, both methods focus on meaning making but Grounded Theory focuses more on the processes of social phenomenon whereas IPA focuses on how people make sense of the phenomenon. Grounded Theory is about generalizability with sample sizes of up to twenty and concerns itself with the building of a theory or a model whilst IPA does not. IPA uses smaller sample sizes to understand how a certain group of people make sense of their experiences using a homogenous sample, whereas Grounded Theory tends to use a heterogeneous sample (Willig, 2013). I believe that the nature of the problem under investigation should determine the method that is used. As I undertook this research, I was guided by constructivist interpretivist epistemology to use qualitative methodology to develop an understanding of what is known about mental health nurses surviving patient suicide loss from an empirical stance. It is against this background that I selected IPA as the most appropriate qualitative research method to address the aims of this study.
4.5. Conclusion

The philosophical underpinnings for this qualitative study were selected after careful consideration and consultation with qualitative methodological literature which is often used in psychology but can be applied to other social sciences such as mental health nursing research. Positivist and interpretivist paradigms were considered and the rationale for choosing a constructivist, interpretivist approach using qualitative methodology was considered the most persuasive for the purposes of answering the research question. The next chapter will consider the research methods that were employed in the design of the qualitative study.
5.1. Introduction

In the field of qualitative research methodologies, there are specific techniques and approaches which can be used in the implementation of the research process. According to Creswell (2013), to engage in qualitative research means that researchers need to have a strong dedication to studying the problem and its demands, in terms of time and resources. To meet these demands, there exists a collection of well-known qualitative research methods which can be used to gather data about the lived experiences of the participants (Finlay, 2011; Silverman, 2013). Qualitative research studies generally rely on the use of three data gathering procedures: observations; interviews; and document or artefact analysis. According to Wagner et al. (2012), each of these methods can be divided into a wide variety of categories, each category with its own structure and many possible variations.

As part of the process of selecting research methods, the researcher needs to achieve methodological congruence. This means ensuring that the purposes, questions, and methods for the research are all interconnected and interrelated, so that the research study appears as a cohesive whole rather than appearing in fragmented, isolated parts (Dahlberg, Drew and Nystrom, 2001; Creswell, 2013). Therefore, it is important for the researcher to make decisions about which research methods to use because each method will influence the type of data that is generated, collected, and analysed. Consequently, this can have an impact on the overall findings of the study once it has been completed. The purpose of this chapter is to present an in-depth discussion about the procedure that I followed when making choices about the qualitative data collection methods for my study.
5.2. Using Interviews as a Qualitative Research Method

In order to address the research aims, I drew on the principles of IPA and I chose to collect individual stories and lived experiences from participants using a series of face-to-face semi-structured interviews (Langridge, 2007; Smith et al., 2009). The rationale for selecting semi-structured interviews was that this approach to interviewing allowed me to have conversations with participants about their subjective experiences of a patient suicide and the meanings that they attribute to those subjective experiences in their social world (Finlay, 2009; Smith et al., 2009; Wagner et al., 2012). Lifeworld researchers use interviews to enter the lifeworld of the participants with a view to exploring a phenomenon of common interest. By facilitating lifeworld interviews, researchers listen to the voice of the lifeworld and strengthen it at the same time. The researcher encourages real-life storytelling in order to be with the participant (Dahlberg, 2002). In support of this idea, Finlay (2011) suggests that “the most productive research encounter is one where the researcher seeks to relate to the participants in a natural, empathetic and genuinely human way.” (p. 201)

Qualitative researchers often collect data in the participant’s natural settings and undertake the fieldwork in the settings where the participants experience the problem or the lifeworld (Ashworth, 2003) issue under investigation. They do not bring people into a science lab and do experiments on them or with them, rather they typically gather up close information by talking directly to people using interviews and seeing them behave or act within their context (Smith et al., 2009; Creswell, 2013; Mason, 2011). Braun and Clarke (2013) use the term ‘interactive data collection’ which promotes the idea that a semi-structured interview involves collaborations and co-production of knowledge with the participant. Therefore, an interview is defined as a:

“two-way conversation and a purposive interaction in which the interviewer asks the
participant, (who takes on the role of the interviewee), questions in order to collect data about the ideas, experiences, beliefs, views, opinions and behaviours of the participant.” (Wagner et al., 2012, p. 133)

The outcome of semi-structured interviews has sometimes been referred to as data with a soul (Brown, 2014; Brinkman and Kvale, 2015) because the aim of an interview is to obtain rich idiographic descriptive stories that will help us to see the world through the eyes of the participant (Langridge, 2007; Smith et al., 2009; Mason, 2011; Creswell, 2013). Facilitating an interview also involves an element of trust between the interviewer and the participant. According to Wagner et al., (2012), if the person that you are interviewing shares the belief that the topic under consideration is important, and if they trust you, they will give you information that you will not be able to collect in any other way. I subscribe to this point of view and I believed that using semi-structured interviews would help me to address the research objectives that I set at the start of this study.

There are three types of interviews: structured; semi-structured; and unstructured (Mason, 2011; Denscombe, 2014; Brinkman and Kvale, 2015). Individual interviews give the researcher the opportunity to offer a one-to-one face-to-face conversation with a potential participant with a view to collecting data. On the other hand, group interviews permit the researcher to talk to a group of people about a shared experience and then elicit their views within a group setting (Braun and Clarke, 2013; Denscombe, 2014). More specialist group interviews are referred to as focus group interviews, which are designed to facilitate debate and discussions about a given topic and the group dynamics become an integral part of the interview process (Wagner et al., 2012). The purpose of this study is not to generate debates, but it is to find out about the lived experiences of a group of people who have been through a certain situation. I avoided using focus group interviews because they would not have been an effective method for collecting data that would help me to address the research question.
After deciding to use semi-structured interviews, the next stage of the research design process was for me to think about what tool I was going to use to structure the interviews. An interview guide or schedule is often used by qualitative researchers, containing essential instructions on how to carry out the interview. It is based on the research problem, the research questions and information that will have been gleaned from the literature review about what is currently known about the topic under consideration. It is common for interview guides to start with an introduction to the study, to include ethical issues of informed consent, confidentiality, request for permission for that interview to be tape-recorded and then present a series of questions that the interviewer will ask (Smith et al., 2009; Mason, 2011; Wagner et al., 2012). The semi-structured interview uses a topic guide or an interview schedule which enables the researcher to use a series of questions with probes or prompt questions which allow the researcher to explore more deeply into the topic under inquiry. Structured interviews ask all participants the same predetermined questions in the same order. Unstructured interviews have a clear focus, where the researcher builds rapport with the participants and then encourages them to open up and express themselves in their own way (Mason, 2011; Wagner et al., 2012; Brinkman and Kvale, 2015).

In the design of this study, I chose to use one-to-one, face-to-face semi-structured interviews because I felt that they would provide me with the best opportunity to engage with participants who have been bereaved by suicide in a sensitive manner, as well as engage in conversations about the topic on a deeper level. I felt that semi-structured interviews would give me the opportunity to understand each individual case from the perspective of the lifeworld of the participant, which also allowed for the inclusion of a relatively small number of participants (Ashworth, 2003; Langridge, 2007; Smith et al., 2009). I chose this approach over the structured interview because structured interviews have very rigid questions and are more useful to researchers who are conducting multiple case studies or surveys involving larger
sample size through the use telephone interviews as opposed to conducting in-depth interviews (Mason, 2011; Creswell, 2013). Langridge (2007) supports the use of semi-structured interviews as opposed to structured interviews because the latter are not considered to be an appropriate form of data collection of a phenomenological study. This is because structured interviews tend to be guided by a rigid questionnaire, which is not designed to elicit meaning. The closed response options within the rigid questionnaire foreclose the possibility of exploration of ideas and life events from which the understanding of meaning emerges. I felt that the use of semi-structured interviews would foster a trusting relationship with the participants, who voluntarily gave up their time to participate in this sensitive research. For example, Hunt and Smith (2004) used semi-structured interviews as they spoke to four participants who had personal experience of caring for a family member who had survived a stroke. They describe that each interview was around forty-five minutes in length, as this would allow for uninterrupted attention and interaction between the researcher and the participant during the interview. A similar approach was used by Bramley and Eatough (2005) who used semi-structured interviews to foster an atmosphere of openness and trust with a participant living with Parkinson’s Disease. Semi-structured interviews were used when conducting sensitive research with participants who struggled with anger (Eatough and Smith, 2006a; Eatough and Smith, 2006b); participants who experienced spinal cord injury (Dickson et al., 2008); and participants who were stroke survivors (Pringle et al., 2011).

A major reason why I chose individual interviews was because I wanted to avoid the complexities associated with group interviews. According to Wagner et al., (2012), the composition of the group is crucial to the success of the interview and ultimately the outcome of the study. From a practical point of view, getting a group of community mental health nurses working in an NHS Trust which covers a large geographical area would have been very difficult. In addition to this, there would have been huge cost implications in terms of time and other
resources for the participants, which could have created more barriers for anyone who may have been interested in participating in the interviews. Instead, I decided to travel to the location where the participants would be most comfortable and would feel safe to talk about the topic under consideration in a relaxed and engaging way. This was important for participants for this study, who, in the course of their daily clinical practice tended to be the ones who travelled to where they were needed. By reaching out to them, I felt that I would be conducting my research in an ethically sensitive way and it was also my way of showing the participants that I was genuinely interested in their lifeworld and not just in collecting data about my study. Likewise, there was a risk that if the participants did get into group interviews, the dynamics of the group could have resulted in the views or life stories of all participants not being equally heard, some may have felt intimidated and inhibited from expressing their honest views in front of other participants that they did not know or trust. Such an approach would have made it difficult apply the idiographic principles of IPA. It may not have been ethical to do focus groups as participants would know each other and would know about high profile patient suicide cases that would inevitably be discussed during the course of the interview. It would have been very difficult to guarantee true anonymity and protect confidentiality. As a novice researcher, I recognised that I would need more training on how to successfully facilitate group interviews in a manner that keeps the discussion going whilst I am gathering data effectively and correctly. I would have also needed to learn how to effectively transcribe group interviews, a skill which would take me a long time to learn and apply during the research process. I believed that this was a situation that could have affected the progress of the research process and that group interviews may not have adequately answered my research question.

Having decided to use individual interviews, I recognised that, although I had done clinical interviews when assessing and engaging with mental health patients in my role as a registered mental health nurse, but I had not actually conducted individual face-to-face research
interviews. This situation presented me with an opportunity to increase my theoretical knowledge about interview research, to understand the ethical principles that underpin research interviews, to develop a researcher’s lens regarding how I view the use of face-to-face semi-structured interviews and finally to develop the skill of undertaking a sensitive lifeworld (Ashworth, 2003) research interview. In other words, my views of conducting face-to-face interviews had to change and adapt to match my role as a novice researcher as opposed to my role as an experienced registered mental health nurse with over twenty years of working with people experiencing suicide thoughts and behaviours. In addition to this, I was mindful that I had also conducted interviews as a senior lecturer in mental health nursing, when I was recruiting potential student nurses onto undergraduate and postgraduate nursing programmes. This experience of having a dual identity has also influenced my views about conducting interviews because I had an idea of what research interviewing might entail, but I had not yet practised it. This phenomenon is not unique. Creswell (2013) comments that novice researchers will have some idea about interviews because we see them being done almost daily. When we watch television, we see talk shows and we watch news reporters and TV presenters interviewing people all the time; it is an interaction that is normal, it looks like it is easy to do, and it can also be taken for granted. However, when exploring the act of interviewing from an IPA researcher perspective, this is not the case. It is not an easy thing to do and novice researchers require training (Smith et al., 2009; Guest et al., 2013).

Braun and Clarke (2013) suggest that the qualitative researcher needs to think about potential participants who may express an interest in participating in the study. They explain that, as a researcher, you may interview people that you know, you may interview strangers and you may interview people from diverse ethnic and cultural backgrounds (Braun and Clarke, 2013). When interviewing people that you know, they recommend that special consideration be given to the unique nature of the participant and professional friend relationship which develops during the semi-structured interview process (Finlay, 2011; Braun and Clarke, 2013). I was
mindful about not coercing anyone that I knew into participating in the research and, with support from my PhD supervisory team, I thought carefully about how I would encourage and manage self-disclosure during the interview. I applied the principles of Patient and Public Involvement (PPI) - as proposed by the National Institute for Health Research (NIHR) (NIHR, 2018) - as I developed the process of working with people that I may have worked within a different mental health clinical context (Mahoney and Stephansen, 2017). The NIHR explain that the process of PPI means that research is carried out ‘with’ or ‘by’ members of the public as opposed to research being carried out ‘to’ them or ‘about’ them or ‘for’ them (Burchell et al., 2017; NIHR 2018). By definition, the NIHR suggest that a member of the public can refer to current service users, past service users, people who use the services, as well as people who represent those who use the services. The latter group of people would include health and social care practitioners and, for the purpose of this study, that would include community mental health nurses (NIHR, 2018). In order to carry out research ‘with’ mental health nurses and to minimise the risk of coercion, I decided to use a research gatekeeper during the advertising and recruitment phase of the pilot and main study. This approach to PPI was fully documented in detail during the ethics application process, which will be discussed in more detail in section 5.3.

When interviewing strangers, it is a challenge to establish a rapport and feel comfortable with having an intimate encounter with someone you do not know (Braun and Clarke, 2013). In order to facilitate rapport-building, I planned to begin the engagement process as soon as the participant came forward, when they sent me an email and expressed an interest in being included in the study. I created template email correspondence using a warm and inviting tone, which would lead to the setting-up of an initial screening interview over the telephone. I planned to use a warm and friendly tone to introduce myself and set the scene for the study. After the initial screening telephone conversation which would last up to ten minutes, I planned to arrange an individual face-to-face follow-up interview with each of the participants who met
the study's inclusion criteria. I planned to send written email correspondence to confirm the research interview appointment followed by a participant information sheet, the official letter of invitation and a poster outlining the main aims and objectives about the research. I planned to send a reminder email to the participants about 4 days before the interview, just to remind them of our arrangement and confirm that I was attending the research interview as planned. I planned to allow time for pre-interview chit-chat to allow the participant to feel at ease in my presence throughout the interview process. Langridge (2007) suggests that researchers need to attend to the issues of embodiments in the research process, regarding their own and the participant's bodies as they occupied the same physical space during the actual research interview. On a practical level, I planned to invite the participant to book an interview room in a location of their choice and they would take the lead in ushering me into the interview room and directing where they wanted me to sit, so that they would feel comfortable with my physical presence. With this in mind, I also planned to engage in debriefing after each interview as a way of checking that the participant felt comfortable after participating in a sensitive IPA research dialogue. I planned to express my appreciation for the participant's time and effort by giving them an information pack with relevant suicide postvention resources that they could keep after the interview was completed. I also planned to send a thank-you card a few days after undertaking the interview.

Braun and Clarke (2013) also encourage researchers to think about how they are going to handle participant distress as they conduct sensitive interviews. With support from my PhD Supervisory Team, I planned to manage participant distress by acknowledging it and asking questions such as, “Are you okay?” and “Would you like to stop the interview for a while?” Such preparation would enable me to be mindful of the thoughts and feeling of participants who were choosing to come forward and share their idiographic stories about their real lifeworld experience of patient suicide. From a practical point of view, I planned to offer a box of tissues and a bottle of water to offer to participants who became distressed or tearful. As an aide
memoir, I planned to have a checklist with all the necessary items which I would need to take with me to each interview, so that I could effectively handle distress as a researcher and not as a mental health nurse.

With regards to the notion of handling distress, I also planned to manage my own distress as I was undertaking qualitative IPA research. Braun and Clarke (2013) recognise that conducting a good qualitative research interview, especially a sensitive one, requires intense focus, and they acknowledge that it is a process which is physically and mentally tiring for the researcher. They warn that if a researcher does more than one interview a day, there is the potential that the researcher can miss asking some questions, can fail to follow up on certain points and they can mix up the content of multiple interviews in their mind. There is a great deal of emotional labour that goes into conducting qualitative research, therefore it can be emotionally and physically draining. The process of doing one interview a day means that you do not over-do data collection, but you maintain your own wellbeing as researcher by pacing yourself. I planned to follow this practical advice and to undertake just one research interview per day.

With regards to managing my responses to questions about my researcher identity, I planned to disclose information about being a registered mental health nurse who has previously worked as a community mental health nurse. I recognised that the participant information sheet would identify me as a PhD research student and felt that I needed to prepare to disclose my professional identity and my credentials as an experienced registered mental health nurse in order for the participants to be able to situate where I was in my lifeworld. I felt that it was important for participants to be aware that I had some experience of interviewing people in my capacity as a clinician, but that I was also learning to become a researcher. In their work about how to undertake relational research as a psychotherapist, Finlay and Evans (2009) acknowledge that when you are clinically practising in an interpersonal and psychodynamic
way, you have the advantage of being trained to listen and to help others to express themselves. Whilst such clinical abilities can be transferrable to conducting research interviews, the researcher needs to be wary of leading the participant to emotional disclosures which may be beyond the terms of the problem or issue that the research is trying to address. On the other hand, Finlay and Evans (2009) also warn against the researcher worrying so much about being a clinician that they become rigid, flat, distanced or appear disengaged in their approach. Neither extremes would be helpful in the research process and new clinician researchers need to reach some middle-ground. To address this issue, Finlay and Evans (2009) suggest the use of a pilot study before undertaking the main study. In my capacity as a novice mental health nursing researcher, I could identify with all the issues just presented and I discussed this with my PhD Supervisory Team. In order for me to develop my researcher identity, skills and levels of confidence, I decided that it would be appropriate to follow the evidence-based guidance presented in the research methods literature, by undertaking a pilot study, to pilot the semi-structured interviews before undertaking my main study.

Pilot testing is a recognised research approach which permits a researcher to try things out, before undertaking the main study (Langridge, 2007; Finlay, 2011; Wagner, 2012; Creswell, 2013; Braun and Clarke, 2013; Guest et al., 2013). The construction of an interview schedule is an important part of the process and it needs considerable thought, discussion with fellow researchers and, ideally, piloting, which includes testing out an early version for feedback (Langridge, 2007). Pilot testing gives the researcher an opportunity to have a go at doing the research, to adjust and make improvements before undertaking the main study. According to Silverman (2013), it is often very sensible and pragmatic to try out the interview questions and procedures with a view to learning from this process, which will inform the main study. He explains that this kind of piloting is a feature of most kinds of good research, both qualitative and quantitative, and it serves to upskill the researcher's ability to undertake the research. However, there is a word of caution with regards to the use of pilot studies as a way of
improving interview techniques. The improved capabilities of a novice researcher do not necessarily equate with improved data. It means that the interview is more likely to run smoothly and the researcher then develops the skill to facilitate a research interview, using an interview schedule that they will have devised with a view to finding out if the interview has the potential to generate interesting and substantial data.

In summary, I decided to use semi-structured individual face-to-face interviews because I believed that this would be the best way to achieve research congruence, where my epistemology, ontology, axiology would be aligned to my chosen IPA qualitative methodology to address the research aims and objectives. In view of my limited experience in conducting semi-structured research interviews, I felt it would be appropriate to undertake a small-scale pilot of the interview process. This decision resulted in the design of a qualitative research study, which employed a two-phase fieldwork strategy, namely a pilot study and a main study. Findings and lessons learned from the pilot study and how these were applied to the main study will be discussed in more detail in chapter 7.

5.3. Sampling methods

Deciding whom to include in the study is an important part of the research design process. According to Guest et al., (2013), whom you include in your study needs to be based on several criteria. However, researchers must select people who will have the information that will help to answer the research questions. They propose a useful question that will help the researcher to know who to sample in their study: “What specific individuals or types of individuals (in terms of roles or occupations) might know a lot about my research topic in the study site?” (Guest et al., 2013). In general, the most common sampling method used in qualitative research is purposeful or purposive sampling. This sampling technique explicitly selects participants who
are likely to generate appropriate and useful data (Green and Thorogood, 2011). The main
goal of purposive sampling is to focus on particular characteristics of a population that are of
interest which will best enable the researcher to answer the research questions. In other words,
purposive sampling can be very useful for situations where the researcher needs to access a
targeted sample quickly and where sampling proportionality is not the main concern
(Denscombe, 2014). This can also be referred as homogenous sampling, which refers to the
targeting of people who share the same occupation and/or experience and is a technique that
fits in well with the IPA approach (Brocki and Wearden, 2006; Langridge, 2007; Smith et al.,
2009). The use of purposive sampling technique would allow me to use my subjective
judgements drawn from the empirical literature about mental health nurses’ suicide loss
survivorship, from my practice experience as a suicide loss survivor and my experience of the
developmental nature of the research process itself (Langridge, 2007; Smith et al., 2009).

For this IPA study, I chose to use purposive sampling as opposed to probability sampling
because I wanted to include cases that would generate rich data for in-depth study.
Specifically, I chose to sample people from a homogenous group, namely mental health nurses
who had experienced a patient suicide within a community setting. Since in-depth interview
studies typically require small sample sizes (Finlay, 2009; Smith et al., 2009), I felt that it would
be appropriate to have 6 participants for the pilot study and 10 for the main study, a number
which is deemed to be acceptable for a PhD study using IPA (Smith et al., 2009).

In order to access this purposeful sample using the principles of PPI, I designed a research
advertising strategy in the form of an NHS Trust-wide intranet announcement for all community
mental health nurses to see. Additionally, email correspondence using a pre-determined
template was sent to all community mental health team managers, in order for them to cascade
and publicise the study to all the community mental health nurses working within their
community mental health teams. The advert invited community mental health nurses to
participate in the suicide loss survivorship study after the suicide of one of their patients between 2002 and the present-day. The specific timeframe of when the patient suicides took place provided a helpful limit, which further ensured that the right people would come forward for the study.

5.4. Ethical considerations

At every step of the design and implementation of the sensitive research process, ethics is an issue that must be considered. Researchers must be mindful that participants can be easily harmed, physically or emotionally, and this can have devastating consequences (Langridge, 2007; Smith et al., 2009; Wagner et al., 2012). There is always the potential for any interaction to lead to harm. During the sensitive research interview, the risk that is most likely to occur is that of participants becoming upset whilst reflecting on, sharing and recalling particular experiences (Gilbert, 2001; Smith et al., 2009; Harper and Thompson, 2012). I strongly believed that the health, wellbeing, and safety of the community mental health nurses who participated in this study was of utmost importance. In the design of my study, I made sure that all ethical principles that govern the research process were adhered to throughout. I designed a checklist which would provide me with visual prompts of the areas that I needed to spend time addressing before the research was initiated. This checklist included reminders of how I was going to go about obtaining informed consent, how I was going to maintain confidentiality, the process that I was going to follow in the management and protection of data, as well as how I was going to inform participants of their right to withdraw from the study at any time, without any penalty being issued against them (Liamputtong, 2009). I made sure that I was honest and open about the potential benefits and potential harms of the research (Haigh and Williamson, 2009; Smith et al., 2009) throughout the research process.

Liamputtong’s (2009) approach to conducting sensitive research guided me in the application
of ethical principles during the design and implementation of all phases of the study. Liamputtong argued that ethically sensitive research aims to minimise the likelihood of the participant experiencing the research process as a “hit-and-run” event. The researcher should deal with the potentially emotive subject matter of patient suicide loss with dignity and sensitivity. (Liamputtong, 2009). I made a commitment that I would make sure that consent from all participants was informed and was given freely without coercion (Burchell et al., 2017; NIHR, 2018). As mentioned in section 5.2, in line with the principles of PPI, this is one of the major reasons why I chose to use a research gatekeeper to act as the mediator between the mental health nurses working within the NHS Trust and myself. This gatekeeper would be crucial in advertising the study in a neutral way, without my involvement and this was a way of increasing the chances of PPI and reducing the risk of coercion. Additionally, this was the best way to ensure that participants who came forward would be enabled to do so of their own volition. For the participants who I had worked with in the past, this approach would also reduce their risk of feeling as though they had been coerced into engaging in the research interviews, because they may have known me in my clinical role as a community mental health nurse or in my academic role as a senior link lecturer in mental health nursing.

I also included written statements specifically related to the giving of informed consent in the letter of invitation, the information sheet for participants and the research publicity poster which gave a simplified infographic about my research study. I designed all of this with a view to spreading the word about the study and also to help potential participants make an informed choice about whether to be involved or not. Once participants had engaged with the interview process, they would be informed verbally at the start of the interview that, if they became distressed or upset during the course of the interview, they had the right to withdraw from the study at any time. Even if they had given any information in the form of a tape-recorded interview, I assured them that they could ask for this data to be withdrawn and any other data to be removed from the study as well. I also decided that I was going to remind participants
that their involvement was entirely voluntary throughout the research process,

In view of the emotive nature of the experience of suicide loss and bereavement, I made arrangements that, should they wish to, all participants could be supported emotionally immediately after the interview had taken place during both the pilot and the main study. To put this arrangement into reality, during the preparation phase for the study, using the principles of PPI (NIHR, 2018), I engaged in some extensive partnership working with the key stakeholders within the host NHS Trust. These stakeholders were the Director of Nursing, The Suicide Prevention Consultant and the Director of Education and Development. The identified NHS Trust stakeholders were keen to ensure that the welfare of the participants was maintained after they had engaged in the research interview. The NHS Trust also wanted to make sure that there was minimal disruption to the community mental health nurses’ daily clinical functioning. In other words, they wanted to make sure that service delivery to patients was not going to be disrupted after the participants had voluntarily participated in the interview. It was agreed that arrangements should be made to provide emotional support for the participants immediately after their interviews, should they require it.

During the pilot and the main phases of the study, I made firm plans that all participants would be signposted to various sources of suicide postvention support, should they require support after the interview. Again, using the principles of PPI (NIHR, 2018), this work was done in partnership with the Suicide Prevention Consultant, who recommended that I plan to encourage community mental health nurses to access already existing support networks which were offered by the host NHS Trust. The Consultant believed that community mental health nurses were more likely to engage with support systems that they were already familiar with, as opposed to accessing a service that they did not know anything about. Following this recommendation, I officially applied for and was granted permission to signpost participants to the pre-existing psychological debriefing services that were already available for staff working
with the host NHS Trust. I was also granted permission to signpost participants to the Head of Spiritual & Pastoral Care, employed by the host NHS Trust to provide professional support for mental health patients and staff after they had experienced a crisis. At the time that I was planning the study, the Head of Spiritual and Pastoral Care was leading a Centre for Spirituality and Wellbeing, which focused on the development and promotion of more integrated and holistic patient care. The centre was also part of an Institute of Nursing, Midwifery and Allied Health Research which was led by a local university and included the local NHS Trust as a partner. The purpose of the centre was to generate practice-based research evidence of the benefits of having an integrated approach to care through research which underpins the development of training for staff so that they are equipped and supported to provide spiritual care to patients.

The plan to include the Head of Spiritual and Pastoral Care was appropriate and it meant that I could signpost community mental health nurses to a senior clinician who provides professional and management leadership whilst working collaboratively with senior staff and department leads. His work included the direct clinical practice on a one-to-one basis with patients and also the facilitation of small group work. As a trained British Association for Counselling and Psychotherapy (BACP) accredited (registered) counsellor and psychotherapist, his work with staff included the provision of one-to-one support, facilitating staff support groups, reflective practice, mediation and clinical supervision. He also coordinated the host NHS Trust staff psychological de-briefing service and many of the participants would be familiar with the work that he was undertaking. In view of his extensive experience, following the recommendation of the Suicide Prevention Consultant, I felt that the Head of Spiritual and Pastoral Support was the most appropriate contact that community mental health nurses would be familiar with, in view of his role as the coordinator of the staff psychological debriefing service. In other words, participants would have known to contact him if they were to experience any distress during the course of their daily clinical practice, not just
for the purpose of this my research study. Therefore, I decided to signpost all participants to him for telephone support immediately after the face-to-face interview.

In order to support participants in the longer term after the interview, I planned to issue each participant with an information pack containing printed documents with details of other sources of online support, printed books about surviving suicide loss and leaflets that they could access. Specifically, I designed each information pack to contain the following information:

- The Participant Consent Form
- The Participant Information Sheet
- Support for participants after the research interview - Information Sheet
- A Poster advertising the Research Study
- An original, hard copy Department of Health Document: “Help is at Hand: Support after someone may have died by suicide” by Hawton et al. (2015)
- An original, hard copy Royal College of Psychiatrists Leaflet: “Help is at hand: Post-Traumatic Stress Disorder”, edited by Dr. Philip Timms
- A researcher contact card with all my contact details such as telephone number, email address and the postal address for the Institute for Health Research

I decided that this information pack would be given to participants at the end of each interview and planned to inform all participants that they could use the information contained in the pack in their professional roles. I decided that I would also recommend that, should the need arise, they could use the resources to support any friends and family members who may have been bereaved by suicide.

During this planning process, I thought about how I was going to preserve my own health and
well-being as the lead researcher for this sensitive study. According to Harper and Thompson (2012), researchers need to acknowledge their own vulnerabilities when facilitating sensitive interviews about death, dying and bereavement, and they must find effective ways in order to manage and understand this vulnerability. Gilbert (2001) acknowledges that, when studying emotional topics, researchers become vulnerable observers. I recognised that I was investing a lot of emotional labour during the data collection, analysis and writing-up phase of the research. If researchers accept that, when talking to participants, there is a need to manage, contain and work sensitively with emotions, then there is a real need to focus on practical strategies to operationalise this intention (Gilbert, 2001). From a pragmatic point of view, I arranged my research diary in a manner which enabled me to undertake one research interview per day, with a view to spending some time thinking about what I had learned from entering the world view of each research participant. In line with the IPA research practice of bracketing, I planned to keep a reflexive journal after each interview, as this would help me to reflect after each interview and to document lessons learned in preparation for the transcription phase.

The process of transcribing sensitive lifeworld (Ashworth, 2003) research interviews from an oral to a written mode allows the researcher to structure the interviews in a format that is amenable to closer analysis. The process of transcribing interviews is itself an initial analytic process (Brinkman and Kvale, 2015). As the lead researcher, I decided that I was going to transcribe my own interviews as opposed to using a transcription service. Having made this decision, I planned to inform all participants that I would be undertaking the task of verbatim transcription of the audio-taped interviewed, in line with the principles of IPA research methodology. Whilst I understood that the process of transcription is a very time-consuming task methodologically, it is recognised as an excellent way for the researcher to become immersed in the lifeworld of the participants and become familiar with the data (Robson and McCartan, 2016). Brinkman and Kvale (2016) explain that researchers who transcribe their
own interviews will learn much about their own interviewing style as they repeatedly listen to the recording of the actual interview. The researcher will have the social and emotional aspects of the interview situation present or reawakened during the transcription process, and this will give them the opportunity to start analysing the meaning of what was said during the interview. IPA requires that interviews be transcribed verbatim, that the final transcript be a semantic record of the interview which would show all the words that were spoken by all the people who were present during the interview (Smith et al., 2009). Based on this knowledge, during the transcription of the data, I planned time to undertake the transcription of all the interviews and to keep a reflective journal to help me record any insights or anything that may have caused me distress.

When undertaking the fieldwork, I decided that I was going to travel to a location which was selected by the participants. As I was travelling alone, I recognised the need to have a process of managing my lone working as I was going to be driving my car to many different locations. Therefore, I arranged a personal safety plan, in the event of my requiring support whilst I was out doing fieldwork. In collaboration with my PhD supervisory team, we agreed that my safety plan included discussing any concerns with my Director of Studies. Alternatively, I had the option to contact my Second Supervisor or my PhD Mentor for additional support, in line with the University of Bedfordshire’s ‘Safety Guidelines for Researcher’s Policy’. I planned that, on the day of each interview, I would arrange a fieldwork callback system, whereby I would notify a colleague directly by telephone of when I was on my way to an interview and when I had successfully completed my interview and had arrived safely at my base. This system would ensure that someone would know that I was safe, and they would be aware of my whereabouts during the data collection phase of the study.

5.4.1. Informed consent
The process of gaining informed consent is a dynamic one which needs to be monitored throughout the data collection and analysis phase of qualitative research in general (Brinkman and Kvale, 2016; Braun and Clarke, 2013). With particular reference to IPA research, informed consent must be gained not only for participation in data collection using interviews but also for the likely outcomes of the data analysis process (Smith and Flowers, 2009). In the design of the study, I planned to ask all participating registered mental health nurses to give their informed consent verbally and in writing. As stated by Harper and Thompson (2012):

“Consent should not be seen as something that is necessarily simply gained once. Researchers need to use their interpersonal skills to provide participants with opportunities to reaffirm (or not) their wish to continue in the study. This so-called ‘processual’ or on-going consent may be particularly important in conducting in-depth interviews with people, which may lead to participants finding themselves revealing information that they had not considered in advance” (Harper and Thompson, 2019, p.29).

As a way of following this guidance, I planned to give written information about the study to potential participants when the pilot and main studies were advertised to all community mental health nurses working within the host NHS Trust.

After I applied the principles of PPI (NIHR, 2018) with stakeholders, it was agreed that I could advertise the study on the intranet site for the host NHS Trust. This advertisement would be in the form of an internet announcement which would be live for 14 days. It was agreed that, if the advertisement did not attract enough participants, it could be extended for another 14 days until the required number of participants had been recruited. It was crucial that the information which advertised the study needed to announce that all interested community
mental health nurses would need to give informed consent to participate in it. Therefore, if prospective participants contacted me to express their interest, I planned to issue more details about the study during the screening process which would take place in the form of a brief ten-minute telephone interview. The purpose of this screening telephone interview would be for me to determine if the interested mental health nurse met the inclusion criteria for the study, to answer any questions that they may have about the study and then arrange a face-to-face interview on a mutually agreed date and time but at a venue that was most comfortable for the participant. Planning to use this approach was particularly important to me because I had worked with community mental nurses who were employed by the host NHS site and it was highly likely that some of the potential participants would be community nurses that I knew. By planning to use the same screening and recruitment approach with each participant, I felt that this would help to set clear boundaries of the researcher-participant relationship which would enable me to undertake the research in an ethically sensitive manner.

Within the preliminary phase, I planned to inform the participants that they would be given more details about the study at the start of the face-to-face interview, where they would be asked to give verbal and written consent to participate in the study. I decided that, after the screening interview, I would set up a mutually convenient research appointment and send out an official invitation letter and a participant information sheet by email. In the email, I planned that I would request that participants confirm that they had received that email and I would ask them to confirm that they would be able to attend the interview appointment. I also decided that, if an interview was arranged in advance, I would send a reminder email 4 days before the interview, to confirm that it would still be going ahead. I felt that this would show the participants that I appreciated the time that they were setting aside to meet and engage in the research process with me.

As soon as participants had confirmed their interest in the study, I planned that I would travel
to the pre-arranged venue and conduct the interview at a location within NHS premises. At the beginning of the interview, I planned to ensure that I would set the boundaries for the research interview by asking the participants to give oral and written consent by completing two copies of a written consent form as evidence that they had given informed consent. I planned to give a copy of the signed consent form to each participant for their records and I would keep a copy as evidence that informed consent had actually been sought and given. Only after following this procedure, would I begin the semi-structured interview. I intended to repeat this process for all the interviews conducted during the data collection phase of the study.

5.4.2. Confidentiality and privacy

In order to ensure privacy, I decided that all the participant names would be withheld to protect their identity. Instead, they were identified by a 2-digit number prefixed by the letters N = Registered Nurse and then they would be given a different pseudonym during the data analysis and writing up phase. As part of conducting ethically sensitive research, I planned to have all the data that would be collected during the study stored in a locked filing cabinet within University of Bedfordshire premises and electronic data stored on university servers that only I could access through the use of password-protected computers. In compliance with GDPR guidelines (2018), I planned to inform all the participants that all their research data would be kept for five years after the research study was completed and the PhD thesis had been written. After this time period, all the information collected would be destroyed and deleted from electronic files.

In order to comply with the GDPR Guidelines (2018), as part of my research ethics application I included an HRA-approved statement in the participant information sheet which confirmed that the data would be kept for five years after completion of the study and that all data collected
would be kept confidential, even if the participant chose to withdraw from the study. In order to maintain confidentiality, I put in place systems which would ensure that no participant contact details were kept with the data, which was anonymised. One such system would be the storage of data on an encrypted USB stick, which would be backed up onto another password-protected system within computer servers. This meant that all the information that I would collect would be treated confidentially and, in my capacity as the Lead Researcher, I would be the only person reviewing the data.

Additionally, it was crucial that I planned to make sure that the patients who had died by suicide could not be identified in any publication which may result from the study. The particular purpose of this action would be to spare the bereaved families any additional distress and to avoid inadvertently breaching confidentiality. In line with this decision, I planned that the research report, and any publications and presentations arising from the research, would include short, anonymised quotations from the interviews. During the data analysis phase, I planned to introduce each participant to the reader by giving them a pseudonym which would add a personal touch to their lived experience without breaching confidentiality.

In an attempt to convey all the emergent themes which capture the voices of all ten participants, I planned to create a visual representation that would give the reader an overview of what the participants had said about their lived experiences. Using online software called ‘WordItOut’ (2019), I planned to create a word cloud using only the anonymised and pseudonymised version of the participant emergent themes. This online software has a feature which allows word clouds to be stored securely using a password. In the overall writing-up of the analysis, I planned to make sure that any quotations used would not include details about workplace or any other material which could inadvertently reveal the identity of the participants or the NHS Trust that the participants work for.
5.4.3. Ethics of interviewing mental health nurses about patient suicide

The fundamental qualities that an IPA researcher needs to have are broad-mindedness, a flexible approach, tolerance, compassion, and a desire to understand and empathise with each participant/s lifeworld (Finlay and Evans, 2009). At the same time, there is a need for the researcher to exhibit the qualities of determination, persistence, and curiosity (Smith et al., 2009; Finlay, 2011). These qualities help the researcher to understand that undertaking sensitive research exposes them to the complexity, chaos and sometimes unpredictability of the lived experience that is being shared by the participant (Finlay, 2009). Discussing what it is like to experience a patient suicide requires sensitivity because it is a topic which may trigger feelings of stress and distress in participants. Therefore, as part of my plan to conduct the semi-structured interviews, I was mindful that some participants could become upset and tearful whilst talking about the death of their patient, so I prepared for this inevitability. As suggested by Braun and Clarke (2013), I planned to use my skill of observation to identify signs of distress so that I could respond appropriately to any changes in the participant’s behavioural and emotional presentation. For example, if a participant became choked up and tearful, I planned to respond compassionately by pausing the interview and checking to see if they wanted to pause the interview or withdraw from it completely, without explanation. From a practical point of view, I arranged to have a packet of tissues and a bottle of water to offer compassionate comfort and support to the distressed participant. I decided that this approach would work well, as it would demonstrate the level of preparation that I had put in to responding to the emotional needs of the participants during the course of the interview (Brinkman and Kvale, 2015).

After the interview, I decided that I would spend some time in a debriefing conversation to make sure that the participants were not upset at the end of the interview and that they were able to return to their clinical duties. This debrief conversation would also include a brief
discussion about where I was on the research journey and would also allow the participants to ask any other questions before I left them. I would also plan to verbally express my thanks for their participation in the research interview.

5.5. The data collection tools

As discussed in section 5.1., I decided to use face-to-face semi-structured, in-depth interviews as the method of data collection. I developed a semi-structured interview schedule, which I used to guide the developmental conversation. This semi-structured interview schedule was designed based on the principles of IPA and a framework provided by Smith et al. (2009) which promoted the use of open-ended questions with a non-directive interview style. The content of some of the interview questions was adapted, with the authors’ permission, from the questions used in Bohan and Doyle’s in-patient-based study (Bohan and Doyle, 2008). I designed the schedule to gather information about what it means for a community mental health nurse to lose a patient to suicide on a personal and professional level (Finlay, 2011). Drawing on the research done by Dewar et al. (2000), the schedule also gathered information about the implications of the patient suicide on each participant’s current and future clinical practice. As this was my first attempt at conducting primary research - as recommended by Smith et al., (2009), Braun and Clarke, (2013), and Brinkman and Kvale (2015) - I developed an interview schedule to pilot. Piloting the interview schedule would give me the opportunity to engage in the interview process with participants as well as gain experience in the actual use of the interview schedule. The open questions in the schedule were included with a view to encouraging participants to open up and begin to talk about the sense they made about their experiences of losing a patient to suicide (Smith et al., 2009; Finlay, 2011; Braun and Clarke, 2013; Brinkman and Kvale, 2015). For a full copy of the interview schedule used during the pilot study, see Appendix #7.
Dahlberg et al. (2002) suggest that, at the conclusion of a research interview, both the interviewer and the participant should understand the phenomenon under consideration better than they did at the start of the interview. In other words, the interview experience should also be seen as an educational one. According to Smith et al. (2009) and Finlay (2011), both parties may have developed an awareness of the emergence of unexpected answers and insights that the researcher may not have anticipated. At the conclusion of every pilot interview, I planned to ask for feedback about the interview schedule from the six participants (Smith et al., 2009; Braun and Clarke, 2013; Brinkman and Kvale, 2015). Having received this feedback, I planned to use it to further develop a data collection tool which would result in a refined edition of the schedule that I would use to interview participants during the main study. (For a full copy of the main study interview schedule, see Appendix #20). Details regarding the outcome of the Pilot Study will be presented and considered in greater detail in Chapter 7.

5.6. Conclusion

The qualitative lifeworld research methods that were designed, using the principles of PPI (NIHR, 2018), and used for this study have been presented in this chapter. In alignment with my constructivist interpretivist epistemological stance, the chapter has presented my ontology resulting in my use of qualitative methodology. The design, piloting and use of in-depth face-to-face semi-structured interviews have also been discussed. The next chapter will present a scoping review of literature that has been published regarding how mental health nurses react to a patient suicide. Findings from this coping review were used to inform the design of the pilot study as the first phase of the fieldwork, which will be discussed in Chapter 7.
Chapter 6: How do mental health nurses react to a patient suicide?

6.1. Introduction

In Chapter 1, the objective to examine the research studies which investigated the effect that a patient suicide had on mental health nurses by means of a scoping review was set. In order to address this objective, this chapter reports on a scoping review of the reactions experienced by mental health nurses, by identifying the nature and the extent of the research evidence using the framework developed by Arksey, O’Malley and Levac (2005). Scoping reviews are used to find out about the nature, the variation, and the range of published research, as well as to evaluate the need for a systematic review (Guest et al., 2013). I decided that undertaking a scoping review would help me to explore the literature with a view to using the findings to inform the study design.

Initially, I had intended to carry out a systematic review to assess literature which examines the impact of a patient suicide and mental health nurses’ psychological and psychosocial responses. However, during the early stages of my literature searching, it became clear there is a dearth of evidence that empirically addresses this issue. The available evidence tended to focus on the impact that suicides had on psychiatrists, clinical psychologists, and social workers, with very few studies exploring the reactions of mental health nurses as a separate qualified professional group. This observation of published literature does not mean that mental health nurses have not been included as participants in research studies. Studies by Linke et al. (2002); Spencer (2007); Gaffney et al. (2009); Heeb et al. (2011); Draper et al. (2014); Dransart et al. (2014; Dransart et al. (2015) and Awenat et al., (2017) all had mental health nurses as participants. However, their views and experiences were captured and reported collectively with the views of other professional groups.
In view of this preliminary discovery during the literature searching process, it made sense for me to undertake a scoping review, rather than a systematic review. Levac et al. (2010) also encourage the use of scoping reviews in disciplines which have an emerging body of evidence such as in nursing, health and social care research. Hence, I chose to utilise the six-stage model proposed by Arksey and O’Malley (2005), which I used to guide how I would commence the scoping review process.

6.2. The aim of the scoping review:

The focus of the scoping review was to find research that has been published about mental health nurses’ psychological and psychosocial responses after a patient that they were working with died by suicide. The review will also investigate the impact that the experience of the suicide had on them whilst they are working in mental health practice.

6.3. Objective:

The objective of the scoping review was to examine and map known psychological and psychosocial responses of mental health nurses after a patient dies by suicide in mental healthcare practice.

6.4. Scoping review questions:

I devised the following questions which I used to address the set objectives and to further guide my investigation:

- What types of nurses’ reactions to a patient suicide have been reported?
- How are mental health nurses affected by a patient suicide?
- How do they respond?
- How has this experience been captured in the research?
6.5. Eligibility Criteria

The review also considered studies that evaluate the personal and professional impact of a patient suicide as well as describe mental health nurses’ responses to a patient suicide. A response is a reaction to something. The word reaction is defined as something done, felt, or thought in response to a situation or event (Cambridge Dictionary, 2016), so this review examined research studies which investigated how mental health nurses are affected on a personal and professional level. The primary outcome of interest is the impression that the patient suicide has upon their personal and professional responses because of the established suicide prevention practice where the mental health nurse uses the nurse-patient therapeutic relationship to mitigate distress in patients presenting with suicide thoughts and behaviours.

6.6. Methods

Participants

This scoping review included studies that have sampled professionally qualified mental health nurses who are registered by a recognised professional body and have experienced a patient dying by suicide in an in-patient or a community mental health setting.

Intervention

Of interest were interventions that are described as suicide postvention for clinician survivors of a patient suicide. This included the coping strategies used by mental health nurses, the meanings that they constructed, and the lessons learned after the patient died by suicide. It also includes nurses’ responses to the post-suicide inquest, attendance at coroner’s court and
supporting the bereaved family.

**Comparator**

Not applicable

**Outcomes**

The primary outcomes were the participants’ experiences of patient suicide. The loss of a patient to suicide can leave an impression or have a powerful effect on a mental health nurse’s individual and professional responses. Any responses to the suicide of a patient were included in the review. Any subjective outcomes, whether identified through thematic analysis or quantitative data collection methods, were included in the review.

6.6.1. *Inclusion and exclusion criteria*

**Settings**

This review included studies which featured mental health nurses as participants who have experienced a patient suicide whilst working on acute in-patient mental health wards or community settings. Examples of in-patient settings could be rehabilitation wards, accident and emergency departments, psychiatric intensive care units, low, medium and high secure units, child and adolescent units, older adult wards, nursing homes, residential care homes, day hospitals, and outpatient units. Examples of community settings could be community mental health assessment and treatment teams, crisis resolution and home treatment teams, assessment and treatment intervention teams, assertive outreach team, early intervention for psychosis services and forensic community mental health teams.

**Study Design**
This review included all study designs that have been used to investigate the impact of patient suicide on mental health nurses.

Language

This review included research articles which reported significant findings in the English language. It excluded research that had not been written in the English language.

6.6.2 Search Strategy

The scoping review included both qualitative and quantitative studies regardless of the study design. It included research studies that were published in peer-reviewed journals and written in or translated into the English language between 1995 and the present day. The year 1995 is significant because in that year service delivery within mental health services began to shift towards delivering more care in community settings in the UK, so the review also aimed to capture any UK-based research which might reflect this.

The following electronic bibliographic databases were searched: PubMed, Medline, CINAHL with Full Text, CINAHL Plus with Full Text, CINAHL, Psychology and Behavioural Sciences Collection, Elsevier, British Nursing Index, Psych ARTtCLE, Psych INFO and Soc Index. This includes university dissertations and theses published on Ethos. The reference lists of included studies were examined and searched manually. Any references which were picked up during conversations with the Suicide Prevention Lead Nurse working within the local host NHS Trust were also considered.

As mental health nurses were the main focus for the scoping review, the population search
terms were “mental health nurse”; “psychiatric nurse” and “nurse psychotherapist”. To capture research regarding patient death by suicide the following terms were used AND ("patient suicide" OR "client suicide" OR "service user suicide") AND ("suicid*") "patient death by suicide", “patient suicide”, and to capture how mental health nurses react, the search terms “experiences” “responses” “reactions” and “impact” were used.

6.7. Data Extraction

Based on the methodology for JBI Scoping Reviews format (Joanna Briggs Institute, 2015), a full data extraction template was created. This template included the following: author, year, country where the research was undertaken, aims and purpose, population and size of the sample, methodology, interventions type, outcomes, details and key findings. The data extraction table was created using Microsoft Word and I manually inputted data from each included study.

This search strategy identified 352 studies, including duplications. Once the 12 duplications had been removed, 340 articles remained consideration. The studies were marked for analysis if mental health nurses were the population sample, if they reported on how mental health nurses reacted after a patient suicide and if they were written in English. After reviewing the titles and abstracts, 90 studies were identified for full text review. 333 studies were set aside because mental health nurses’ reactions to patient suicide were not included. Subsequently, 10 studies were identified and included for full data extraction as illustrated in the figure below.
Figure 4: Flow chart of the study selection process

Key words identified for search terms

Databases searched by key words in titles and in abstracts

N = 352 studies found by key words in the Abstract and Titles

N = 12 duplicates removed

N = 340 studies left after duplicates were removed

N = 340 titles and abstracts screened for inclusion in the scoping review.

331 = Excluded studies because they did not meet the inclusion criteria.

N = 7 studies identified

N = 3 studies identified after manual searches

N = 10 studies included for full data extraction
Table 3: Data Extraction Chart of Ten Studies Included in the Scoping Review

<table>
<thead>
<tr>
<th>Title</th>
<th>Author &amp; Year</th>
<th>Journal</th>
<th>Place of Research</th>
<th>Main Aim</th>
<th>Methodology</th>
<th>Sample</th>
<th>Findings</th>
<th>Author Recommendations</th>
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<tbody>
<tr>
<td>The effects of patient suicide on nursing staff.</td>
<td>Midence et al, (1996)</td>
<td>Journal of Clinical Nursing</td>
<td>In-patient hospital. Wales</td>
<td>Investigate the effects of suicides on nursing staff, their attitudes and ways of improving on their coping skills</td>
<td>Qualitative exploratory design. Paper Pencil Questionnaire Thematic Analysis</td>
<td>27 Psychiatric Nurses 12 Males 15 Females Aged between 24-54 years of age</td>
<td>The vast majority reported feelings of sadness, frustration, shock, fear, anger and guilt. The study reported that there was a lack of emotional support for the nurses, there was a need for training in suicide prevention and postvention, the importance of formal assessment of patients at risk, and regular multidisciplinary meetings are needed following a suicide. Nursing staff also accepted that the suicide was the patient's personal choice.</td>
<td>Emotional support for nursing staff is of paramount importance and should be provided. Training on suicide and its prevention to be organized for all nursing staff. Formal assessment of suicide risk could be developed, and ward policies and procedures should be closely reviewed. Nurses should make a contribution to the assessment of patients at risk of suicide since they have to look after those suicidal patients.</td>
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<td>Aftermath of a patient suicide: A Case Study</td>
<td>Valente (2003)</td>
<td>Perspectives in Psychiatric Care. United States of America</td>
<td>This case study illustrates the meaning of the suicide loss to the nurse and its influence on professional identity, self-confidence and self-esteem.</td>
<td>Qualitative Reflective Approach Case Study</td>
<td>1 Nurse Psychotherapist</td>
<td>Nurse psychotherapists experience their own grief as a lack of omnipotence over suicide and a fear of their colleague’s responses.</td>
<td>Understanding bereavement and factors influencing bereavement may help nurse therapists to facilitate and reduce negative consequences of their own grief. More research on the experiences of nurses after patient suicide.</td>
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<td>Effects of suicidal behaviour on a psychiatric unit nursing team</td>
<td>Joyce and Wallbridge (2003)</td>
<td>Journal of Psychosocial Nursing &amp; Mental Health Services</td>
<td>Canada</td>
<td>To gain insight into the effects on nursing staff of a series of patient suicides associated with a psychiatric unit.</td>
<td>Qualitative interview technique</td>
<td>9 mental health nurses who were involved in one or more critical incidents involving patient suicide.</td>
<td>Suicide on an in-patient unit can have significant, though diverse effects on the emotions and behaviours of nurses and team functioning. Participants felt there was a need for formal debriefing or counselling after a critical incident.</td>
<td>This research highlights the need for advanced training of critical incident stress management team members and for flexibility in the application of critical incident stress management techniques to help nurses to cope after a suicide.</td>
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<td>Nurses’ experiences of patient suicide and suicide attempts in an acute unit</td>
<td>Bohan &amp; Doyle (2008)</td>
<td>Mental Health Practice</td>
<td>Ireland</td>
<td>To describes nurses’ experiences of patient suicide or attempted suicide and the support they received afterwards.</td>
<td>Qualitative Descriptive Study Semi-structured interviews,</td>
<td>9 mental health nurses working on acute inpatient units within three hospitals in a large urban area.</td>
<td>Nurses’ experiences of patient suicide/suicide attempts were challenging. Nursing care following an incident of suicide/suicide attempt was affected. Feelings of distress were experienced by nurses following a suicide/ suicide attempt. Support for nurses following a suicide/suicide attempt was crucial.</td>
<td>It is crucial that staff who experience a patient suicide or attempted suicide are provided with the relevant informal and formal supports to enable them to minimise the adverse effects of such a tragedy on their personal and professional lives and to help them reflect on and learn from the traumatic incident.</td>
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<td>Accounting for Accountability: A Discourse</td>
<td>Robertson, Paterson, Lauder, Fenton and Gavin</td>
<td>The Open Nursing Journal</td>
<td>Scotland, United Kingdom</td>
<td>To explore how psychiatric nurses construct and orient to accountability</td>
<td>Qualitative Methodology Discourse Analysis using</td>
<td>2 mental health nurses who had worked on the</td>
<td>Findings highlight that, as a consequence of internalising fundamentally unrealistic expectations regarding suicide</td>
<td>Analysis of the nurses’ talk can make a valuable contribution to understanding the nature and the impact of</td>
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<tr>
<td>Study Title</td>
<td>Authors/Source</td>
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<td>Methods</td>
<td>Findings</td>
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<td>Analysis of Psychiatric Nurses’ Experience of a Patient Suicide</td>
<td>(2010)</td>
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<td>when talking of their experiences of a patient suicide.</td>
<td>Potter and Edward’s Discursive Action Model same ward and had experience the same patient suicide. prevention, nurses can hold themselves to blame, raising significant concerns around their needs in terms of support, which may not be recognised. ‘accountability’ in a mental health setting and so, help nurses and other professionals gain an insight into their practice. Existing support practices may need reform and nurses may benefit from a clear support strategy specifically attending to patient suicide.</td>
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<td>The impact of inpatient suicide on psychiatric nurses and their need for support.</td>
<td>Takahashi et al (2011) BMC Psychiatry Japan</td>
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<td>To explore how nurses felt after a suicide in an inpatient setting</td>
<td>Anonymous self-reported questionnaire &amp; Impact of Event Scale-Revised (IoES-R) 531 Mental Health Staff nurses working at a mental health hospital. 55% of nurses had experienced a patient suicide. It was reported as being a significantly distressing event. Only 15.8% reported having access to post-suicide mental health care programmes. Low rates of nurses (26.4% and 12.8%) reported attending in-hospital seminars on suicide prevention or mental health care for nurses. Nurses need to have post-suicide follow up care in the form of a mental health care programme as well as a case study session. Nurse educational programmes need to prepare mental health nurses regarding the complex issues related to patient suicide.</td>
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<td>A Qualitative Study of Mental Health Nurses’ Experiences of Patient Suicide or</td>
<td>Shanley (2012) Electronic Thesis United Kingdom</td>
<td></td>
<td>This study explores the combined effect of experiencing a patient’s suicide or unexpected death and the</td>
<td>A qualitative study Constructivist grounded theory methodology. It explores the experience of fifteen mental health nurses from four NHS The findings of this study identified that the participants all experienced varying degrees of psychological distress, which for two were similar to experiences more in relation to most deaths in the community, the death of a client would not necessarily always be perceived to be as a direct error by a member of staff.</td>
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<td>Unexpected Death and its Aftermath</td>
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<td>subsequent process of professional scrutiny that frequently follows such a death.</td>
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<td>trusts and their response to a patient suicide or unexpected death.</td>
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<td>normally associated with post-traumatic stress disorders. The psychological response to the distress of the death and process of scrutiny was similar to that found in second victim studies. However, the nurses in this group did not believe they had made an error, often a factor associated with second victim studies.</td>
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<td>This study has shown that the psychological effects on staff are similar to the studies on second victims. A further exploration of whether a perceived error has any further consequences on the psychological response on the mental health practitioner may be beneficial.</td>
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<tr>
<th>Mental Health Nurses’ Experiences of Caring for Suicidal Patients in Psychiatric Wards: An Emotional Endeavor</th>
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<td>Hagen, Loa Knizk &amp; Hjelmeland (2017)</td>
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<tr>
<td>To explore how mental health nurses deal with the variety of demands in the care of potentially suicidal patients in psychiatric wards, including how they react to suicide, suicidal acts, and deal with the emotional challenges in the care of patients at risk of suicide.</td>
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<tr>
<td>Various emotions such as guilt, failure, anxiety, fear, and sadness are evoked by suicidal behaviour. Mental health nurses seem to regulate their emotions and emotional expressions by outwardly appearing confident and calm reacting to a suicide whilst that are internally distressed. They also balance involvement and distance to provide good care of patients and themselves.</td>
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<td>Mental health nurses have an important role and should receive sufficient formal support. Nurses need more formal and informal support systems to help them to continue caring for suicidal patients and this could contribute to lowering levels of burnout.</td>
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<td>Title</td>
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| Staff experiences and perceptions of working with in-patients who are suicidal: qualitative analysis. | Awenal, Peters, Shaw-Nunez, Gooding, Pratt & Haddock (2017) | United Kingdom | The aim of this study was to investigate the experiences of working with in-patients who are suicidal. A qualitative study guided by a thematic analysis of semi-structured interviews with mental health staff with experience of working in psychiatric inpatient care. 20 participants: 10 came from nursing (8 registered nurses and 2 health care assistants); 6 allied health professionals and 4 psychiatrists. All participants had experienced a patient suicide as well as suicidal behaviour. Three key themes were identified: *Theme 1*: the experience of suicidality (encountering suicide; maintaining business as usual; blame and fear of blame; severe and enduring effects); *Theme 2*: conceptualising suicidality (symptoms of illness versus escape; genuineness; inevitable and untreatable) and *Theme 3*: Talking about suicidality (a delicate topic; ‘not my role’, fear of doing harm). The authors acknowledged that the participant sample came from a variety of professional groups and they recommended further investigation in specific professional groups to find out their experiences of working with suicidal patients. They recommended the provision of structured peer support in the form of mandatory clinical supervision to support staff at all levels; a genuine ‘no blame’ culture and further training in holistic models of suicidality as well in the use of psychosocial interventions with patients who are suicidal.

| Feelings, thoughts and experiences of nurses working in a mental health clinic about individuals with suicidal behaviours and suicide attempts | Turkles, Yılmaz & Soylu (2018) | Turkey | To investigate the feelings, thoughts and experiences of nurses working in a mental health clinic regarding patients with suicidal behaviours, suicide attempts and those who die by suicide. A qualitative study design was employed. Data in this research study were collected through individual in-depth interviews. 33 nurses who had been working at a hospital for at least one year, had experience working with patients who attempted or died by suicide. The nurses understood the patients; they experienced sadness, worry, anxiety, stress, upset and fear; they were blamed by the hospital administration when a patient died by suicide; they blamed themselves and doctors for patient suicides. It is recommended that planned group meetings for nurses be arranged and that follow-up guidelines/protocols for patients with suicidal tendencies who are residing in mental health clinics be prepared by a committee of healthcare professionals. |
6.8. Discussion

The review revealed that there is national and international interest in researching how mental health nurses react to distressed patients who engage in suicide behaviours and subsequently die by suicide. Included studies were presented in chronological order, starting with the work of Midence et al. (1996) through to the work of Turkles et al. (2018). They discuss experiences of mental health nurses practising in England, Wales, Scotland, Ireland, North America, Canada, Norway, Turkey and in Japan. It is interesting to note that all the studies were triggered after a series of patient suicides had taken place in hospital wards and clinics, prompting researchers to investigate the aftermath of the suicide behaviours as a form of critical incident analysis, in the interest of critical incident stress management to find ways of helping mental health nurses to cope on a personal and professional level as they work with people experiencing suicide thoughts and behaviours.

A critical analysis of the literature yielded the following themes: the effects of suicide on nurses; nurses’ coping strategies after a patient suicide; how nurses continue to work with patients experiencing suicide thoughts and behaviours after a patient has died by suicide by trying to navigate the complex work of suicide prevention and intervention in clinical environments where suicide behaviour is common; how nurses experience the investigative process that occurs after a patient suicide and how nurses can learn from and move on after experiencing a patient suicide.


This scoping review of literature confirmed what has been reported by research studies that
have been undertaken with other mental health professionals: that mental health nurses experience strong emotional reactions which include trauma, shock, sadness, anger, grief, anxiety, stress and distress after a patient suicide. Midence et al. (1996) reported that an in-patient suicide has complex effects on nursing staff and it should not be viewed as simply being on a negative to positive continuum. Suicide is conceptualised as being on a continuum of suicide ideation: thoughts, feelings, attempts and subsequently death by suicide (Hagen et al., 2017; Awenat et al., 2017). Nurses reported experiencing feelings of anguish when working therapeutically with patients experiencing suicide thoughts and behaviours before their death, and when they described the experience of professional bereavement after their patient had died. It is acknowledged that it is inevitable that some patients will experience suicide thoughts and behaviours, and some will die by suicide on an in-patient ward. Whilst nurses are aware of this inevitability, findings from the research suggest that nurses do not cope well after a patient dies by suicide and that they continue to be negatively affected by a patient suicide; hence the need for more research in this area.

Valente (2003) also reported experiencing feelings of grief as a professional nurse, whilst feeling powerless to prevent patient suicide which resulted in the experience of a professional identity crisis. To further illustrate the notion of experiencing a professional identity crisis, the nurses who took part in Joyce and Wallbridge’s (2003) study felt stressed, traumatised, and feared being blamed by their colleagues and by their senior managers. These feelings played themselves out in the form of dysfunctional team-working, resulting in divisions and splitting, with teams blaming each other after a patient had died by suicide. In addition, Joyce and Wallbridge (2003) tell us that, after a patient suicide, a nurse’s professional identity is affected on finding themselves in the challenging situation of being expected to help other patients who have been traumatised, whilst at the same time having to internally and privately cope with their own reactions to the patient death. The feelings of stress and trauma were also reported by participants in studies conducted by Bohan and Doyle (2008); Takahashi et al. (2011);
Shanley (2012); Hagen et al. (2017) and Turkles et al. (2018). It is worth noting that nursing participants in all the studies appeared to experience the trauma within the milieu of the nurse-patient therapeutic alliance, which is used as a platform for working with people experiencing suicide thoughts and behaviours. As the nurse-patient relationship is unique to nurses, these studies capture the close way in which nurses work with patients and they gave participants the opportunity to give voice to and to share those experiences.

6.8.2. Nurses coping strategies after a patient suicide

Awenat et al. (2017) conceptualised a common coping strategy that mental health nurses use after a patient dies by suicide and that is to maintain business as usual in the mental health ward environment. In other words, nurses felt that the show must go on, as they felt responsible and accountable for continuing to provide care for all the other patients on the ward. Some nurses described the process of wearing a mask as a way of coping with how they were really feeling about the patient suicide (Hagen et al., 2017). This has been described as an emotionally exhausting coping strategy by participants in Midence et al. (1996); Joyce and Wallbridge, (2003) and in Hagen et al. (2017). Participants experienced conflict as they tried to meet the needs of the mental health services as well as trying to self-care and self-soothe. Along with trying to maintain business as usual, some nurses have felt the need to talk about the suicide whilst others prefer not to talk about it (Awenat et al., 2017). The desire to talk about suicide may have been affected by the proximity that the individual nurse had been in relation to the patient. Some participants had worked with the deceased patient in the past, whilst others had worked intensively with them up until their death. Participants in Hagen et al.’s (2017) study confirmed that they experienced higher levels of distress when the suicide behaviour escalated significantly before the patient died by suicide.

6.8.3. How nurses continue to work with patients after a patient suicide.
This review has also revealed how nurses try to navigate the complex work of suicide prevention and intervention in clinical environments where the patient experience of suicide thoughts and behaviours is common. This is very challenging because the suicide of one inpatient can have significant ripple effects on all the other patients who are being cared for on the same ward. There is the clinical expectation that nurses will continue to assess and work with the patients experiencing suicide thoughts and behaviours on the ward, whilst undergoing the process of dealing with a patient who has died by suicide (Midence et al., 1996; Joyce and Wallbridge, 2003; Bohan and Doyle, 2008; Awenat, 2017). In an attempt to engage in developmental learning after a patient suicide, researchers have investigated the attitudes of mental health nurses towards suicide prevention (Midence et al., 1996; Awenat et al., 2017), and this gives us some insight into nurses’ attitudes toward it, with responses ranging from accepting that a patient suicide is their choice through to nurses feeling powerless to prevent a patient suicide, with some even blaming themselves for failing to prevent a patient suicide (Robertson et al., 2010).

6.8.4. How nurses experience the investigative process that occurs after a patient suicide

All the studies in this review reveal that the investigative process that occurs after a patient suicide is a challenging experience for mental health nurses. This may be due to the fact that in-patient settings aim to provide a safe and secure environment which provide 24-hour care to highly distressed patients. Therefore, when a suicide does occur in an inpatient setting, it is common practice for an investigation or a serious incident review to take place. Shanley’s work provides us with an insight into the experiences of 15 mental health nurses from both inpatient and community mental health services, after their experience of a patient suicide. His grounded theory study resulted in the development of the second victims theory in relation to how mental health nurses experience the investigation process but, in their case, there was
no error on their part, because the patient chose to die by suicide (Shanley, 2012).

6.8.5. What nurses say they need in order to learn from and move on after experiencing a patient suicide.

After nurses have had a patient suicide death, they stated that they needed formal emotional support to help them to process and learn from the traumatic incident (Midence et al., 1996; Joyce and Wallbridge, 2003; Bohan and Doyle, 2008; Hagen et al., 2017; and Awenat et al., 2017). Participants also spoke about the need for educational programmes to prepare them to deal with a patient suicide (Midence et al., 1996; Bohan and Dole, 2008; Takahashi et al., 2011; Turkles, 2018), and the need for post-traumatic stress debriefing and education after a patient dies by suicide (Joyce and Wallbridge, 2003; Takahashi et al., 2011; Shanley, 2012) in order to minimise the risks of experiencing emotional fatigue and burnout (Hagen et al., 2017; Awenat, 2017; Turkles, 2018).

With regards to the research methodology, nine out of the ten studies employed qualitative research methods to gain insights into the reactions of mental health nurses after a patient suicide. The use of qualitative methods makes sense because researchers were interested in finding out the experiences of mental health nurses who play a crucial role in making clinical judgements in the reduction of suicide risk. All research was conducted within the context of in-patient mental health settings and the participants tended to be mental health nurses who had worked directly with the patient. The focus on in-patient settings is also appropriate because in-patient settings are supposed to be a place of safety where patients presenting with high levels of suicide risk and whose risk cannot be contained in a community setting are often admitted. Consequently, in-patient care is often led by mental health nurses delivering
care to a number of patients experiencing suicide thoughts and behaviours who are housed in one confined space. An in-patient suicide can have a substantial effect on the nursing staff who are caring for these patients. While insights into the suicide loss experiences of mental health nurses working in in-patient settings are extremely valuable, with more and more mental health care being delivered in the community, there is also a need for the study of community mental health nurses’ experience of patient suicide. It is worth noting that Shanley’s (2012) study began to capture the community experience because he had participants who represented in-patient and community-based mental health settings. Shanley was interested in researching how these nurses experienced patient suicide loss as well as how they experienced the professional scrutiny in the form of investigations and coroner inquests which take place after the suicide has occurred. Therefore, Shanley’s study reported on the second victimisation of mental health nurses after the post-suicide investigative process has been undertaken, regardless of which setting the suicide took place in.

Takahashi et al.’s (2011) survey with 551 nurses is the only study to employ survey methodology. This study was a duplication of the nationwide survey method used by Chemtob et al.’s (1988) seminal study which explored the trauma experiences of consultant psychiatrists after a patient suicide through the use of the Impact of Event Scale-Revised (IoES-R). By duplicating Chemtob et al.’s (1988) study, Takahashi et al. (2011) were able to confirm that nurses working predominantly in in-patient wards also experience indications of stress and post-traumatic stress as a consequence of a patient suicide. Post-suicide education, in addition to training, was recommended as a way of helping mental health nurses to continue to care for people experiencing suicide thoughts and behaviours within an in-patient setting.

It is worth noting the range of sample sizes for eight of the qualitative studies. They tended to range from 1 participant (Valente, 2003) through to 33 participants (Turkles et al., 2018), which would justify the use of face-to-face interviews in seven of the studies. By using the interview methods...
approach, the researchers were undertaking emotionally sensitive research, as they were interested in exploring the lived experiences (Finlay, 2011) of a patient suicide from the perspective of the bereaved mental health nurses. Researchers appear to be interested in in-depth explorations of how mental health nurses feel about their accountability and responsibility in the work of preventing suicides (Robertson et al., 2010; Hagen et al., 2017; Turkles et al., 2018). Valente’s (2003) case study was reflective of her experience of a patient suicide and it presented a detailed narrative account of how she experienced grief, loss and sadness after experiencing the suicide of a patient who was in treatment. Valente’s subjective experience of her patient suicide has greatly influenced other researchers because this study has been well cited in seven of the studies which have been included in this review. Similar interest in in-depth analysis of what losing a patient to suicide means for mental health nurses was shown by Robertson et al. (2010) who analysed the experiences of two mental health nurses who had cared for the same patient. They explore the issue of professional accountability by stating that “if suicide is perceived to be largely preventable and predictable, this may foster a culture of blame and ‘blame’ may also be self-blame” (Robertson et al., 2010, p1). This finding shows that some mental health nurses can have high expectations of themselves when it comes to their understanding of what suicide prevention is and how effective it can be in saving lives. By having high expectations, it is understandable that some mental health nurses may blame themselves unduly after a suicide and this may greatly affect their ability to seek or access post-suicide support (Robertson et al., 2010).

Within this collection of literature, there is overall agreement that mental health nurses have significant suicide postvention needs which are triggered after a patient suicide. These needs are significant, important and worth researching. The presence of psychological distress is well-established but there is no general consensus regarding what would be considered the best approach to support mental health nurses to ameliorate their distress after a patient
suicide. Suggested support interventions for mental health nurses include processes such as debriefing, additional instruction and guidance about suicide prevention, intervention and postvention (Andriessen et al., 2017). Researchers have focused mainly on in-patient settings with little focus on community mental health settings, which means that it is essential for the experiences of community mental health nurses to also be explored. The findings from this scoping review were used to influence the design of this qualitative research study.

6.9. Conclusion

This scoping review of the literature relating to the experiences of mental health nurses after a patient suicide indicates that research has been conducted predominantly with mental health nurses based in in-patient settings. In-patient settings are seen as a place of safety where distressed patients are admitted when they are deemed to be a high suicide risk which can no longer be managed within a community setting. Whilst it is understandable and useful to have insights into mental health nurses’ experience after patient suicide loss in an in-patient setting, the experiences of community mental health nurses as a distinct professional group are not so well-represented in the literature. Accordingly, the design of this qualitative research study has been influenced by the findings from this review.
Chapter 7: Pilot Study

7.1. Introduction

This chapter will present findings from the suicide loss survivorship pilot study which I conducted with community mental health nurses. By undertaking the pilot study, I sought to establish the feasibility of carrying out a full-scale main study as a part-time PhD research student undertaking sensitive research for the first time. Research is deemed as being sensitive when it deals with areas in human life which are seen as controversial, shrouded in taboo or issues which address the darker side of human nature. Sensitive research can investigate social issues such as trauma, exploitation and abuse, dying and death, disease, complex health problems, experiencing or perpetrating violence as well as looking into the problems associated with deviance and crime (Liamputtong, 2009; Gilbert, 2001). These emotive topics often prompt researchers to reflect on the important role that emotions play when sensitive research is being carried out. Deep emotional reactions can be experienced both intellectually and emotionally by both the researcher and the participant (Liamputtong, 2009).

Sensitive research captures emotions, sensations, drives, and insights which are personal, intimate, meaningful, and possibly overwhelming. It involves the experience of being affected and moved by sharing a part of ourselves - an aspect of interconnection with others which is unique to human beings (Gilbert, 2001). Six community mental health nurses agreed to take part in the pilot study, which meant that I had the opportunity to pilot the semi-structured interview schedule to encourage and facilitate detailed conversations about their lived experience of patient suicide loss in a community-based mental health setting, thus testing adequacy or inadequacy of the research instrument. Lessons learned from the pilot study will and a discussion of how my experience of undertaking the pilot study influenced the development of the main study will be presented in this chapter.
7.2. Aims of the pilot study

The overall aim of the pilot study was to ascertain the possibility of undertaking this sensitive research with community mental health nurses. The theoretical principles proposed by Silverman (2013) had a strong influence on how I designed the pilot study. According to Silverman (2013), it is often very sensible and pragmatic to try out the interview questions and procedures with a view to learning from this process, which will inform the main study. As discussed in Chapter 6, pilot testing is a recognised research approach which permits a researcher to try things out, before undertaking the main study (Langridge, 2007; Finlay, 2011; Creswell, 2013; Guest et al., 2013).

With reference to the process of undertaking sensitive research, Gilbert (2001) describes the sensitive researcher as being a research instrument. She explained:

“What is at issue then, is the impact of immersion in an emotionally charged environment, and the elicitation of painful and inspirational stories, and the telling of these stories. Researchers are taught to question their ability, event their right to use themselves fully as the principal, perhaps only, research instrument. Yet to know the phenomenon about which they write and to be fully honest about how they came to their interpretation, one can argue that it is dishonest not to draw on their own emotional experience and incorporate those emotions into the final telling of their ‘research tale.’” (Gilbert, 2001, p. 12)

As a novice qualitative researcher, I felt that this statement helped me to make sense of the unique role that I had as the ‘research instrument’, as I embarked on my first experience of
conducting sensitive research. I recognised that, in order to maintain sensitivity, clinical details about community mental health nurses’ patient suicide needed to be kept confidential. I took into consideration that the clinical cases of patient suicide which they would be discussing would need to be handled in a sensitive manner. The motivation behind this was to undertake sensitive research in an ethically sensitive manner and also to protect the reputation of the wider NHS Trust where the suicides had taken place. Suicide statistics are widely reported in the public domain, but details pertaining to the people who died by suicide and their relatives are usually not disclosed, in order to maintain confidentiality. It is against this background that 7 key objectives of the pilot study were identified. These are presented in section 7.2.1.

7.2.1. Pilot study objectives

The 7 key objectives of the pilot study were:

1. To assess the feasibility of successfully recruiting research participants who would be willing to be interviewed about their lived experience as mental health nurses who had survived one or more cases of patient suicide loss whilst working in the community between 2002 and 2014.

2. To establish whether the chosen purposive sampling frame and technique would be effective.

3. To develop and test the adequacy of the semi-structured interview schedule as a research instrument which would be used to guide the interviews. As the Lead Researcher, I would administer a semi-structured interview schedule to pilot subjects with a view to testing out the questions used and to ask the participants for feedback in order to identify any ambiguities or difficult questions. I would then use such feedback to adjust, re-word and further develop the semi-structured
interview schedule for use in the main study.

4. To record the time that it would take to actually complete the interview using the semi-structured interview schedule and then decide whether that timeframe is reasonable.

5. To explore how and whether gender, culture, levels of training, clinical supervision and the individual nurse's experience of personal loss or trauma may affect their experiences of patient suicide.

6. To explore community mental health nurses' views about the support they received at the time of the suicide in order to ascertain how this support may have been received and interpreted from their lived experiences.

7. To train the novice Lead Researcher in as many elements of the IPA qualitative research process as possible.

7.3. Methods

The interpretive epistemological stance (Denzin and Lincoln, 2011) affected the way that I undertook the pilot study as it guided my exploration of the lived experiences of patient suicide from the perspectives of the participants rather than generate new theory. I was able to apply the principles of the qualitative research paradigm because I wanted to explore the individual’s experiences from their perspective and their lifeworld (Ashworth, 2003). The pilot study was launched on the 16th September 2014 through to the 27th February 2015. To analyse the data, Interpretive Phenomenological Analysis (IPA) was used because it is committed to the exploration of how people make sense of their major life experiences. Therefore, the pilot study explored the subject in question by focusing on each mental health nurse who had experienced a patient suicide in the community.
7.3.1. Target Population

The target population for the pilot study consisted of registered mental health nurses who were working within a community mental health setting within a pre-selected NHS Foundation Trust. This host site provides mental health and community services in the South of England. This region has a suicide rate of 9.5 per 100,000 population according to National Health Service (NHS) Region of residence, which is a similar average to neighbouring London, which has a rate of 8.0 per 100,000, and the Midlands and East of England, which has a rate of 8.5 per 100,000 population (Appleby et al., 2013). Therefore, the suicide rates for the host NHS site were in the range that was normal for neighbouring and close-neighbouring NHS Trusts.

I selected the local NHS Host Site because of the range of primary, secondary and tertiary services provided within community settings. Moreover, the local NHS Host Site had undergone a significant reduction of in-patient service provision since 2002 up until the time that the pilot study was launched, covering a period ranging from 2002 to 2014. Therefore, it was a typical example illustrating the service delivery changes that have been taking place in mental health services across the NHS. For the purpose of this study, community mental health clinical settings include: Crisis and Home Resolution Teams; Assertive Outreach Teams; Child and Adolescent Mental Health Teams; Community Mental Health Teams for Adults; Community Mental Health Teams for Older Adults; Early Interventions Services for Psychosis; Primary Care Community Mental Health Teams (Improving Access to Psychological Therapies ~ IAPT); and Forensic Community Mental Health Teams.

7.3.2. Eligibility criteria

Participants who were included in the pilot study were community mental health nurses who
have experienced a completed patient suicide between 2002 and 2014 and were willing to be interviewed about this experience. Mental health nurses who had previously been employed as a Community Mental Health Nurse by other NHS Trusts but were working for the local Host NHS Trust during this time period were also eligible to be included in the pilot study.

The pilot study excluded mental health nurses who were working in in-patient settings and had experienced a patient suicide; unregistered nursing assistants who have experienced a patient suicide; mental health student nurses; allied health and social practitioners; mental health nurses who had worked in the community prior to 2002 and retired mental health nurses.

7.3.3. Sampling strategy

As discussed in Chapter 6, the pilot study used a non-probability sampling technique which harmonises with interpretivist epistemology and qualitative research methodology, namely purposive sampling. The main goal of purposive sampling was to focus on particular characteristics of a population of interest which would best enable me to answer the research questions. In other words, I used purposive sampling because I felt it would enable me to access a targeted sample quickly as sampling proportionality was not my main concern (Denscombe, 2013).

As I was applying this sampling method during the pilot study, I understood this to be homogenous sampling, which refers to the targeting of people who share the same occupation and/or experience and is a technique that fits in well with the use of the IPA approach (Brocki and Wearden, 2006). I chose a homogenous sample because the research question that I was asking was specific to the characteristics of my particular group of interest: community mental health nurses who had experienced a patient suicide. This purposive sampling technique also allowed me to use my subjective judgements drawn from academic literature about the
experiences of mental health nurses’ suicide loss survivorship, my own clinical practice experience as a patient suicide loss survivor and the developmental nature of the research process itself (Smith et al., 2009).

7.3.4. Data collection tool – The semi-structured interview schedule

As discussed in Chapter 6, a semi-structured in-depth interview schedule was designed in line with guidelines provided by IPA’s authors (Smith et al., 2009) and used to guide the developmental conversations with the participants. I designed my semi-structured interview schedule based on a developmental framework provided by Smith et al. (2009), a framework which promotes the use of open-ended questions with a non-directive interview style. With permission from Dr. Louise Doyle, the content of some of the interview questions from her 2008 qualitative research study with in-patient mental health nurses (Bohan and Doyle, 2008) was adapted and used to create my semi-structured interview schedule. I designed the schedule to elicit and gather the maximum possible information about what it means for a community mental health nurse to lose a patient to suicide. I also wanted to gather information about the implications of patient suicide loss on the participants’ current and future clinical practice.

Table 4 below shows the questions and prompts which I developed as a guide for the interviews.
### Table 4: Semi-Structured In-depth Interview Schedule for Pilot Study

<table>
<thead>
<tr>
<th>Semi-Structured in-depth interview Schedule for Interpretative Phenomenological Analysis (IPA) – Pilot Study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Exploring the experiences of mental health nurses in the aftermath of a completed patient suicide.</td>
</tr>
<tr>
<td><strong>Can you tell me how you came to be a community mental health nurse?</strong> Possible prompts: <em>when did you start? What made you start?</em></td>
</tr>
<tr>
<td><strong>Please tell me about the nature of the work that you currently do in the community.</strong> Possible prompts: <em>What is the nature of your community team? What things are involved? Describe a typical day?</em></td>
</tr>
<tr>
<td><strong>As you know, my study is about surviving suicide. Since joining the community, can you tell me about your experience of a patient dying by suicide?</strong> Possible prompts: <em>When did it happen? What happened? Can you describe how you felt at that time?</em></td>
</tr>
<tr>
<td><strong>What does losing a patient to suicide mean to you?</strong> Possible prompts: <em>What does it mean to you as a mental health nurse? What does it mean to you personally?</em></td>
</tr>
<tr>
<td><strong>Can you tell me what happened to you after the patient completed suicide?</strong> Possible prompts: <em>Can you describe how you felt at that time? What did you do to cope? Was there anything else that helped you to cope?</em></td>
</tr>
<tr>
<td><strong>How has this experience affected your current practice in the community?</strong> Possible prompts: <em>Is there anything that you are now doing differently? Can you give me some examples?</em></td>
</tr>
<tr>
<td><strong>What are your views about the support that you received at the time of the completed suicide?</strong> Possible prompts: <em>What was the source of the support? How long did it last? Can you describe how you felt at the time?</em></td>
</tr>
<tr>
<td><strong>What does this experience of a completed patient suicide mean for your future practice in the community?</strong> Possible prompts: <em>Can you think of anything that you will do differently in the future?</em></td>
</tr>
<tr>
<td><strong>Do you have anything else that you wish to add? Thank you for participating</strong></td>
</tr>
</tbody>
</table>

#### 7.3.5. Ethics approval

In view of the sensitive nature of the subject, I applied for ethics approval and this was granted by the Institute for Health Research Ethics Committee (IHREC) at the University of Bedfordshire. I applied the principles of PPI (NIHR, 2018) and I approached the Deputy Director of Nursing from the host NHS Trust and I had a face-to-face meeting where I submitted
a pilot study research proposal and explained the purpose of my pilot study. I asked for permission to access community mental health nurses and to use local NHS premises as venues for data collection. This was a productive meeting because the Deputy Director of Nursing accepted my research proposal and approached the Director of Nursing on my behalf to present my research proposal. Both Directors of Nursing approved the pilot study and issued me with written permission and approval to access NMC registered community mental health nurses who were employed by the host NHS Trust.

7.3.6. Launch of Pilot Study

In line with the principles of PPI (NIHR, 2018), my first activity was to contact the Research Gatekeeper, informing her that I had been given ethics approval to go ahead and to launch the pilot study. I also presented the evidence of NHS permission from the R&D Department and then sent a pre-written template for the advertisement and asked the Research Gatekeeper to launch this on the local NHS Trust intranet site. The research study was successfully advertised by the Research Gatekeeper, who sent notification of the pilot study to all registered mental health nurses working within the local host site through the use of the internal communication systems such as the local Trust intranet site, emails to community mental health team managers and various community mental health nursing forums. We chose to use emails because service managers and many community mental health nurses employed by the host NHS Trust used iPads, which meant that they were more likely to see the announcement and express an interest in participating in the study. The role of the Research Gatekeeper was crucial to the successful launch of the pilot study and to signposting any community mental health nurses who expressed an interest in being participants. The initial research advertisement was posted on the intranet site for a period of 14 working days.
In communicating with the pilot study participants, from the screening process through to facilitating the research interview, I made every effort to maintain confidentiality and anonymity. Prospective participants were invited to contact me by email, in my capacity as the Lead Researcher and express their interest in participating in the pilot study. After receiving the email, I responded to the prospective participant by email or telephone in order to arrange a screening interview with them. All screening interviews were undertaken on the phone and, if the interested community mental health nurse met the inclusion criteria, a research interview was arranged at a mutually convenient time at a venue chosen by the research participant. A confirmation email with an official letter of invitation, a participant information sheet, and a poster with a brief overview about the study were sent to each participant who had been selected to participate in the study. When documenting any information about the participants, I protected the identity of the participants by withholding the real names of the participants and I identified them using a 2-digit number prefixed by the letter N = Registered Nurse.

7.3.7. Data collection – Conducting the pilot interviews

When the screening phase was completed, I invited 6 participants who had met the inclusion criteria to attend one individual face-to-face semi-structured interview with me as the interviewer (Brocki and Wearden, 2006; Smith et al., 2009). Prior to each interview, I made sure that I was prepared to undertake the interviews in the best way possible. I was acutely aware of the sensitive nature of the research and its potential to trigger feelings of distress in some participants. In anticipation of this, I prepared a procedure for handling distress or crying if this was triggered during the interview. I decided that I would pause the interview and acknowledge the emotion. I felt it was important to stay with the interviewee and be present with them during that moment of distress. I decided that I would check that the interviewee was okay to carry on with the interview and I would sensitively remind the participant that they
could pause or completely stop the interview at any time and would be under no obligation to give a reason for their withdrawal from the pilot study. In order to handle distress and crying in a practical way, I made sure that I was prepared with a small bottle of water and a small packet of tissues which I would give to any participant who may become tearful during the interview. In addition, I developed a resource folder with a ‘Support after Interview’ leaflet, relevant pilot study documentation and relevant suicide postvention information which would signpost participants to other sources of support. I gave this information to each participant at the conclusion of their interview. I felt that this would dignify and show respect for each participant.

As a novice researcher, I experienced some anticipatory anxieties at the prospect of conducting a research interview and so I engaged in some mental and emotional preparation. I made sure that I was safe at all times and I followed the University of Bedfordshire’s Lone Worker Policy as reflected in the “Personal Safety Guidelines for Researchers”. I carried a form of identification with me at all times, I made sure that I had a fully-charged mobile telephone which I carried with me at all times. I also established a call-back system where I verbally notified a work colleague about my whereabouts at the start and at the end of each fieldwork session. I also notified my line manager, who was also the head of department, about my whereabouts using the Microsoft Outlook Calendar which I agreed to share with her and her personal assistant. I also planned to have extra support for my own health and wellbeing during the pilot study. I got additional support from my PhD supervisory team, my Head of Department at the University, my PhD mentor and I also contacted the university’s counselling service in case my sensitive research activities were to trigger a strong emotional reaction in me, as I was using myself as a research instrument.
With regards to my equipment, I made sure that my digital recorder was working and that I had spare batteries in case I needed to replacements. Additionally, I made sure that my research bag was organised and packed in advance in order to minimise the risk of forgetting something. It was crucial that I rested my mind and that I had a good night’s sleep prior to each interview. With regards to my time management, I allocated enough time in my diary to be able to engage in some reflective and reflexive thinking immediately after each interview.

On the day of each interview, I travelled to the pre-arranged location by car and I made sure that I allowed sufficient time to be able to find a car parking space on busy NHS sites. After meeting the participant for the first time, I engaged in preliminary conversations as a way of helping the participant to feel at ease. Once we had entered the interview room and had settled down, I went through the consent process, I explained the interview procedure and then I turned on the tape recorder and began the interview. For each interview, I used the semi-structured interview schedule and asked each question in sequence. I encouraged participants to share their lived experience through the use of prompt questions and this technique worked well.

At the conclusion of each interview, I turned off the tape recorder and engaged in a debrief with each participant. I asked them how they were feeling after sharing their story within the context of the research interview. If a participant was tearful, I spent some time with them until they had regained their composure and were ready to return to the activities that they had planned for the day. I also gave each participant the opportunity to ask me questions about my research. At the conclusion of the interview, I thanked each participant for their involvement and for sharing their story with me. I then issued the information pack signposting them to relevant suicide survivorship resources. With each interview still fresh in my mind, before I
transferred each tape-recording onto a format which I could store securely in preparation for data transcription, I engaged in reflective and reflexive thinking.

7.3.8. Reflexivity

Smith et al. (2009) acknowledge the major role played by the researcher within the process of undertaking lifeworld (Ashworth, 2003) qualitative research. Whilst the researcher aims to see the world as it is experienced by the participants, it is almost impossible for the researcher to be completely detached or neutral when approaching the research (Finlay and Evans, 2009). The researcher’s use of self is the most important tool during the analysis of the data, hence it is important for the researcher to engage in reflexivity (Finlay, 2011). As I was conducting the pilot study interviews, I was especially conscious of my own partial-insider experience of suicide loss survivorship since 1996, as described in Chapter 1. I am an NMC registered mental health nurse with the lived experience of being a community mental health nurse and I have experienced patient suicide loss. My identity as a community mental health nurse was a topic of conversation with some of the participants, who were inquisitive about why I had chosen to undertake this sensitive research. Some participants were intrigued about the fact that I was undertaking a PhD as a mental health nurse and they were eager to discuss the pros and cons of undertaking post-graduate study at doctoral level. Other participants were just so grateful that somebody had taken the time and effort to undertake this suicide loss survivorship research in recognition of the experience of the community mental health nurse. Therefore, I was acutely aware that I needed to practice reflexivity because such experiences would have a profound effect on how I was learning and developing as a qualitative researcher using IPA methodology. Consequently, I applied the principles of reflexivity by completing an audio record and a written diary with reflexive field notes after I completed each pilot study interview. I engaged in reflexivity with a view to capturing my thoughts and feelings which had
been triggered before, during and after each interview. I also used my partial-insider experience (Braun and Clarke, 2013) as a community mental health nurse and patient suicide loss survivor as motivation to gain more understanding about the participant’s experiences as I engaged in data transcription and analysis. For more details of how I engaged in the process of transcription and analysis, please see Appendix 11.

7.4. Findings

1 Assess the feasibility of recruiting participants who would be willing to be interviewed about their experiences as mental health nurses who survived a patient suicide whilst working in the community between 2002 and 2014.

As part of the recruitment strategy for the pilot study, I initially sought to recruit 6 community mental health nurses, working in a variety of community-based mental health services within the host NHS Trust, who had experienced a patient suicide between the years 2002 and 2014. The Research & Development team granted permission for me to interview 6 participants and this number had also been approved by the University of Bedfordshire’s IHR Ethics Committee.

In view of the sensitive nature of studying death by suicide, I was able to assess the feasibility of recruiting suitable participants who would be willing to share their experience of losing a patient to suicide. After launching the pilot study, I was pleasantly surprised to see the almost immediate reaction to the advertisement. It was encouraging to note that 11 mental health nurses responded to the call for participants. This meant that the study had attracted more interest from community mental health nurses than I had anticipated when I was putting the pilot study research proposal together. This gave me
confidence to continue with the research and to progress to the main study.

2 Establish whether the sampling frame and technique are effective

The pilot study used purposive sampling and I sought to include a homogenous sample, which is true to the principles and practice IPA qualitative research methodology (Smith et al., 2009). I sought to find a quota sample of the six mental health nurses in the pilot study sample, where I hoped that three participants would be male and the other three participants would be female. I decided that the sample could be further divided into three categories which would include: two nurses (one male and one female) who had experienced a suicide recently, within the last 12 – 18 months (November 2012 to May 2014); two nurses (one male and one female) who had experienced a suicide in the 12 to 18 months nearer to 2002 (January 2002 to July 2003) and finally two nurses (one male and one female) who had experienced suicide between July 2007 to January 2009.

Although quota sampling was the intent, it did not happen during the pilot study, therefore I did not use quota sampling for the main study. The reality was that two males (both had experienced the suicide in 2013) came forward and the nine females who had experienced a patient suicide between 2005 and 2014 also came forward. This experience helped me to recognise that perhaps the use of quota sampling was a little ambitious, in view of the small-scale size of the research and also the time constraints imposed by the demands of part-time PhD Study. Therefore, as a lesson learned from the outcome of using a purposive sampling strategy during the pilot study, I decided to use purposive sampling for the main study.
3 Develop and test the adequacy of research instruments

I designed and used a semi-structured interview schedule as the research instrument for the pilot study. I used the schedule to interview the participants whom I had screened and selected. I gained valuable experience in the actual use of the semi-structured interview schedule. The responses which I got from the participants helped me to understand that the open questions which I had built into the schedule were effective. They encouraged the participants to open up and to converse honestly about their experiences of a patient suicide and what it meant to them on a personal and professional level.

After undertaking each interview, I made sure that I asked for feedback about the interview schedule from the six participants. All participants felt that the questions were well-constructed. They had helped them to formulate a meaningful response which prompted them to think deeply about their experiences and to reveal their lived experiences from their perspective. I also noted that the inclusion of prompt questions was useful in keeping the interview going, especially with two participants who became quite tearful and distressed during the interview. I handled episodes of tearfulness and distress among participants in an ethically sensitive manner, as outlined in the ethics section of the original research proposal. In response to their distress, I gently and compassionately informed the distressed participants that they could stop the interview if they wished. I desisted from asking any further questions and allowed as much time as they needed in order for them to regain their composure. In order to comfort them, I gave them a pocket-sized pack of tissues and a bottle of water. My gestures of kindness...
were well-received and the participants expressed appreciation for the effort which I had put into making sure that their emotional needs were addressed during the interview.

Regarding the content of the interview schedule, I noted that it required some refinement after the pilot interviews. According to Smith et al. (2009), the process of developing the IPA interview schedule should be seen as iterative. Therefore, ideas can develop and change over time. The wording of some of the questions needed to be changed to include more direct prompts relating to the psychological, physical, and emotional feelings experienced by community mental health nurses after a patient suicide. In response to this, for the main study, I updated the interview schedule and designed a biographical data form which the participants would fill in at the start of each interview. The updated interview schedule will be discussed in Chapter 8.

4 Record the time that it takes to complete the interview using the semi-structured interview schedule and decide whether it is reasonable

The participant information sheets which I gave to the participants indicated that the pilot study interview would last up to 60 minutes but could possibly last longer. All six interviews were conducted and timed using a digital recorder. The timings for each interview were as follows:
Table 5: The Duration of Pilot Study Interviews

<table>
<thead>
<tr>
<th>Participant</th>
<th>Date of Interview</th>
<th>Duration of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thursday 25&lt;sup&gt;th&lt;/sup&gt; September 2014</td>
<td>40 minutes &amp; 55 seconds</td>
</tr>
<tr>
<td>2</td>
<td>Monday 29&lt;sup&gt;th&lt;/sup&gt; September 2014</td>
<td>36 minutes &amp; 8 seconds</td>
</tr>
<tr>
<td>3</td>
<td>Wednesday 1&lt;sup&gt;st&lt;/sup&gt; October 2014</td>
<td>42 minutes &amp; 18 seconds</td>
</tr>
<tr>
<td>4</td>
<td>Tuesday 7&lt;sup&gt;th&lt;/sup&gt; October 2014</td>
<td>68 minutes &amp; 9 seconds</td>
</tr>
<tr>
<td>5</td>
<td>Tuesday 16&lt;sup&gt;th&lt;/sup&gt; December 2014</td>
<td>60 minutes &amp; 8 seconds</td>
</tr>
<tr>
<td>6</td>
<td>Tuesday 6&lt;sup&gt;th&lt;/sup&gt; January 2015</td>
<td>39 minutes &amp; 32 seconds</td>
</tr>
</tbody>
</table>

The timings show that the interview length was reasonable both for the participants and for me as the researcher. It is also important to mention that I spent approximately 10 to 15 minutes engaging in the preliminary introductions before the interview, setting the scene, completing consent forms as well as answering any questions that participants may have had. Additionally, I spent approximately 10 to 15 minutes providing debrief after the interview. I also used this time to answer any questions that the participants had about why I was undertaking this sensitive research and its potential implications for mental health nursing practice.

By engaging in such practice, I was demonstrating that I had an appreciation for the relationship-centred approach to qualitative interviews as well as making sure that I was undertaking ethically sensitive research. I aimed to follow the same approach and to use similar interview timings when I interviewed participants during the main study.

5 Explore how and whether gender, culture, levels of training, clinical supervision and the individual nurse’s experience of personal loss or trauma may affect their experiences of patient suicide.
The pilot study revealed that this objective could not be met using IPA methodology. On reflection, I acknowledge that this objective was too specific and that if I wanted to find the answer, I would need to use a different approach, perhaps by means of a survey instead of using an interview schedule. Additionally, I came to realise that I had not provided clarity with regards to how the term “culture” would be used within the context of this study. Qualitative research aims to explore meaning from the perspective of the participant. In line with the homogeneity of the sample, after completing the pilot study I chose to exclude this objective and did not pursue it in the main study. As an alternative, in order to capture the identity of each participant, I decided to design and use a Biographical Data Form, which each participant would include at the start of each interview. A visual sample of this form will be presented in Chapter 8.

6 Explore mental health nurses’ views about the support they received at the time of the suicide in order to ascertain how this support may have been received.

During each interview, I asked community mental health nurses about their views regarding the support that they had received at the time of the suicide. All participants were able to talk about their patient suicide loss which shed light on their experiences. Some of the comments revealed that the Line Manager has a significant role in the delivering of the news about the patient suicide as well as the coordination of support to mental health nurses after the suicide. Some participants commented that the manner in which the news about the suicide had been delivered was significant to them. Suggestions of what would have been more helpful in the aftermath of the patient suicide in the community were made, especially in the provision of support during the
investigative process. Therefore, the interviews gave me some insight into some of the challenges faced by the participants. However, such themes needed to be treated with caution, because the discussion of key findings was not an objective in the pilot study. Therefore, findings from the pilot study will not be included in the overall analysis of the main study.

7 Train the novice Lead Researcher in as many elements of the research process as possible

The use of the pilot study gave me the opportunity to participate in primary research and to demonstrate that I have developed the key skills required to undertake qualitative research. I developed an understanding of the importance of literature reviewing when starting a study. I learned why so much time is spent reviewing literature and how findings from a review of the literature can shape the design of a research study. My skills of applying for permission and ethics approval from the university and the main stakeholders within the host NHS Trust were greatly enhanced during the pilot study. By enlisting the help and support of a Research Gatekeeper, I was able to eliminate the perception that community mental health nurses were coerced to participate in the pilot study. The Research Gatekeeper was also able to navigate internal NHS communication systems to which, as an outsider, I did not have access.

7.5. Conclusion

By undertaking this pilot study, I learned that it was feasible for me to undertake a full-scale main study. After undertaking this pilot study, I developed deep insights, knowledge and lived experience of what it is like to construct a research question, develop data collection tools, engage in qualitative semi-structured interviews, transcribe, analyse and present the findings
from a pilot study. I developed the skill of interviewing as a researcher and not as a clinician, a significant process which helped me to make the transition from clinician to researcher. Quota sampling was a good idea, but it did not prove viable for my purposes, so I chose to exclude it from the design of the main study. As a novice researcher, I learned how to handle distress and crying in participants. I came to fully appreciate that just because community mental health nurses are very experienced clinicians and some of them have many years of mental health nursing experience, it does not mean that they are immune to feeling vulnerable or distressed when they share their stories about what it means for them to have a patient die by suicide. By applying the theory of qualitative research methodology, this pilot study gave me the knowledge, research skills, tools and the confidence to progress to the main study.
Chapter 8: Main Study

8.1. Introduction

The main study was launched in August 2018 as the second phase of fieldwork with the aim of exploring the experiences of community mental health nurses after a patient dies by suicide. Building on the outcome of the pilot study, as discussed in Chapter 7, the main study methodology was refined to use purposive sampling and the schedule of the semi-structured interviews was redesigned. Using the principles of PPI (NIHR, 2018), I followed the same process which I had followed during the pilot and enlisted the help a Research Gatekeeper to advertise the study to the same NHS Host site. Based on the findings from the pilot study, this chapter will present the research process which I followed during the main study.

8.2. Methods

The methods discussed in Chapter 6 were applied to the design of the main study. Ethics approval was granted by the Health Research Authority (HRA) and permission was granted by the Research and Development Department (R&D) and the Institute for Health Research Ethics Committee at the University of Bedfordshire.

Development of the interview schedule for the main study:

As discussed in Chapter 7, I made some minor adjustments to the data collection tool, which resulted in the production of an updated version of the interview schedule for the main study. Table 6 shows the updated interview schedule.
<table>
<thead>
<tr>
<th>Semi-Structured in-depth interview Schedule for Interpretative Phenomenological Analysis (IPA) – Main Study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Exploring the experiences of community mental health nurses in the aftermath of a patient suicide.</td>
</tr>
<tr>
<td>1. Can you tell me how you came to be a community mental health nurse? Possible prompts: When did you start? What made you start?</td>
</tr>
<tr>
<td>2. Please tell me about the nature of the work that you currently do in the community. Possible prompts: the nature of your community team? What things are involved? Describe a typical day?</td>
</tr>
<tr>
<td>3. As you know, my study is about experiencing patient suicide loss. Since joining the community, can you tell me about your experience of a patient dying by suicide? Possible prompts: When did it happen? What happened? Can you describe how you felt at that time?</td>
</tr>
<tr>
<td>4. What does losing a patient to suicide mean to you? Possible prompts: What does it mean to you professionally as a mental health nurse? What does it mean to you personally?</td>
</tr>
<tr>
<td>5. Can you tell me what happened to you after the patient died by suicide? Possible prompts: Can you describe how you felt at that time? What did you do to cope? Was there anything else that helped you to cope?</td>
</tr>
<tr>
<td>6. How has this experience affected your current work as a community mental health nurse? Possible prompts: Is there anything that you are now doing differently? Can you give me some examples?</td>
</tr>
<tr>
<td>7. What are your views about the support that you received at the time when your patient died by suicide? Possible prompts: What was the source of the support? How long did it last? Can you describe how you felt at the time?</td>
</tr>
<tr>
<td>8. What does this experience of losing a patient to suicide mean for your future practice in the community? Possible prompts: Can you think of anything that you will do differently in the future?</td>
</tr>
<tr>
<td>9. Do you have anything else that you wish to add?</td>
</tr>
</tbody>
</table>

Thank you for your participation.
The key difference in this interview schedule is that questions 4 and 7 have been edited to reflect an improved style of questioning. For example, the main question 4 in the pilot study was:

“What does losing a patient to suicide mean to you?”

The prompt questions were:

“What does it mean to you as a mental health nurse?”

After testing out the interview schedule, in order to gather more information about the meaning of this loss on a professional level, I edited this prompt question to read as:

“What does it mean to you professionally as a mental health nurse?”

The second prompt question, “What does it mean to you personally?” remained the same for the main study.

With regards to question 7, the pilot study question was worded:

“What are your views about the support you received at the time of the completed suicide?”

I designed this question to elicit mental health nurses’ views about an issue of existential significance, but I felt that the use of the term “completed suicide” was not appropriate. I felt that it gave the impression that suicide was like a task to be completed, when in reality it
resembles the choices people sometimes make in response to high levels of distress as a consequence of mental illness. Therefore, I changed the wording of question 7 as follows:

"What are your views about the support you received at the time when your patient died by suicide?".

As with question 4, the prompt questions for question 7 remained the same.

As discussed in Chapter 7, in order to capture more idiographic biographical details about the participants, I designed a Biographical Data Form which would allow the participants an opportunity to tell me a little bit more about their age and gender. I decided that I would ask the participants to complete this form at the start of each interview so that I could get responses to some baseline questions. This form also guided me during the analysis phase of the main study as it helped me to further understand their lifeworld and experiences from their perspective.
Table 7: Biographical Data Form for Main Study

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  What is your age?</td>
<td></td>
</tr>
<tr>
<td>2  What is your gender?</td>
<td></td>
</tr>
<tr>
<td>3  What is your ethnicity?</td>
<td></td>
</tr>
<tr>
<td>4  What type of work setting do you work in?</td>
<td></td>
</tr>
<tr>
<td>5  How long have you worked as a registered mental health nurse?</td>
<td></td>
</tr>
<tr>
<td>6  How many years have you worked in your current role?</td>
<td></td>
</tr>
<tr>
<td>7  How many instances of patient suicide have you experienced?</td>
<td></td>
</tr>
<tr>
<td>8  How many days off sick have you had in the last 12 months?</td>
<td></td>
</tr>
<tr>
<td>9  Have you had any experience of work-related stress after the patient suicide?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Tick the appropriate response.</td>
<td></td>
</tr>
<tr>
<td>10 Have you had any experience of work-related burnout after the patient suicide?</td>
<td>Yes No</td>
</tr>
<tr>
<td>Tick the appropriate response.</td>
<td></td>
</tr>
</tbody>
</table>

8.3. The interviews

I conducted in-depth semi-structured interviews with ten community mental health nurses during the main study as designed. Overall, the interviews lasted from 34 to 73 minutes. Participants were recruited after the main study was advertised on the local NHS intranet site. As mentioned in section 8.1, using the principles of PPI (NIHR, 2018), a Research Gatekeeper...
launched the main study through different channels, which included sending emails directly to
community-based mental health team managers and to mental health nurses who were
members of community mental health nursing forums. I also contacted the five community
mental health nurses who had expressed an interest in the pilot study but were excluded
because I had already selected six participants for the pilot study. Two of the ten nurses who
were interviewed were recruited from this reserve list. One mental health nurse no longer met
the inclusion criteria and the remaining two nurses did not respond to the invitation to
participate in the main study. Once they had completed the consent form, all ten participants
completed a biographical data form at the start of the interview. This was a homogenous
sample and they were all community mental health nurses who were professionally registered
by the NMC. Nine participants were female, and one was male. This is not a surprise in view
of the fact that nursing is largely a female-dominated profession. In line with the study's ethical
principles, the names of the participants were anonymised.

I screened participants against the inclusion criteria for the main study and, if they met the
criteria, I invited them to a research interview on a mutually convenient date and at a time and
venue of their choice. The participants chose the interview venue and all interviews were
conducted in NHS premises. All participants chose a venue where they could speak freely
and in confidence. I followed the same procedure for each interview, where I started by
seeking consent to proceed. After discussing the purpose of the study, participants completed
the consent form, the biographical data form, and they read through the participant information
sheets. They also had the opportunity to ask me any questions before we conducted the
interview. All the interviews were audio-recorded. To ensure that the data were captured and
to minimise the risk of mechanical failure, I used two digital recording devices. I made sure
that mobile phones were switched off and removed from the vicinity of the audio recorder, in
order to minimise the risk of the recorders picking up electromagnetic interference from the
mobile phone signals.
Once the participant was comfortable, I turned on the tape recorders and began the interview. The interview schedule went from broad to the specific and I asked the questions as stated on the interview schedule. The first two questions were designed to prompt a descriptive lifeworld (Ashworth, 2003) narrative about how the participants became community mental nurses, how they had established their identity in this role and also how they understood the existential significance of being a community mental health nurse. For example, I asked them: “Can you tell me how you came to be a community mental health nurse?” The next three questions were designed to elicit participants’ lifeworld (Ashworth, 2003) narratives about the experiential significance of losing a patient to suicide and what such an experience meant to them on a professional and personal level.

In order to facilitate the participants’ experiential narratives and stories, I made use of probes and prompt questions. For example, I asked, “Can you describe how you felt at the time?” and “What did you do to cope?” The next two questions were designed to explore participants’ views about the experiential significance of patient suicide loss and how this has affected their current and future clinical practice, especially when engaging in the therapeutic work of connecting with and helping people experiencing suicide thoughts and behaviours. The next question in the interview schedule encouraged participants to share their views about the support they received at the time of the patient suicide. For example, I asked the participants about the sources of support, types of support and how they had experienced that support or the lack of it. To conclude the narrative, the final interview questions asked participants to share their story about the existential significance of patient suicide and the meaning that this would have on their future clinical practice.

8.3.1. Transcription of interviews
Using the transcription skills which I learned during the pilot study, I engaged in the transcription of the interviews. Each transcript took approximately 10 hours to complete. This significant amount of time allowed me to immerse myself in the data as I listened to each interview before, during and after the transcription. Each transcript was formatted with a wide margin and I printed and bound each copy as a way of organising each transcript. Throughout the transcription process, I made notes about what I was learning about each participant. This helped me gain further insight into their lifeworld (Ashworth, 2003). The table below gives an overview of the interviews which I conducted and how long they took.
Table 8: Participant Biographical Data & The Duration of Main Study Interviews in Chronological Order

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age Range</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Number of Years Worked as a Mental Health Nurse</th>
<th>Work Setting</th>
<th>Years Worked in Current Role</th>
<th>Number of Patient Suicides</th>
<th>Duration of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rachel</td>
<td>25-35</td>
<td>Female</td>
<td>White British</td>
<td>8</td>
<td>CAMHS</td>
<td>2</td>
<td>1</td>
<td>51 minutes and 34 seconds</td>
</tr>
<tr>
<td>2 Liz</td>
<td>45-55</td>
<td>Female</td>
<td>White British</td>
<td>27</td>
<td>Community</td>
<td>4</td>
<td>5</td>
<td>34 minutes and 57 seconds</td>
</tr>
<tr>
<td>3 Peter</td>
<td>35-45</td>
<td>Male</td>
<td>White British</td>
<td>10</td>
<td>CMHT Older Adults</td>
<td>4</td>
<td>3</td>
<td>67 minutes and 32 seconds</td>
</tr>
<tr>
<td>4 Mary</td>
<td>35-45</td>
<td>Female</td>
<td>British</td>
<td>16</td>
<td>CMHT Older Adults</td>
<td>14</td>
<td>1</td>
<td>38 minutes</td>
</tr>
<tr>
<td>5 Hannah</td>
<td>35-45</td>
<td>Female</td>
<td>Irish White</td>
<td>21</td>
<td>Community</td>
<td>8</td>
<td>4</td>
<td>54 minutes and 57 seconds</td>
</tr>
<tr>
<td>6 Jessica</td>
<td>45-55</td>
<td>Female</td>
<td>White British</td>
<td>10</td>
<td>CMHT</td>
<td>3</td>
<td>1</td>
<td>73 minutes and 46 seconds</td>
</tr>
<tr>
<td>7 Emily</td>
<td>45-55</td>
<td>Female</td>
<td>White British</td>
<td>6</td>
<td>Community</td>
<td>4</td>
<td>3</td>
<td>42 minutes</td>
</tr>
<tr>
<td>8 Olivia</td>
<td>25-35</td>
<td>Female</td>
<td>White British</td>
<td>5</td>
<td>Adult CMHT</td>
<td>1</td>
<td>2</td>
<td>46 minutes and 56 seconds</td>
</tr>
<tr>
<td>9 Barbara</td>
<td>55-65</td>
<td>Female</td>
<td>British White</td>
<td>34</td>
<td>Community</td>
<td>22</td>
<td>10</td>
<td>66 minutes and 59 seconds</td>
</tr>
<tr>
<td>10 Alice</td>
<td>45-55</td>
<td>Female</td>
<td>White British</td>
<td>30</td>
<td>CMHT Older Adults</td>
<td>13</td>
<td>2</td>
<td>62 minutes and 8 seconds</td>
</tr>
</tbody>
</table>
8.4. Data analysis

Clear guidelines for analysis have been published by leading IPA researchers who continually provide novice researchers with supportive guidance that can be used when undertaking IPA research (Smith et al., 2009). In this section, I have chosen to insert Table 9 below, as it shows a paraphrased version of the basic stages of the IPA Analysis process. In the sections that follow, I give a detailed description of this process during the analysis stage and this will be supported by evidence in the form of excerpts that I have selected from my analysis of Rachel’s interview.

Table 9: The Six Stages of IPA Analysis

<table>
<thead>
<tr>
<th>Step</th>
<th>Stages of IPA Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td><strong>Reading and re-reading the transcript</strong> to get the context, narrative aspects and the feel of the transcript. Areas of richness, detail, spontaneity, recognition of questions that may have led are noted.</td>
</tr>
<tr>
<td>Step 2</td>
<td><strong>Initial noting and coding of the transcript.</strong> The researcher considers the description and content of the interview; the language used and then engages in conceptual and interrogative coding.</td>
</tr>
<tr>
<td>Step 3</td>
<td><strong>Developing emergent themes.</strong> The researcher develops themes from the transcript.</td>
</tr>
<tr>
<td>Step 4</td>
<td><strong>Searching for connections</strong> across the emergent themes within that transcript.</td>
</tr>
<tr>
<td>Step 5</td>
<td><strong>Moving to the next case</strong> and repeating steps 1 to 4.</td>
</tr>
<tr>
<td>Step 6</td>
<td><strong>Looking for patterns across all cases.</strong></td>
</tr>
</tbody>
</table>

Adapted from Smith et al. (2009)

This section will demonstrate how I followed the 6 Stages of IPA Analysis by using Rachel’s Interview as my chosen example.
Step 1 – Reading and Re-Reading the Transcript.

To begin with, I prepared Rachel’s transcript with wide margins (Smith et al., 2009; Gee, 2011) which created spaces where I could make my notes, comments and my initial observations. I also used double-spacing to format Rachel’s transcript, which meant that, although the document became 41 pages long, it gave plenty of space to work with. Next, I had her transcript professionally printed on a single side and comb-bound with a transparent plastic cover, so that I could have a neat document to work with. This is illustrated in the images below. For more images, please see Appendix 22.

Image 1 – Rachel’s Bound Interview Transcript – Front Cover
Even though I had undertaken the transcription, as I worked with Rachel's interview transcript, as she was the first participant that I had interviewed, I listened to the audio recording of her interview and heard her voice as I read and re-read her transcript. Smith et al. (2009) give a strongly emphasise the researcher engaging in the hermeneutic circle as they engage in the IPA analysis process. The hermeneutic circle is designed to help the researcher to see the dynamic relationship between the part and the whole, with a view to allowing the researcher to encounter the new, in the form of the participant's experience, in a manner that minimises preconceived ideas and allows for the researcher to optimally immerse themselves in the participant's account of their experience (Hefferon and Gil-Rodriguez, 2014). I felt that I had begun my engagement in the hermeneutic circle in relation to Rachel's transcript as a novice IPA Researcher and that, by engaging in this iterative, step-by-step process, I would end up engaging in double hermeneutic, where the researcher makes sense of the participant making sense of something (Smith et al., 2009). This process helped me to become even more
immersed in her lifeworld (Ashworth, 2003); listening to the audio interview and reading the transcript took me back to where we were at the time of the actual interview, which then prepared me to move onto Step 2.

**Step 2 – Initial Noting and Coding**

I started to engage in the initial noting and coding of Rachel’s transcript. I used a pencil to make a note of what stood out to me. I also made a note of points that generally stood out for her. For example, in response to my question about her experience of a patient suicide, Rachel started by telling me,

‘It was in 2014…when we last spoke, and it was all quite recent when your first pilot was happening….ummmm…so yeah…4 years ago….’

This response stood out to me because Rachel had waited for 4 years to speak to me about her experience and she was letting me know that she was invested in sharing her story with me, which explained why she was the first mental health nurse to volunteer to speak to me when the Main Study was launched in the host NHS Trust.

The next phase of step 2 was for me to engage in more detailed analysis and interpretation by following the framework set out by Smit et al. (2009). The three main areas of exploratory coding and interpretation are descriptive, linguistic and conceptual or interrogative coding. Using the guidance provided by Smith et al. (20019), the next section will explain what is involved in each area and I will describe how engaged in this process as exemplified in my analysis of Rachel’s transcript.

**The Descriptive:** This refers to what the participant has said to describe the content, including
significant words. The expressions or explanations which the participant uses are noted and the language used is explored (Smith et al., 2009).

The next thing that I did was to look at the description and content in Rachel's transcript. As I read Rachel's transcript, I asked myself a series of questions that were proposed by Hefferon & Gil-Rodriguez (2014), ‘How can the sentences, phrases and ideas that Rachel is sharing be explained?'; ‘What experiences are being claimed and described by Rachel?'; ‘What are the key features of those experiences for Rachel?’. I chose to use a blue coloured pen to capture what was happening in Rachel's lifeworld by identifying the key events and experiences that were happening to her, in response to the series of questions as stated above. For example, with regards to her identity as a mental health nurse, what I heard Rachel telling me was that her interest in mental health nursing started when she was 14 years old. From that point onwards, she had designed a well-thought-through and career pathway to becoming a good mental health nurse with a specialist interest in working with children and young people. Mental health nursing was the work that she wanted to do as it bought her significant emotional rewards, until a patient suicide took place. The timing of events was very significant for her because her narrative focused on how she had waited for four years to share her story with me. She had lost a 14-year-old boy to suicide, which interestingly is the same age that she was when she decided to become a mental health nurse.

“Ummmm…and…. he was 14 and ummm…quite a cheeky lad…um got on pretty well. built a good therapeutic relationship. And he was struggling with his mood…and a lot of other things that were going on in his life…he’d changed schools ummm…due to his behaviour…ummm….and…was feeling suicidal. And we had concentrated on our sessions in coping skills and things like that. He’d responded really, really well to those…ummm…was
implementing a lot of them within a couple of weeks. Ummm, he was started on some medication a couple of weeks in…..ummm…. and he wasn't really feeling much of an effect of them (the medication) at that stage….but…ummm…said he wasn't feeling actively suicidal…but obviously, there were a lot of…err….risk flags that were….that still made us very cautious.” (Lines 65-71)

Rachel was also telling about what life could have been for her 14-year-old patient who had died. She mentioned that he would have been turning 18 at the time that she was participating in the interview:

“Yeah…I mean he had not long turned 14…Ummm….and then, like I’d thought of all the things that you've done and experienced since 14. Like 14 was kind of where you start living and experiencing different things in your life…” (Lines 206 – 2018)

“So, he would have been 18…. ummm….this Christmas…yeah…” (Line 592)

“Ummm….and another thing that I thought about quite a lot was….did he….did he really want to? Because, when he left the house, he put the door on the latch so he could get back in…he walked a long way to get to where he was…and on the CCTV…ummm…err…they could see him walk past, look up at the tall building…walk back and then walk towards it…ummm…so err….yeah I don’t….I've always wondered….did he….did he mean to die? And what’s worse, a young person of 14 who meant to die or a young person who accident…accidentally died…” (Lines 214 – 220)

**The Linguistic:** This refers to the precise dialectal language used to denote emotions such as happiness, the tenor and the rate of recurrence of commonly used words. The linguistic
analysis also refers to how the participants utilise pronouns, how fluent their speech is, and how they utilise similes and metaphors (Smith et al., 2009). I chose to use a red-coloured pen and made a note of the emotive language that Rachel used to articulate her experiences. As I read Rachel’s transcript, I asked myself a series of questions that were proposed by Hefferon and Gil-Rodríguez (2014): ‘How is Rachel saying what she is saying?;’ ‘Is she hesitant, forceful, stumbling, pausing, speeding up or slowing down?;’ ‘Is Rachel using shifting tenses or pronouns in her speech?;’ ‘Has Rachel used any metaphors or interesting phrases during her interview?’

I noted that Rachel spoke with excitement, a high pitch and a fast pace at the start of the interview when she was describing how she came to be a community mental health nurse. However, when she began to speak about the patient suicide, her tone of voice changed from being quite animated to being slow. There were times when she paused and then, as she continued to speak slowly, she used ‘ummm’s’ and ‘err’s’ about 192 times during the course of the interview. She used the adverb ‘really’ 36 times before she described an emotion or situation and occasionally she used absolute words such as “entire”, “absolutely” and “totally” to describe her experiences. For example, I have included a selection of quotes to illustrate examples of some of the above-mentioned linguistic statements that Rachel said:

“And we had concentrated on our sessions in coping skills and things like that. He’d responded really, really well to those…ummm…was implementing a lot of them within a couple of weeks. Ummm, he was started on some medication a couple of weeks in…..ummm…. and he wasn’t really feeling much of an effect of them (the medication) at that stage” (Lines 68-73)

“And then he’d had a really good weekend, gone out with his mates skating for the first time in ages. Ummm…so it was a shock to them as well…as to
me...ummm...and...the way that it all came about was...Monday morning...ummm...we’d got a phone call at 5 minutes past 9...and I hadn’t got to my desk yet because I was in the kitchen making coffee....ummm...got another phone call...at quarter past 9 and...and....mum said, “Just calling to let you know that Sam’s jumped off a building and we are about to switch off the life support.” (Lines 79-85)

Rachel also expressed her emotional reaction when she cried at the time of her patient’s death.

“Ummm....and my....colleague who was...who is an administrator had that message told to her...(raised voice) and she was in such a state of shock...she had a massive grin on her face....as she came into the office and told me that. And I was like, “You’re joking?” and she was like, “No!!”... I was like, “You are joking!!” She said, “No!!”...just this massive smile. And I was like, “You are joking!!” and I just burst into tears!” (Lines 85-90)

“I was in absolute shock!! Ummm...I bawled my eyes out....for the entire day...umm (long pause) and I just felt....really responsible and really guilty.....for quite a long time.” (Lines 100-103)

These are the most powerful idioms that Rachel used during the interview. She told me how she “burst into tears”, which means that she began to cry out suddenly in response to the news that her patient had died. She was telling me how deep and sudden her emotional reaction of crying had been triggered by the news of the suicide:

“That day...I stayed at work, but I didn’t have any clinical work to do...my colleagues just took it all....and I think I just sat with different people in their offices for a little while...ummm...until I felt like I needed to get some fresh air...Like I just went to the park just around the corner and called my mum...and I just sat...err...crying
uncontrollably...ummm...I don’t think she understood what I was saying for a long time. Ummm...plus even a gardener who was working in the park came over and checked I was OK.” (Lines 251-257)

Rachel then used the language “I bawled my eyes out” to describe an intense and prolonged outburst of crying, which carried on at regular intervals during the days that passed, the reaching a crescendo when she attended Sam’s funeral.

“I felt like everyone was looking at me and it was....ummm....I think it was my fault....probably looking at me because I was just crying uncontrollably.....outside.” (Lines 311 – 313)

“It was just strange being at a funeral for someone so young as well and all these young people and like they had all his favourite music! And I couldn’t listen to Metallica for a good year without crying.” (Lines 316 – 318)

“Yeah....Ummm...I was glad I went...Ummm...but I think I also felt embarrassed about being there...and crying so much. (Laughs softly). Ummm...” (Lines 333-334)

I also noted that Rachel used language to try and quantify the intensity of her emotional experience of sadness, regret and guilt, after her patient died by suicide. This is exemplified by the following quotes:

“Umm...yes, I think ummm....the guilt was probably the most, well...obviously the sadness...and sort of regret, but that was probably the...one of the biggest, most overwhelming feelings.” (Lines 119-121)

“Umm....so I didn’t talk to friends outside the profession...Ummm...but even knowing
how I would...How I’d felt a month before when my friend had told me about her patient [dying by suicide]...ummm...that sort of helped me understand...that you don’t really realise how bad it feels until it happens to you. Like...you know obviously it’s awful...but I hadn’t been prepared for that sense of overwhelming guilt and responsibility and ummm...blaming myself.... ummm...yeah…” (Lines 194-200)

This selection of quotes indicates that, linguistically, Rachel was telling about her experiences of a hierarchy of distress, starting with regret as the foundation, with sadness in the middle level and with feelings of overwhelming guilt above all else. After engaging in this exploratory linguistic coding, I was ready to move on to the next phase of interrogative and conceptual coding.

The Conceptual: This is the third level of annotation which is more interrogative. During this stage of analysis, the researcher shifts the emphasis of the analysis to focus on how the participants make sense of their narrative (Smith et al., 2009). I chose to use a green-coloured pen to complete the conceptual and interrogative coding. As I read Rachel’s transcript, I asked myself a series of questions that were proposed by Hefferon and Gil-Rodríguez (2014), ‘What is Rachel trying to say?'; ‘What is going on for Rachel here?'; ‘What is underlying what Rachel is trying to say?'; ‘What do these experiences appear to mean for Rachel?'; ‘What is missing and what is Rachel not saying?’. These questions helped me to identify what Rachel was saying about herself and her identity in relation to the experiences that she had shared with me. Rachel’s identity as a community mental health nurse was strongly affected after her patient Sam died by suicide. She told me:

“errr...yeah...I remember just thinking that it was [becomes tearful] my responsibility.....[soft sobbing]....to make him feel better....[sobbing]...” (Lines 136 –
“Yeah, I just remember really feeling responsible. That I should have made him feel better and err… Not so much now, but very much in the first 6 months…feeling like I have really failed him ummmm…and I think, I think earlier on….my feeling of making statements to myself or other people of…ummmm… “I have failed as a nurse and I…I couldn’t keep him safe and that was my job…ummm very much in the beginning…but then obviously as time goes on, you do….you are able to rationalise it.” (Lines 144 – 150)

It was very emotive as Rachel allowed herself to be vulnerable and she cried at this point in the interview. My interrogative coding helped me to see how the loss of her patient had had a significant effect on her lifeworld as a mental health nurse. After completing the descriptive, linguistic, conceptual and interrogative coding, I then started to interpret what Rachel was saying, seeking to find meaning from what she was saying about her experience of losing a patient to suicide. This was an intensive and powerful process, which helped me to immerse myself into Rachel’s lifeworld. My general interpretation was that, as a mental health nurse, she would rather sacrifice herself to keep her patients alive, rather than having her patients sacrifice themselves to suicide.

“And also, that feeling of responsibility! And I really think that in the nursing culture, and I don’t know whether it’s part of our training or part of who we are…that we go in to become nurses…but we take on so much for other people and we would put other people before our own health, before our own families, before our own bladders and stomachs! You know like, ‘If you need that, I’ll do it for you…it doesn’t matter that I am sacrificing myself’…” (Lines 167-172)

Developing emergent themes: Having completed the descriptive, linguistic and interrogative
coding of Rachel's transcript as described above, I used a Word document that was separate from the transcript and started to note all of the 17 emergent themes. I then inserted all the quotes which I had selected to support the emergent themes and referenced them according to the line numbers from Rachel's initial transcript. This was my first attempt at classifying the themes as they were naturally emerging during the interview, in the course of Rachel sharing her story with me. In order to stay true to the hermeneutic cycle, I put in the line numbering, as this helped me to keep checking back with Rachel's original transcript in order for me to make sure that the themes were as closely associated as possible.

During the process of classifying the emergent themes, as part of my reflexivity as a novice researcher, I kept brief summaries, also referred to as potted summaries (Holland and Montague, 2019), which helped me to gather the gist of Rachel's main transcript. Consequently, I was able to highlight key quotes from Rachel's story and to identify any gems that emerged from her interview. I used a reflexive journal and wrote down my potted summaries by hand and I also made audio recordings of the process.

From my interpretation of Rachel's transcript, I observed that the emergent themes reflected her lifeworld experience of the timing of the patient suicide, within the context of a therapeutic nurse-patient relationship. There was the existential tension between Rachel and her patient regarding whether to choose to live or to die. It was interesting for me to observe how Rachel could rationally make sense of her experience of losing a patient to suicide but on an emotional level told me that she felt guilty because she had failed to live up to her responsibility to keep him safe. For more details of all the emergent themes and accompanying quotes, please see an excerpt from Rachel's interview transcript in Appendix #22.

Once I had identified the emergent themes from Rachel's interview, I started to cluster the themes. In a new Word document, I used a large font and wrote down each emergent theme,
writing her name on each theme and assigning the colour yellow to all of Rachel’s themes. For a visual representation of what the colour coded emergent themes looked like, please see Table 10 below.

Table 10: Rachel’s Colour Coded Emergent Themes

<table>
<thead>
<tr>
<th></th>
<th>CPN001 - Rachel’s Emergent Themes &amp; Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>The time spent working with the patient</strong></td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td>2</td>
<td><strong>Evaluation of the therapeutic relationship: “I was happy with the standard of care that I had given”</strong></td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td>3</td>
<td><strong>He was getting better, so what went wrong?</strong></td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td>3a</td>
<td><strong>I was away from the office when the patient died by suicide: During the weekend</strong></td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td>4</td>
<td><strong>Absolute shock!</strong></td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td>5</td>
<td><strong>Strong feelings of guilt - Hierarchy of guilt</strong></td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td>6</td>
<td><strong>My responsibility.</strong></td>
</tr>
<tr>
<td>Page</td>
<td>After a patient suicide, nurses should be able to cope with equanimity:</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Just get on with it!</td>
</tr>
<tr>
<td></td>
<td>Nurses are expected to be super resilient human beings!</td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td></td>
<td>Unwritten rules about coping or not coping in mental health nursing:</td>
</tr>
<tr>
<td></td>
<td>“It's not talked about”</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Self-blame</td>
</tr>
<tr>
<td></td>
<td>“I feel I should have done something more”</td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td>9</td>
<td>Failure:</td>
</tr>
<tr>
<td></td>
<td>I have failed him, I failed to keep him safe therefore I failed as a mental health nurse. (Rachel)</td>
</tr>
<tr>
<td>10</td>
<td>Reality versus imagination:</td>
</tr>
<tr>
<td></td>
<td>“I didn’t realise how bad it feels to lose a patient to suicide.”</td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td>11</td>
<td>Concern for the deceased:</td>
</tr>
<tr>
<td></td>
<td>Did he mean to die? I will never know.</td>
</tr>
<tr>
<td></td>
<td>(Rachel)</td>
</tr>
<tr>
<td></td>
<td>“We concentrate so much on the bad things that happen”. What about all the good that we do? (Rachel)</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13</td>
<td>Needing and Receiving Support - Distancing from work by means of sick leave. (Rachel)</td>
</tr>
<tr>
<td>14</td>
<td>Courage to return to work after being off sick: Reconnecting with clinical work (Rachel)</td>
</tr>
<tr>
<td>15</td>
<td>Funeral attendance: Seeking closure (Rachel)</td>
</tr>
<tr>
<td>16</td>
<td>Moving forward with empathic understanding: Waking up after “every mental health nurse’s worst nightmare!” (Rachel)</td>
</tr>
<tr>
<td>17</td>
<td>Lessons learned: It taught me to have empathy and to support other nurses after their patient dies by suicide. (Rachel)</td>
</tr>
</tbody>
</table>
Inspired by the work of Smith et al. (2009) and Gee (2011), I printed off this document and cut it into 17 pieces according to the themes and physically put the themes onto a large sheet of flip chart paper. I had an aerial view of the flip chart and I could see all of the themes. From that vantage point, I was able to fully make sense of the hermeneutic interpretation that I had carried out. After completing this intensive process, I was ready to move on to the next interview transcript that I had developed after my conversation with the second participant, who I chose to call Liz. Using the strategy that I had followed with Rachel’s transcript, I followed the same data analysis process until I had analysed all 10 of the interview transcripts. After I had identified emergent themes, I duplicated the format presented in Table 10 and presented each participant’s emergent themes, using the colours blue, orange, purple, red, pink, aqua, lime green, peach and olive, in preparation for engaging in case-by-case analysis of the emergent themes with a view to creating ordinate and superordinate themes. Looking back, I recognise that the analysis process was intensive, but it was an iterative process which helped me to enter the lifeworld of each participant. I did my best to engage in the double hermeneutic aspects of interpretation as a novice IPA researcher. The idiographic case-by-case analysis was challenging at first. However, as I persisted with the work, I became more confident in my ability to engage in in-depth IPA data analysis.

**Developing Synergy After Cross Case Analysis:** After undertaking the analysis of all 10 transcripts and colour coding each participant’s emergent themes, using the colours yellow, blue, orange, purple, red, pink, aqua, lime green, peach and olive, I cut up all the themes and put them on 10 sheets of flip chart paper. I started the process of case-by-case analysis of the emergent themes with a view to creating synergy, ordinate and superordinate themes by studying the connections across the cases. I started by clustering similar themes together and I studied them for a week. This period of time gave me the opportunity to move some of the emergent themes around and, in some cases, discard
them. As I was doing this work, I made a note of all the clustered themes in my reflexive journal so that I could think about the themes and how they related to each participant. During this process, I was able to identify some gems from each interview. These gems will be discussed in more detail in Chapter 9.

To further illustrate how I developed the ordinate themes, I created a master table as suggested by Smith et al. (2009) to provide a visual representation of the themes that resulted in the development of superordinate themes. In Appendix 24, I have chosen to provide an example from the first master table which developed the first of three superordinate themes. All three superordinate and six ordinate (two themes to support each superordinate theme) will be discussed in greater detail in Chapter 9. After analysing all ten transcripts and generating themes, I then developed the master theme table in order to see how the major themes were represented across each transcript. Details of these themes can be found in Table 12 on the following page.
Table 12: Representation of cross-case analysis of themes for all participants

<table>
<thead>
<tr>
<th>Superordinate Theme</th>
<th>Ordinate Themes</th>
<th>Rachel</th>
<th>Liz</th>
<th>Peter</th>
<th>Mary</th>
<th>Hannah</th>
<th>Jessica</th>
<th>Emily</th>
<th>Olivia</th>
<th>Barbara</th>
<th>Alice</th>
<th>No of Yes’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>The experiential significance of a therapeutic relationship ending unexpectedly for the mental health nurse.</td>
<td>Dealing with suicide distress against a shifting landscape of mental health nursing care in the community</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Forming, establishing, sustaining and coping with the prematurely ending therapeutic relationship with the patient.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>10</td>
</tr>
<tr>
<td>Searching for the meaning of the patient suicide in the face of public scrutiny.</td>
<td>The interface between feelings of failure and responsibility in the face of public scrutiny after the suicide.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>The levels of scrutiny, inquiry and fault-finding after a patient suicide.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>9</td>
</tr>
<tr>
<td>After the suicide, the experience of intense grieving, learning, growing and moving on.</td>
<td>The lived experience of coping after the suicide</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>The journey of growth following patient suicide loss.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>9</td>
</tr>
</tbody>
</table>
8.5. Chapter Conclusion

This chapter has presented how the main study was undertaken in terms of data collection and data analysis using all phases of the IPA Analysis framework as presented by Smith et al. (2009). It gives a clear description of the analysis process which results in the development of superordinate and ordinate themes after I undertook an idiographic analysis of each and every interview transcript, whilst adhering closely to the principles of double hermeneutics. The next chapter will present the findings from main study, in the form of divergent and convergent themes.
Chapter 9: Divergent and convergent themes – the findings from the main study

9.0. Introduction

This chapter presents the participants’ experiences of patient suicide loss which emerged from the IPA interview, transcription, and data analysis process. To start with, I constructed the idiographic biographies of all the experiences of the participants in the chronological order in which they were interviewed. As described in Chapter 8, the emergent themes for all the participants are presented, leading to the presentation of all the super-ordinate and ordinate themes. Each participant story is presented, with a selection of the emergent themes and a selection of accompanying quotes from each interview, to reflect the idiographic nature of analysis (Smith et al., 2009).

9.1. The individual participants’ experience of patient suicide loss

The experiences of the ten participants who were interviewed in the main study will be presented and discussed in this section. Each participant story begins with brief information regarding their biography, the setting, the duration of the interview and a brief synopsis of patient suicide loss as they experienced it. I will highlight three unique aspects of each interview and discuss one precious gem (Holland and Montague, 2019) which I identified during the intensive data analysis process. I chose to conclude each participant lifeworld story with a table of the emergent themes from their interview transcript. I was inspired to adopt this approach based on the style used by Flynn (2018) in her IPA PhD thesis which explored pre-registration adult nursing students’ experiences of using their sense of humour when they are engaging in clinical placements. I made direct contact with the author Dr. Flynn and requested
permission to adopt a similar presentation style to formulate the results from the data analysis. The permission was granted.

9.1.1. Rachel

In Chapter 8, I used Rachel's example to illustrate how I engaged in all the stages of data analysis. In this section, I present a biographical account of Rachel in order to give some context about where she was in her lifeworld (Ashworth, 2003). Rachel was a community mental health nurse in her late 20's and she was the first participant to volunteer to share her story. At the time of the interview, she had been a registered nurse for eight years and had been working in her current role as a community mental health nursing team manager for two years. I interviewed Rachel at her place of work, in a comfortable meeting room which she had previously booked. Our interview lasted 51 minutes and 34 seconds and yielded very rich data. Before and after the interview, Rachel and I talked about our joint interest in and experience of community mental health nursing. We talked about some of the rewards of working in the community as well as some of the challenging aspects of the role. This pre-interview conversation resulted in Rachel appearing visibly relaxed and comfortable, by which time we were ready to begin the interview.

As Rachel shared her story, she described her lived experience of one patient suicide. She talked compassionately about a young person that she had worked with for approximately three weeks. In her lifeworld, Rachel explained how she had established an intensive therapeutic relationship with the patient and his family. Rachel described her feelings of distress and shock after the suicide. She disclosed that she experienced work-related stress and burnout after the suicide, which resulted in her being signed off on sick leave. Throughout the interview, Rachel answered the questions fully, used humour appropriately and gave a
detailed account of her lived experience.

As discussed in Chapter 8, linguistically there was a distinct change in the tone of her voice when she was describing her role as a community mental health nurse, where she spoke fluently, with passion and excitement.

“Ummmm…so….ever since I was about 14, I realised that such a thing as a mental health nurse existed, and so I was like…..That is what I wanna be!! And so….in my Year 10 placement, I went and did like….ummmm…. a 1 week’s work experience in Supported Housing with people with schizophrenia…. I ab-so-lutely loved it!!” (Lines 22-26)

As soon as I asked her to tell me her story about patient suicide loss, her tone of voice changed dramatically. She became less articulate, there was more hesitation in her speech and she repeatedly used word whiskers such as “ummm” ….“errr”, which denoted that the content of the conversation was affecting her on a deeply emotional level.

“Uh Uhumm….so….ummmm…when I was a Band 6 Nurse, ummmm…it was….I had to go away and check the dates…because I have not got….I am not very good at remembering dates….ummmm…but err….it was in 2014…..when we last spoke and it was all quite recent when your first pilot was happening….ummmm…so yeah…4 years ago….errr…ummmm…and I worked with a young person called Sam [pseudonym]….And ummm….he had come in for an assessment with me and ummmm…I hadn’t actually realised…or I hadn’t remembered…until I got back and looked at the notes that how short a time that we had actually worked together?” (raised intonation). (Lines 47-54)

From my observation, it appeared as though the picture of the patient, as set in Rachel’s mind, came to life again and this mirrored her associated distress, as the patient was no longer just
a name and a person who had died. Her reality response seemed to indicate that in that moment the patient was alive again, then died again in the space of the interview. Therefore, it looked like she was reliving the patient suicide, even though it had taken place approximately four years prior to this interview.

Her language was representative of previous feelings that she had tried to suppress. The interview questions were catalytic in that they triggered a cathartic response in Rachel. This was revealed in the embodied language which she used to denote some intense overwhelming feelings. Rachel described herself as “bursting into tears”; “bawling my eyes out” and also experiencing “absolute shock” within her body. Shortly after using such shades of expression, Rachel became very tearful and began to cry during the interview.

“Ummm…I’m surprised that I got upset about it today.” (Line 576)

“Ummm…I thought I’d come to terms with it a lot more…It’s all really sad” (Lines 578; 583)

This was a very emotionally moving moment during the interview, which affected me on a deeply emotional level. Reflexively, I recognised that I was touched by her sadness as it permeated the physical and emotional space that we were both occupying. Rachel also talked about how losing the patient to suicide had affected her experiential identity as a mental health nurse and she reported feelings of guilt along with a strong sense of ‘failure’ and ‘responsibility’.

“I was in absolute shock!! Ummm…I bawled my eyes out….for the entire day…umm (long pause) and I just felt….really responsible and really guilty…..for quite a long time.” (Line 101-103)
I felt honoured to have finally met Rachel after I had spoken to her during my pilot study which I launched and carried out in 2014 and had put her name on the reserve list. I was very grateful that she had emotionally invested in this interview and had truly wanted to share her story with me. When I screened her for the main study, she expressed a keen interest in participating, as she had missed out on the opportunity to share her story when I undertook my pilot study.

Three unique elements about of Rachel’s interview were:

- She expressed her interest in the welfare of mental health nurses after a patient died by suicide. She commented on how she had reacted nonchalantly to her friend, a fellow mental health nurse who had experienced patient suicide loss, without fully realising what it meant to experience an emotional reaction after a patient suicide.

- She suggested that mental health nurses needed to be given the opportunity to experience distress after a patient suicide. Rachel described the hidden curriculum associated with coping or not coping after a patient dies by suicide. She felt that it was an issue that was not talked about, that it tended to reside in the liminal space within the mind of the mental health nurse who had been bereaved. Rachel was advocating for such stories to be moved from liminal spaces to shared professional spaces, in order to facilitate shared expressions of loss and grief after a patient suicide.

- She was determined to counteract the negative experiences that are often capitalised upon after a patient dies by suicide, by helping fellow colleagues to focus on the good things that mental health nurses do accomplish when predicting and responding to people experiencing suicide thoughts and behaviours.
Rachel’s approach to her work indicated that she had very high professional standards which she applied to her work with patients experiencing suicide thoughts and behaviours. When she described the work that she did with her patient, the language she used indicated that she paid close attention to detail when engaging in suicide risk assessment and interventions using the therapeutic relationship as the foundation:

“But I don’t just want things to be average, I want them to be good! Which is fine for me…but I very much expect other people to do that as well. Ummm…and in my more managerial role, I do find myself saying to people…."Would you be happy with that if it was bought into Coroner’s?”…and people…sometimes people…Or like if someone hasn’t done a risk assessment in a year…I’m like, “How can you justify that?” (Lines 359 – 364).

From her perspective, it felt that she had made a major emotional investment in this therapeutic relationship, which ended prematurely, thus triggering high levels of distress in Rachel. Rachel disclosed that she had had to have some time off work on sick leave shortly after her patient died by suicide, in order to create a safe space for her to process what had happened.

As Rachel was the first participant that I interviewed, I recognise that I may have missed out on opportunities to ask further probing questions. Therefore, after interviewing Rachel, I decided to further develop my interviewing skills with the remaining 9 participants.
My second participant was Liz, an experienced community mental health nurse who was in her 50’s. She had been a registered mental health nurse for 27 years, spending 10 of those years working in in-patient settings. She had been working in her current role for four years at the time of the interview. Liz had experienced five instances of patient suicide loss throughout her nursing career; three were in-patients and two were suicides which occurred within the context of care in the community.

The interview took place in an NHS base, in a comfortable interview room which Liz had chosen. Our interview lasted 34 minutes and 57 seconds. During the interview, Liz chose to share her lived experiences of two of the patient suicides which she experienced within the
context of a community mental health setting. Liz related that she had experienced work-related stress after the patient suicides in the community, but she had not developed any work-related burnout.

Liz answered the research interview questions in an articulate manner. She was quietly spoken, had high levels of self-control and fully answered the questions I was asking. She was subtly nervous at certain points during the interview, especially when she was discussing the way in which the investigation process had been dealt with after the patient suicide.

“*We weren't supported very well by the Psychiatrist, who actually rang the Coroner and said, “It's nothing to do with me.”* (Lines 141-143)

“I think that would be her [the psychiatrist] or their way of dealing with that sort of thing.” (Lines 149-150)

The questions also acted as a further catalyst for reactivating Liz’s emotions associated with the serious and untoward incident investigation that she had been through. As she related her story about the investigation process and how it was handled, it was as if she began to relive the process and became visibly distressed.

“*Yeah…it was really, really horrible! And I think that I was more upset about that…also I was really upset that he’d died…it was really…really sad…it was really a tragic…thing but I was more upset about how it was managed.*” (Lines 242-245)

“There was nothing in there about the relationship that I had built up with his wife. You know…the…the…you know…you know…the…she…this really good piece of work around
working with families had gone on." (Lines 257-260)

The pace of her speech speeded up and at times she did not finish her sentences. Her face appeared flushed in line with the emotions that she was experiencing at that point in the interview.

“And as a CPN, you know, you don’t feel like you have got the power to challenge that anymore…” (Lines 615-617)

Three unique elements of Liz’s interview were:

- Her strong concerns about the investigative process that occurs after a patient dies by suicide, with special focus on how mental health nurses are treated. Liz voiced her displeasure at how the investigation was handled and the guilt that this triggered within her.

- Liz’s story was an example of growth after patient suicide loss. As a way of making the best use of the lessons that she had learned from her experience, Liz described how she had chosen to become actively involved in teaching and learning activities regarding suicide prediction, prevention, intervention and postvention with community mental health nurses.

- Liz had invested in her continuing personal and professional development as a mental health nurse. She has become highly skilled in the use of psychosocial interventions such as family interventions, suicide risk assessment and management. Liz’s interview revealed that she was very passionate about acknowledging and celebrating the good therapeutic interventions which mental health nurses engage in, including the crucial
bereavement work that she had done with families after a patient suicide.

Reflexively, I took into consideration the fact that I had worked with Liz in the past and that this prior knowledge may have had an effect on how quickly we established a rapport within the context of a researcher and participant interview. Liz and I had engaged in the mentorship of pre-registration mental health student nurses together. Therefore, there was some familiarity and shared references during the course of the interview. I was mindful of my partial insider-perspective in this interview and made sure that I followed the interview schedule rigidly, in order to stay close to the focus of the research.

Ethically, I was conscious about making sure that I followed the interview schedule so that I did not take any aspect of our previous relationship for granted. Liz concluded the interview by stating that she had done the best that she could have done for her patients whilst they were still alive. However, she understood that the investigators did not share her point of view and this prompted her to keep asking for feedback about the positive aspects about the care she had delivered, even though her patient had chosen to die by suicide. The emergent themes from Liz’s interview are listed in the table below.
Table 14: Liz’s Emergent Themes

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<tr>
<th>Liz’s Emergent Themes</th>
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<tbody>
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<td>1</td>
<td>Community caseload management: High levels of responsibility and autonomy</td>
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<tr>
<td>2</td>
<td>Use of psychosocial interventions: Family work, suicide prevention theories.</td>
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<td>3</td>
<td>Professional isolation.</td>
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<td>4</td>
<td>Patient isolation.</td>
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<tr>
<td>5</td>
<td>The element of surprise: “I thought the patients were getting better. They died suddenly”.</td>
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<td>6</td>
<td>Utter tragedy and devastation.</td>
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<td>7</td>
<td>Shock: I was away on annual when the patient died by suicide.</td>
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<td>8</td>
<td>Peer support.</td>
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<td>9</td>
<td>The investigative process after my patient died by suicide – “I was not happy with how it was handled”.</td>
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<td>10</td>
<td>Failure.</td>
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<td>11</td>
<td>Concern for the family left behind after the suicide.</td>
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<td>12</td>
<td>Questioning self: Would any of my actions have made a difference?</td>
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<td>13</td>
<td>Levels of scrutiny and fault-finding: Who has the power?</td>
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<td>14</td>
<td>Guilt.</td>
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<td>15</td>
<td>Attending the funeral: Providing compassionate support for relatives and for self.</td>
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<td>16</td>
<td>Coping.</td>
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<td>17</td>
<td>I am proud of what I did.</td>
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<tr>
<td>18</td>
<td>After the investigation, questioning others: “So, what are the positives?”</td>
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</table>

9.1.3. Peter

Peter was a community nurse in his late 30’s who had been a registered nurse for ten years. He had been working for four years in his role when he expressed an interest in taking part in the study. He was in the process of moving jobs at the time that I met him, therefore he felt that the interview would be a good way to conclude his employment with the local NHS Trust.

When I arrived at Peter’s work base, he was kind enough to come to the car park and meet with me, as I had taken a wrong turn and ended up in the wrong car park. As we walked towards the building, we engaged in a casual discussion about the research that I was doing. Peter was intrigued as he stated that he had never met a mental health nurse doing a PhD.
study and wanted to know what it was all about. This opening question marked the start of our conversation about the research and it helped to put both of us at ease, having just met.

Our interview was held in a comfortable interview room which was secluded and quiet. Once we got comfortable, Peter felt able to talk and share his story with ease. He disclosed that he had experienced 3 patient suicides during the course of his career, all of them occurring within the context of care in the community. The interview lasted 67 minutes and 32 seconds, making it the longest interview that I had conducted at that point of my data collection journey. Peter was an articulate man who gave a beautiful narrative about his experience of self-grief and of helping others to grieve after a patient suicide.

Pater’s presence in the interview was quite charismatic and he was very well composed and rational as he shared his story. The language that he used reflected his real interest in existential epistemology and ontology, which indicated that he was not new to the process of meaning making in life in general but also in relation to his work as a community mental health nurse.

“*We are…it’s strange, isn’t it…that we’ve got this desire…to…in the NHS…in healthcare…to promote life to the maximum…yeah…or that people should live well into their 90s and 100s with the best of health…and that’s all great. To prolong life is good, as long as it’s healthy and enjoyable. And we miss that other things, which is that death is inevitable…and the one thing that a lot of people…especially with our patients who are over 65…is that they might wanna actually talk about death…and that’s really important for them.*”  (Lines 1002-1010)

In his story, Peter cited the work of Victor Frankl and he made reference to logotherapy – man’s search for meaning - as he shared his story about losing a patient to suicide. My observation
was that Peter was an existentialist whose epistemology aligned with the philosophy of Sartre, which yielded richer answers to the interview questions, with lots of rich meaning making data.

Three unique elements of Peter’s interview were:

- He acknowledged that death by suicide is a choice, a free choice that each human being has got the right to make. He asked an existential question regarding that choice:

  “If it is one of our patients who makes the choice to die by suicide, are we personally comfortable that people will make those choices and that it’s OK for the person who has died to make that choice?”

  He thinks he can help people to give them hope and compassion to stay alive. However, he recognises that suicide is not just a symptom of mental distress, but it is an option for those who are distressed.

- He told his story with a sense of closure not just because he was leaving his job but also because he felt that he had “somewhere” to leave his story about his experience of patient suicide loss as part of moving on from it. His story had been stored in a liminal space because of professional and societal stigma of being associated with a person who decided to end their own life.

  “Ummm...so yeah...there was a lot of reflection on that. Ummm...Him being in our...my local village...which I hadn't lived in very long anyway... Ummm...I think I remember...I remember my colleague and I saying...let's write a card to the family and just to say...to offer our condolences...and that was very much poo pooed... It was very much like...” you don't...you don't do that. There's a Coroner's
Inquest...Stand back!” And that was difficult on a personal level. Ummm...that you can't reach out when someone has experienced such tragedy. You can't reach out as a person. To...to...to wish them all the best really.” (Lines 466-475).

However, by participating in the interview, I got the sense that he moved his experience from the liminal space into the shared intimate that was created during the research interview, alongside the narratives of other participants.

- He talked with such composure and courage and really wanted to share his story. He was rational but sensitive as he did so. His narrative was representative of a person who had professionally and personally come to terms with the deaths of patients he had looked after.

Peter talked openly about how he felt about his experience of losing more than one patient suicide. Having worked through the post-suicide investigative processes after his patients had taken their own lives had not detached his humanity and compassion for the loss. This was evident by his disclosure about his feelings of shock, sadness and grief, which he acknowledged were still there. However, his participation in our research interview had helped him to talk about these experiences in order to put them into perspective and then to put them away.

Peter was especially grateful when I gave him his information pack at the end of the interview. He had never seen the signposting materials which were contained therein, and he was particularly pleased to see that there were resources available to help and support people after they experienced a patient suicide. He decided to make use of these resources with the large multi-professional team that he was going to be working with in his new role. The table below lists Peter's emergent themes.
### Peter's Emergent Themes

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<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>Power, influence, advocacy and mental health patient representation.</td>
</tr>
<tr>
<td>2</td>
<td>Making the transition from the supportive ward to the risky community setting.</td>
</tr>
<tr>
<td>3</td>
<td>Increased autonomy, increased risk and less support for the Community Psychiatric Nurse.</td>
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<tr>
<td>4</td>
<td>The lived experience of professional isolation: &quot;I'm the only Community Mental Health Nurse in this cluster&quot;.</td>
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<tr>
<td>5</td>
<td>Building a therapeutic relationship: &quot;I just wanted to build and establish a rapport with the patient.&quot;</td>
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<td>6</td>
<td>Short-term interventions: &quot;I didn't see the patients for very long...&quot;</td>
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<td>7</td>
<td>Risk assessment conversations: &quot;We had a good open conversation about his interest in guns.&quot;</td>
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<td>8</td>
<td>After the suicide: Tragedy!</td>
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<td>9</td>
<td>Shock.</td>
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<td>10</td>
<td>The element of surprise: &quot;Things were actually improving – then all of a sudden, there was this change in behaviour.&quot;</td>
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<tr>
<td>11</td>
<td>Feeling compassion for the person or people who discovered the body: Imagining the imagery of the scene.</td>
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<td>12</td>
<td>The nurse's identity intertwined with the lived experience: &quot;Dealing with human behaviour is part and parcel of our job. We don't escape from experiencing those emotions and feelings ourselves&quot;.</td>
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<tr>
<td>13</td>
<td>When the personal and professional identities merge: &quot;We lived in the same village and I had my work hat on&quot;.</td>
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<td>14</td>
<td>Accountability: How are we accountable for this?</td>
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<td>15</td>
<td>My internal process of scrutiny and fault-finding: &quot;The lived experience of questioning self in the back of my mind&quot;.</td>
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<td>16</td>
<td>Guilt.</td>
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<td>17</td>
<td>The external levels of formal scrutiny and fault-finding - The lived experience being interviewed after a patient suicide: &quot;It felt almost like a Police Interview&quot;.</td>
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<td>18</td>
<td>The investigative process - the lived experience preparing for a Coroner's Inquest after a patient suicide: &quot;I had to do a Coroner's Report&quot;.</td>
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<tr>
<td>19</td>
<td>Reflection about my practice: &quot;The lived experience of feeling mixed emotions ranging from insightful realism to real tragedy!&quot;</td>
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<tr>
<td>20</td>
<td>After the patient suicide: &quot;Being realistic and acknowledging that when it is beyond your control, people do take responsibility over their life&quot;.</td>
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<tr>
<td>21</td>
<td>After the patient suicide, &quot;What's going to happen to me now?&quot; Feeling the cycle of anticipatory anxiety, uncertainty; like we have not been able to protect life.</td>
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<tr>
<td>22</td>
<td>Debriefing and support: &quot;After the patient suicide, I had a very supportive Clinical Team Lead&quot;</td>
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<td>23</td>
<td>Fear after the suicides: &quot;The local NHS Trust dealt with things from a place of fear and not compassion&quot;.</td>
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<td>24</td>
<td>Questioning others: &quot;So, what could we have done differently?&quot;</td>
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<td>25</td>
<td>After the suicide: &quot;How I held the emotions of other nurses&quot;.</td>
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<td>26</td>
<td>Seeking closure – discreetly attending the funeral.</td>
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<td>27</td>
<td>Lessons learned: Understanding how the whole clinical team works with people at risk of suicide, improved risk processes</td>
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<tr>
<td>28</td>
<td>Lessons learned: &quot;The importance of sharing the load with the wider team.&quot;</td>
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<tr>
<td>29</td>
<td>Perspectives about the meaning of life and death: &quot;Those feelings are still there, but it helps just to put things into perspective again&quot;.</td>
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</tbody>
</table>
Mary was a community mental health nurse in her early 40s. She had been working as a registered nurse for 16 years. At the time of the interview, she had been working in her current role for 14 years. During the screening process, she informed me that she had experienced 1 patient suicide and was keen to share her story with me.

When I arrived at the venue, Mary came to meet with me in the reception area of an NHS site. She was very warm and friendly as she showed me the way to another building where she had booked a comfortable room for us to use for the interview. Mary’s interview lasted 38 minutes. Although it was a short interview, she spoke with such fluency and she answered the questions with ease.

Mary disclosed that she had not had any time off on sick leave from work after she experienced a patient suicide loss, nor did she experience burnout. The content of her interview revealed that this one experience of patient suicide had had a significant impact on her on a personal and professional level. Mary’s narrative revealed that she had experienced some deep emotional reactions when she perceived that she was being blamed by some of her colleagues who were working with her in her clinical team. Mary’s experience of the investigative process caused ripple effects for her, as the story of her patient had been reported in the public media as a consequence of the investigative process. This created within her a sense of existential distress, as she felt that her identity as a nurse had been shaken by the way the suicide had been reported in the public domain.

Three unique elements of Mary’s interview were:

- Her description of her experience of being blamed by a colleague and members of the
patient's family whilst the investigation was taking place was quite significant as a trigger for her internal distress. She reported:

“And I think…our Consultant was very angry…ummm…and then sort of…few days after the Inquest…our Consultant came to speak to me about it…ummm…(Lines 463-466)… He said…have you heard about the inquest? And I said, “I hear it was really tough”… And he said, “Basically, I had to go and eat your shit!” (Lines 468-470)

“And I couldn’t believe it…I was a bit shocked really! I couldn’t believe it!!” (Lines 472-473)

Her description of how she had felt blamed by the family after the patient suicide and how she continues to live in fear of meeting those family members during the course of her clinical practice… She said:

“I suppose a lot as well, depends on the family of the person who…they’ve lost. Ummm…because in this case I had a family who were quite militant…really…and they wanted answers.” (Lines 611-613)

“when [the family] wanted to know about medication and obviously they’d researched things and found that some of the antidepressants had got on them… "high risk of suicide”…as a lot of them do…so they wanted to know why he was given the medication…that could increase thoughts of suicide…ummm…so that was quite good because they could direct that at the psychiatrist. Ummm…” (Lines 318-324)

“So, it depends on the family really…I think… How much they want your blood… (nervous laugh)” (Lines 621-623)
“And if I pop into Tesco’s in the town where he lived, am I going to bump into his wife in Tesco’s?” (Lines 639-640)

- Her description of how she had been blamed by the media and how this had impacted the other patients who were on her case-load. Mary said:

  “And soon after, the Inquest was actually in the local paper…and actually named me in the paper…Lines 524-525)… Ummm…something that it highlighted was that a risk…a thorough risk assessment wasn’t undertaken…something like that…and that actually put my name in the paper…and I think that…I felt that was very unfair!” (Lines 527-530)

Throughout the interview, Mary spoke in a soft measured tone and she used shifting tenses when she was describing uncomfortable feelings such as failure, guilt, anxiety and shame as a consequence of being blamed. Mary kept her composure during the interview, despite talking about some very difficult experiences.

The table below lists Mary’s emergent themes.

**Table 16: Mary’s Emergent Themes**

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<tr>
<th>Mary’s Emergent Themes</th>
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<td><strong>1</strong> Care co-ordinating in the community: Working with older adults.</td>
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<tr>
<td><strong>2</strong> The lived experience of having a patient die by suicide: “This is the only person that I have ever experienced this with.”</td>
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<td><strong>3</strong> Anxiety about working with high levels of suicide intent: anxiety-provoking.</td>
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<td><strong>4</strong> The element of surprise – I thought the patient was getting better: “They were “an absolute Model Patient. Then all of a sudden…”</td>
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<td><strong>5</strong> “I was away on annual leave when the patient died by suicide”</td>
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<tr>
<td><strong>6</strong> Shock after the suicide!</td>
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<tr>
<td><strong>7</strong> Evaluating the therapeutic relationship: searching for meaning</td>
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<td>8</td>
<td>Experiencing human connection in the therapeutic relationship: “You get to really know someone…”</td>
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<td>9</td>
<td>Questioning others</td>
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<td>10</td>
<td>Questioning self after the suicide:</td>
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<td>11</td>
<td>The existential experience of feeling responsible.</td>
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<td>12</td>
<td>Formal scrutiny &amp; fault-finding: “Going through an investigation and inquest after a patient suicide”</td>
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<tr>
<td>13</td>
<td>The lived experience of being blamed by the statutory and non-statutory processes which influenced family and others.</td>
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<tr>
<td>14</td>
<td>The stigma associated with being named and shamed in the local paper.</td>
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<tr>
<td>15</td>
<td>Coping after a patient suicide: “Just keep plodding on!” “Business as usual”</td>
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<tr>
<td>16</td>
<td>Varying levels of support by colleagues.</td>
</tr>
<tr>
<td>17</td>
<td>Lessons Learned: I am now the care plan queen!</td>
</tr>
<tr>
<td>18</td>
<td>Lessons Learned: Patient Safety Systems when a CPN is on annual leave.</td>
</tr>
<tr>
<td>19</td>
<td>Personal growth: “I feel I have become a better clinician”.</td>
</tr>
</tbody>
</table>

### 9.1.5. Hannah

Hannah was a community mental health nurse consultant who was in her late 40’s. She had worked as a registered mental health nurse for 21 years. Hannah had worked as a community nurse consultant for 8 years at the time of the interview. During the screening interview, Hannah disclosed that she was willing to travel to a location with the premises located within the NHS Trust site.

I arrived at the venue at the appointed time, but Hannah had not yet arrived. I rang her on her mobile telephone to check that she was OK. She informed me that she was running late but that she was on her way to the venue where we had agreed to meet. I used this time to set up and mentally prepare for the interview with Hannah. After I got her a coffee, she settled down and indicated that she was ready to engage in the interview. Hannah’s interview lasted for 54 minutes and 57 seconds.

Hannah answered all the research questions in an articulate way. She was open and honest as she shared her story, disclosing that she had experienced 8 patient suicides, 4 of them in a community setting. She chose to start her story by telling me about one of the most
distressing patient suicides that she had experienced:

“Ummm…OK…so, one….one of ummm…the first suicides that I experienced was when I was in a Crisis Team…Adult Crisis Team in Hertfordshire. And it, quite interestingly, this was someone, I actually had never met…but had **one of the most profound effects on me** as a mental health nurse. Ummm…and… So, I worked as an A&E Liaison Nurse.” (Lines 75-80).

Consequently, Hannah stated that she had experienced work-related stress and burnout after the patient suicides. As she told her story, Hannah expressed strong narrative descriptors of loss, guilt, grief and sadness. There appeared to be a disconnect with her being truly in touch with these feelings on a cognitive level. However, a physical visceral reaction became clear in her linguistic descriptors which were associated with her strong feelings and all of these were related to her **stomach and gut feelings**. For example, Hannah reported experiencing strong physical sensations, such as feeling “**gutted**” and having “**strong feelings in her stomach**”. She said,

“So, (deep sigh) …ummm…when…yeah…so when I heard his name…I think probably, most nurses that you might have spoken to…or anybody not even just a nurse…anybody who knows someone…ummm…your heart….you just get this **drop in your stomach**…that makes you feel really sick.” (Lines 110-115)

“Ummm…how did I feel?  **Just gutted!**” (Line 284)

“**Gutted that this young person had felt that this was the only option that they’d had****.”” (Lines 289-290)
“I was actually on leave when I found out about her death. I think I must have been managerial at that point...because one of the staff rang me...on my personal mobile...on a Sunday...to tell me the news... I wish they hadn’t done that...but they thought that for whatever reason...that it would be the right thing to do...and I just remember being exactly where I was sat and in my mum’s house and my stomach just dropped...I felt I wanted to throw up!” (Lines 303-310)

“Yeah! It’s...it’s right...it’s right there (pointing to her abdomen) ...you actually want to wretch! And just...you know...for however long that lasts...but it is that feeling of sinking...you know...in the pit of your stomach.” (Lines 316-319)

The narrative above revealed that, in that moment during our interview, Hannah was experiencing a conflict between professional perceptions of how she should respond as a nurse consultant, versus how she actually feels after the patient suicide. I observed Hannah using many hand gestures as she was describing her embodied visceral sensations.

Three unique elements of Hannah’s interview were:

- Her narrative revealed the possibility that she was experiencing unresolved grief in relation to her identity as a nurse consultant. This was revealed by her interest in engaging in mental health nursing research, especially about sensitive subjects. Before and after the research interview, Hannah expressed appreciation for research that I was doing, as she felt it would have wide-reaching benefits for mental health nurses.

- Her discussion about the traumatic effects of the suicide of a patient who had been referred to her as an emergency, a patient who was in the system but had died before she had met him. Hannah’s story revealed that the patient still existed in the liminal
space in her mind, that she had started to mentally engage with him. However, before she got a chance to meet him, he had died by suicide and this traumatic experience caused her significant distress.

- Hannah listened very carefully to each interview question. Before she answered each question, she would repeat it back to me, pause and then give a detailed and eloquent response. I got the sense that she was trying to compartmentalise her experiences, in order for her to stay in control of her emotions.

The table on page 218 provides an overview of Hannah’s emergent themes:
Table 17: Hannah’s Emergent Themes

<table>
<thead>
<tr>
<th>No.</th>
<th>Hannah’s Emergent Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Being a Community Mental Health Nurse involves flexibility.</td>
</tr>
<tr>
<td>2</td>
<td>Establishing the therapeutic relationship in people’s homes</td>
</tr>
<tr>
<td>3</td>
<td>Working at top speed!</td>
</tr>
<tr>
<td>5</td>
<td>Prioritising the needs of your patients: “You are always trying to do your best for your patient. You don’t want your patients to die!”</td>
</tr>
<tr>
<td>6</td>
<td>My first experience of a patient suicide: “Someone who was referred to me, but I had never met them.”</td>
</tr>
<tr>
<td>7</td>
<td>My visceral reaction after the suicide: “My heart just dropped to my stomach.”</td>
</tr>
<tr>
<td>8</td>
<td>This patient never entered my caseload, but he always sticks in my head.</td>
</tr>
<tr>
<td>9</td>
<td>Because I had never met the patient, they didn’t think that I needed a debrief...</td>
</tr>
<tr>
<td>10</td>
<td>Coping with equanimity: “Because I am a nurse consultant, they thought that I would be alright...”</td>
</tr>
<tr>
<td>11</td>
<td>Levels of scrutiny and fault-finding.</td>
</tr>
<tr>
<td>12</td>
<td>Strong emotion of guilt.</td>
</tr>
<tr>
<td>13</td>
<td>Fear of professional blame from others: “Big story with big headlines in the national media.”</td>
</tr>
<tr>
<td>14</td>
<td>Fear of the coroner’s process.</td>
</tr>
<tr>
<td>15</td>
<td>Loss of perceived control: “I was on annual leave from the office when the patient died by suicide.”</td>
</tr>
<tr>
<td>18</td>
<td>The Team reaction after the second suicide: “It floored everyone!”</td>
</tr>
<tr>
<td>19</td>
<td>Utter shock!</td>
</tr>
<tr>
<td>20</td>
<td>Seeking closure - funeral attendance.</td>
</tr>
<tr>
<td>21</td>
<td>Questioning self: emotional reaction.</td>
</tr>
<tr>
<td>22</td>
<td>Reflective self-blame.</td>
</tr>
<tr>
<td>23</td>
<td>Fear that someone else will want to apportion blame.</td>
</tr>
<tr>
<td>24</td>
<td>Strong feelings of sadness.</td>
</tr>
<tr>
<td>25</td>
<td>The tragedy of suicide and the ripple effect it has on those affected by it.</td>
</tr>
<tr>
<td>26</td>
<td>After the first patient suicide: “I had to go off on sick leave.”</td>
</tr>
<tr>
<td>27</td>
<td>After the patient suicide: Getting debrief and support.</td>
</tr>
<tr>
<td>28</td>
<td>Not blaming self: “Actually, it was not my fault.”</td>
</tr>
<tr>
<td>29</td>
<td>Lessons learned: “Make sure a patient is fit for assessment.”</td>
</tr>
<tr>
<td>30</td>
<td>Lessons Learned: “Never stop making referrals to social care.”</td>
</tr>
<tr>
<td>31</td>
<td>Lesson Learned: “Trust your gut instinct.”</td>
</tr>
<tr>
<td>32</td>
<td>Improved process of managing people in crisis.</td>
</tr>
<tr>
<td>33</td>
<td>“The experience of the first suicide helped me to cope with the second suicide.”</td>
</tr>
<tr>
<td>34</td>
<td>Lessons Learned: “Your risk assessment is only valid at that particular time.”</td>
</tr>
<tr>
<td>35</td>
<td>Suicide risk assessment – “Red flags of burden.”</td>
</tr>
<tr>
<td>36</td>
<td>The lived experience of participating in the research interview: “Thank you.”</td>
</tr>
</tbody>
</table>

9.1.6. Jessica

Jessica was a community mental health nurse in her late 40’s. She had been practising as a registered nurse for ten years at the time that she expressed an interest in participating in the
study. She had been working in her current role for 3 years at the time of the interview.

When I arrived at her community mental health team base, Jessica was waiting for me in the reception area and she warmly welcomed me. When I engaged in a screening conversation with her over the phone, she had indicated that she would be willing to meet with me for the interview after she returned from a family holiday abroad. I asked Jessica about her holiday and she informed me that she had had a wonderful time. This conversation helped us both to relax and it set the scene for the interview, which lasted for 73 minutes and 46 seconds.

Jessica took me to a comfortable interview room which she had booked, and she was able to speak freely and in confidence. She told me that she had experienced one patient suicide in the course of her career.

“He was found at home…apparently he didn’t turn into work on the Monday…ummm…and his friend…I think his friend called the police and he’d hung himself at home.” (Lines 480-483)

As she began to speak, Jessica began to re-live the process that she had gone through when she was still working with the patient. Her speech was slow, interjected by ellipses, pauses and tears. Jessica described feelings of sadness which were accompanied by intense physical reactions and sensations.

“Initially, I didn’t know what to think of it…apart from…apart from having that gut wrench as soon as I heard…like…like…yeah… A lot of shock! [Nervous laugh] But ummm…yeah, you sort of go through all sorts of emotions…really… [Long pause]…yeah…” (Lines 614-620)
“It’s really sad…[becomes tearful]…It’s really sad…because…l…l…you think….I don’t know…even if he’d given a little bit away…that might have made a difference…Yeah…sad [tearful]” (Lines 492-494)

“Ummm…I don’t know…I just think I will never know…It’s just that…I think…I think…it’s a real shame that he felt that he couldn’t call…you know…that there’s a whole team…and he couldn’t call…ummm…yeah…sad.” (Lines 517-522)

“It’s sad…it’s really sad! You know…it’s really…really… I find it quite mind-blowing…sort of…almost that I…errrm…errrm…” (Lines 611-613)

“it was just so sad that he...you know...if that’s what he did...that things were unbearable...that...that’s what he did. I...I...struggle to get my head around that actually!” (Lines 626-629)

“[heavy sigh]…Ummmm…pretty gutted…yeah…I am pretty gutted…I am…I am very gutted actually…ummm… I think I ….it’s very sad…” (Lines 770-772)

On reflection, Jessica’s interview was unique because of:

- Her attention to detail as she took the time to read all the information on the participant information sheet, the biographical data and the consent form at the start of the research interview process. I felt that, as a participant, she was really committed to the quality of the research process and she was not just paying it lip service.
• Her generosity with her time. Jessica used the time which had been allocated to interview to the full and she expressed herself freely as she shared her story. Her narrative reflected that she still felt the loss of the patient, an experience which had significantly affected her identity as a community mental health nurse.

• Her commitment to sharing her story, despite crying through a significant part of the research interview. The research question regarding the meaning that she attributed to patient suicide loss elicited strong emotional reactions.

Jessica’s honest, open and relaxed nature enabled her to share her story and to engage in meaning making about her experience of losing a patient to suicide.

The table below provides an overview of Jessica’s emergent themes.

**Table 18: Jessica’s Emergent Themes**

<table>
<thead>
<tr>
<th>Jessica’s Emergent Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Care coordination &amp; working with people in their homes.</td>
</tr>
<tr>
<td>2  Commitment to person-centred patient care</td>
</tr>
<tr>
<td>3  Endlessly busy.</td>
</tr>
<tr>
<td>4  Working and learning with others.</td>
</tr>
<tr>
<td>5  Managing patient caseload.</td>
</tr>
<tr>
<td>6  The element of surprise: “The last time that I saw him, he was doing OK.”</td>
</tr>
<tr>
<td>7  The shock after the patient suicide.</td>
</tr>
<tr>
<td>8  I was away from the office when the patient died by suicide: “It was my day off.”</td>
</tr>
<tr>
<td>9  Feelings of shock, sadness &amp; tears after the suicide.</td>
</tr>
<tr>
<td>10 Existential searching for answers.</td>
</tr>
<tr>
<td>11 Questioning self.</td>
</tr>
<tr>
<td>12 Self-blame</td>
</tr>
<tr>
<td>13 Blame from others</td>
</tr>
<tr>
<td>14 Guilt</td>
</tr>
<tr>
<td>15 Strong feelings of failure.</td>
</tr>
<tr>
<td>16 Anger</td>
</tr>
<tr>
<td>17 Acceptance: “Rationally, I did everything I could”.</td>
</tr>
<tr>
<td>18 Coping after a suicide: “Talking, talking and talking”.</td>
</tr>
<tr>
<td>19 Support &amp; debrief.</td>
</tr>
<tr>
<td>20 Coping after the suicide:</td>
</tr>
</tbody>
</table>
“I am a CPN – I am human – feelings of sadness about the patient suicide resurface from time to time....”

21 “Using mindfulness as a strategy to self-care.”
22 Levels of scrutiny and investigation.
23 Lessons learned: “Processing patient suicide loss in a public way”.
24 Being a role model with younger members of the team.
25 Future practice.
26 Carrying on after a patient dies by suicide: “Do not avoid...feel the emotions and keep going...”
27 Evaluating the therapeutic relationship: “I will never forget this patient...”

9.1.7. Emily

Emily was a community mental health nurse in her late 40’s. She had been practising as a registered nurse for 6 years. When I screened Emily, with a view to assessing her eligibility to be included in the study, she had been very distressed over the phone. She explained that she was working with some very challenging cases and mentioned that the team had just had a patient die by suicide. After she had vented her feelings and frustrations, we managed to set up a research interview at a mutually convenient time. At the time of the interview, Emily stated that she had been working for 4 years in her current role as a community mental health nurse.

When I arrived at Emily’s community mental health nursing base, I waited for her in the reception area. I happened to look at my mobile phone and noticed that I had had a missed call from her. She had called me and informed me that she was in the middle of dealing with a crisis situation involving a patient who was actively experiencing suicide thoughts and behaviours. As I finished reading the message, Emily came to meet me in the reception area, and looked very distressed. Emily explained that she was in the process of trying to find a hospital bed so that she could admit a patient who was presenting as a high suicide risk and it was no longer possible for the patient to be cared for safely in the community. Therefore, I would have to wait until she had dealt with this emergency, before she could engage in the
research interview with me. I defused the situation by referring to my partial insider perspective. I told Emily that I understood that patient care came first and that as a former community mental nurse who has faced the challenge of managing patients experiencing suicide thoughts and behaviours in the community, it was crucial that she put patient care first. I told her that I would be happy to wait until she had managed to address the patient presenting in crisis. Once I had done this, Emily became visibly calm and relaxed. She took me to the staffroom, where I made myself comfortable whilst she was dealing with her clinical emergency. As soon as she was ready, she came to find me, and we went to a room where we could undertake the interview.

The interview took place in an office. In total, Emily’s interview lasted for 42 minutes and she described her experience of losing 3 patients to suicide and how this had affected her. Unfortunately, we were interrupted once during the interview. When this happened, I simply paused and waited until the person had left. I checked to see if Emily was OK and if she was willing to carry on with the interview. Once she confirmed her willingness to carry on, I continued asking the questions.

“You know…you lose sleep…you know, you feel completely stressed…you can’t concentrate on your work…it’s very distracting…you know, it impacts on your family life… Obviously, things…things move forward…because you know…we…I’m not…that…I’m not the mum or the dad…or someone that’s lost their son…so you move on. But, it does impact how you feel…for the person. You know I’ve cried…you know…for the first couple of patients…I really…I cried a lot at home…I was so upset…” (Lines 607-615)

Three unique elements about Emily’s interview were:

- Her commitment to sharing a very powerful story, which was a true lived experience for her on that very day.
“It was just heart-breaking! And I still… I am getting upset now… because I just feel… I feel desperately upset and sad for her… ummm… and it was awful…” (Lines 194-196)

“the husband had gone out… and she basically waited for him to go out and she hung herself from the bannister in the house…” (Lines 184-186)

“I can’t even claim to even know what it would feel like… so you can only use your imagination as to how absolutely dreadful it would be. But you know… it sort of impacts how you are outside work. You worry… you know… you worry a lot… you think you… I can’t stop thinking about that person… and it takes a long time.” (Lines 602-607)

“And I had absolutely horrendous visualisations… it was the first one… you know… it’s just like everyone remembers their first one… of seeing… I just almost fantasize… almost that I can see her hanging! It was horrible!” (Lines 196-200)

- Her powerful use of idioms to illustrate the strong feelings which she had about her experiences of patient suicide. I felt that we were talking about a living subject and that we were having a conversation right in the frontline of community mental health nursing. One such example is:

“But it does… you know… impact you… but you’ve gotta get on with it… you’ve gotta… you know… pull your socks up… get on and go into work and you’ve got another person that needs you… needs your focus, so you have to… to… you’ve got to shelve it… you have to do it. Suck it up! That’s what we have to do…” (Lines 662-667)

- Emily had an unexpected turn of events. One of her patients was actively experiencing
suicide thoughts and behaviours, yet she did not turn me away or cancel the interview with me. I was very grateful that Emily still wanted to share her story, despite the chaotic nature of her day. Table 19 presents Emily's emergent themes:

### Table 19: Emily's Emergent Themes

<table>
<thead>
<tr>
<th></th>
<th>Emily's Emergent Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Care Coordination &amp; Working with people from diverse cultural and economic backgrounds in community settings.</td>
</tr>
<tr>
<td>2</td>
<td>The importance of the therapeutic relationship.</td>
</tr>
<tr>
<td>3</td>
<td>Working flexibly with risk; anticipating and responding to risk...</td>
</tr>
<tr>
<td>4</td>
<td>The lived experience of being a busy CPN: “You have to juggle...”</td>
</tr>
<tr>
<td>5</td>
<td>Using reflective practice to cope with complex cases.</td>
</tr>
<tr>
<td>6</td>
<td>Time spent working with patients on the caseload</td>
</tr>
<tr>
<td>7</td>
<td>Looking back: “The crisis leading up to the first suicide...”</td>
</tr>
<tr>
<td>8</td>
<td>The lived experience of losing a patient to suicide for the first time: “I don’t think I’ll ever forget it”</td>
</tr>
<tr>
<td>9</td>
<td>Trauma after the first suicide: “Horrendous visualisations about the death”</td>
</tr>
<tr>
<td>10</td>
<td>The ripple effects...</td>
</tr>
<tr>
<td>11</td>
<td>After the first suicide: Feelings of devastation and anger.</td>
</tr>
<tr>
<td>12</td>
<td>Making sense of the first patient’s choice to die by suicide: “She made her mind up”</td>
</tr>
<tr>
<td>13</td>
<td>The levels of scrutiny and fault-finding</td>
</tr>
<tr>
<td>14</td>
<td>Crisis leading up to the second patient suicide</td>
</tr>
<tr>
<td>15</td>
<td>The lived experience of losing a patient to suicide for the second time: “I was devastated!”</td>
</tr>
<tr>
<td>16</td>
<td>After the second suicide: “I am professional and human too...”</td>
</tr>
<tr>
<td>17</td>
<td>Trauma after the second suicide: “Horrendous visualisations about the death and the ripple effects!”</td>
</tr>
<tr>
<td>18</td>
<td>Making sense of the second patient’s choice to die by suicide: “It was a relief for this young man... he was so troubled”</td>
</tr>
<tr>
<td>19</td>
<td>Crisis leading up to the third patient suicide.</td>
</tr>
<tr>
<td>20</td>
<td>The lived experience of losing a patient to suicide for the third time: “It felt awful!”</td>
</tr>
<tr>
<td>21</td>
<td>After the third suicide: “I am still a professional and human too...”</td>
</tr>
<tr>
<td>22</td>
<td>Trauma after the third suicide: “Horrendous visualisations about the death and the ripple effects”</td>
</tr>
<tr>
<td>23</td>
<td>Questioning self</td>
</tr>
<tr>
<td>24</td>
<td>Making sense of the third patient’s choice to die by suicide in front of a fast train: “She knew exactly where she was going”</td>
</tr>
<tr>
<td>25</td>
<td>Crisis leading up to the fourth patient suicide.</td>
</tr>
<tr>
<td>26</td>
<td>The lived experience of losing a patient to suicide for the fourth time: “I felt awful!”</td>
</tr>
<tr>
<td>27</td>
<td>The levels of scrutiny and fault-finding.</td>
</tr>
<tr>
<td>28</td>
<td>The investigation process: “It has been so badly handled.”</td>
</tr>
<tr>
<td>29</td>
<td>Support... “What support? Just deal with it!”</td>
</tr>
<tr>
<td>30</td>
<td>Immense guilt.</td>
</tr>
<tr>
<td>31</td>
<td>After all the patient suicides: “I have been affected physically, socially and emotionally...”</td>
</tr>
<tr>
<td>32</td>
<td>Lessons learned: “Moving forward, share the suicide risk as a team.”</td>
</tr>
<tr>
<td>33</td>
<td>Lessons learned: “The emotional, physical and social effects of patient suicide on staff needs to be acknowledged.”</td>
</tr>
</tbody>
</table>
9.1.8. Olivia

Olivia was a community mental health nurse in her early 30’s. She had been practising as a registered nurse for 5 years. She had occupied her current role as an Acting Team Leader for 1 year. When I arrived at the NHS site where Olivia was based, I reported to reception and Olivia came to meet with me. After we exchanged greetings, Olivia took me to her office, which she had decided to use for the interview, which lasted for 46 minutes and 56 seconds.

Olivia was very welcoming and motivated to share her story. I used the interview schedule to ask the questions and Olivia answered them fully. There were parts of the interview where I made good use of prompt questions in order to encourage her to keep sharing her story. Olivia disclosed that she had experienced two patient suicides.

“The first was in…I’m gonna need to pause and recall…it was about two years ago…it was 20…I think it was 2016…round about Spring 2016. It was ummm…ummm…a male…[who was] in his early sixties, a patient who I had known for a quite a long time actually. He wasn’t a…ummm…I wasn’t in the role of care coordinator…I was a ‘Primary Worker’. I worked with him alongside…ummm…the Team Psychiatrist at the time.” (Lines 180-187)

“I’d been seeing him for ummm…about a year and ummm…felt that I knew him really well and had a good therapeutic relationship with him.” (Lines 189-191)

“He…he completed suicide actually…very shortly after we discharged him from the Team. Ummm…and that was linked to actually….ummm…some police charges which he got new information about…after we had discharged him.” (Lines 191-195)
“So, it felt very difficult at the time…in that we had just obviously withdrawn care…he had died. But actually, in the long run, we kind of found out the trigger was a clear trigger…that wasn’t necessarily linked to the…the discharge. Ummm…so that was…that was the first ummm…yeah…experience…I had had…” (Lines 195-200)

With regards to the second suicide, Olivia said,

“… So, it was three months ago…so, that would have been…it was the eighth of… [Long pause]…yeah…it was the start of August. Ummm…a patient who I had errr…I didn’t know particularly well…he wasn’t particularly well known to Mental Health Services.” (Lines 213-217)

“Ummm…it’s a really… [heavy sigh] …I don’t know… It’s a really thought-provoking one because he himself had very recently experienced suicide. Ummm…he’d been bereaved by suicide.” (Lines 218-221)

“Ummm…it was his partner…” (Line 223)

Although she had been distressed by these experiences, she did not experience work-related stress which warranted sickness absence from work and she reported that she did not experience work-related burnout after the suicides.

Three unique elements of Olivia’s interview were:

- Olivia had just finished writing a Coroner’s Report and she was able to tell me all about it during the interview. It felt like she was sharing the lived experience of the investigative process whilst it was actually happening. She said,
“I’ve just been writing a Coroner’s Report! It’s a coincidence that I’m having the opportunity to talk to you about it. It is hard to process the information, but I have done it.”

Olivia had shared some of her unique insights regarding this process of Coroner’s Report Writing during our interview.

- Olivia shared her story from clinical and managerial perspectives. This added extra layers of meaning to her story.

- Olivia chose to sign up to be interviewed for the study because she felt it was poignant, relevant and timely as it was her reality at the time.

The table below lists Olivia’s emergent themes:

Table 20: Olivia’s Emergent Themes

<table>
<thead>
<tr>
<th>Olivia’s Emergent Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Care coordination &amp; working with people in their homes and other community settings</td>
</tr>
<tr>
<td>2 The Community Mental Health Nurse as Team Leader: “Operational work”</td>
</tr>
<tr>
<td>3 Lone working as a CPN: “The use of face-to-face and virtual support…”</td>
</tr>
<tr>
<td>4 Working flexibly with risk; anticipating and responding to risk as a team “Sharing the burden of risk and responsibility…”</td>
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<td>15 Daily functioning: “I’m always busy…”</td>
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<td>16 The events leading up to the first suicide – the element of surprise: “He was getting better…”</td>
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<td>17 Losing a patient to suicide for the first time: “It was very difficult at the time”</td>
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<tr>
<td>18 Time invested in working with the patient on the caseload.</td>
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<td>19 The important therapeutic relationship.</td>
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<tr>
<td>20 Trauma after the first suicide: “Horrendous visualisations about the death and the ripple effects”</td>
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<tr>
<td>21 Emotional reactions after the first suicide: “Feeling numb…”</td>
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<tr>
<td>22 Making sense of the patient’s choice to die: “He had made the decision”</td>
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<tr>
<td>23 The support available after the first suicide.</td>
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</tbody>
</table>
Crisis prior to the second suicide: The struggle to initiate a therapeutic relationship.

Crisis: “He was found hanging, but he was rescued and survived for a short while”.

Blame after telling the family about the serious suicide attempt...

The second patient suicide: “He died when I was on annual leave.”

Support from management & colleagues: Supervision & debrief.

Support from spouse and family

After the second suicide: “I am professional and human too…Am I entitled to grieve?”

Distress after the second suicide: “Clinical panic…will this happen again?”

Levels of scrutiny, blame and fault-finding.

Failure.

Making sense of the second suicide: “The risk was really unmanageable.”

Meaning making after a patient suicide: “It’s an occupational hazard…it’s bound to happen.”

Questioning self.

After the suicides: “I am still professional, and I am human too…”

Moving on…moving forward.

Lessons learned… “It builds you as a clinician…”

9.1.9. Barbara

Barbara was a community mental health nurse in her late 50’s. She had been practising as a registered nurse for 34 years. She had worked as a community mental health nurse for 22 years and had become highly skilled in the use of psychosocial interventions such as cognitive behavioural therapy.

When I arrived at her community mental health nursing team base, I reported to the reception and Barbara came to meet and greet me. She had reserved a place for us to meet. Initially, we started the interview in a small meeting room, which was quite hot because the radiators did not turn off. The interview was interrupted twice due to room booking issues within the building. I had to stop the interview and we relocated to another space. I was able to put Barbara at ease by reminding her that, having been a community mental health nurse myself,
I understood that room bookings can be challenging at times. This helped to put Barbara at ease, and we were able to resume the interview once we had found an alternative meeting room. Eventually, the interview lasted for 65 minutes and 59 seconds.

Barbara spoke very fluently as she described her experiences of over ten patient suicides:

“Ummm…I mean…there have been a few… Errr….I think the one that came to mind since being a community nurse…coz I think I explained on the phone…ummm…because I was a nurse for 20 years on the wards…ummm…and experienced probably the more upsetting ones were then…” (Lines 149-154)

“And that there was one after that…that happened…well…I mean there have been a few [suicides] after that actually…ummm…(Lines 271-273)

She reported that she had experienced work-related stress as a consequence of the suicides, but she did not experience burnout. Barbara became quite tearful during the interview as she shared her story about the multiple patient suicides which she had experienced.

“Apparently, she’d been upset by something a friend had said…ummm…in her shared house and had gone off…ummm…and had gone to the woods and…had a drink…you know, had a lot to drink. This is…this was all planned… Ummm…the Blue Bell Wood, which always felt very, kind of poignant to me actually. Ummm…I’ve still got these images of her…and I forgot…perhaps because I don’t talk about it…ummm…and then she hung herself… [becomes tearful]” (Lines 195-203)

Barbara’s interview was unique because of:

- Her willingness to share her story, even though she had experienced a patient suicide
two days prior to our interview taking place.

- Her description of how she visualised the deceased patient after they took their own lives. Her description of her mental imagery was very vivid.

- Her narrative about the challenges that she faced when she had developed a therapeutic nurse-patient relationship with the child of a fellow community mental health nurse.

“There was another patient who committed suicide after we assessed her. [Heavy sigh] ...Ummm…. Again...soon after the first lady I told you about…and again…she…her mum was [also] affiliated with mental health…ummm…work and again, it wasn’t expected...” (Lines 292-296)

She related how this young person had taken her own life and the huge sense of failure which she felt.

“I just remember my...my colleague the Psychiatrist, having to call...ummm...her mum...and...they were...her mum and I’ve worked with...a wonderful woman...just...you know...I think because I had...[sob]...you know...she worked like me...in mental health...community...you know...I kind of...just my heart went out to her. How...you know...how do you reconcile with that, really?” (Lines 205-212)

“It felt very tragic [heavy sigh]...and the self-blame comes in very quickly...or at least...the self-doubt...ummm...maybe not blame as such...but self-doubt...ummm...until you feel that
you’ve…or until I’ve felt that I had done enough, you know…to sort of…to begin to put to
rest…ummm…that I couldn’t have done anymore.” (Lines 297-302)

At the end of the interview, Barbara evaluated that she had had a positive research interview
experience. She said that it was much better than she had expected. She was surprised at
how she had found it very easy to speak about experiences that she had not spoken about
before.

Table 21 below lists Barbara’s emergent themes:

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<thead>
<tr>
<th><strong>Barbara’s Emergent Themes</strong></th>
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</tbody>
</table>
Guilt.

Anger towards the person who has died by suicide.

Sadness at the tragedy.

Grief and needing support to grieve after a patient suicide.

“The effects of the suicides on me: *I am still human, I can never really relax, I experience clinical panic.*”

Making sense: “Did the person mean to die?”

After the suicides: “*A therapeutic relationship has ended.*”

Seeking closure: funeral attendance.

“*Until the next suicide…your work is never done*…”

9.1.10.  Alice

Alice was a community mental health nurse in her early 50’s. She had been practising as a registered mental health nurse for 30 years and working in her current role for 13 years. When I arrived at the venue, I reported to reception and Alice came out to meet and greet me. Alice took me to a really comfortable interview room and was very welcoming and hospitable.

As a researcher, I was mindful of the fact that I had known Alice for about 23 years. We had worked together in clinical practice. Alice had mentored me when I was a pre-registration student nurse. We had also worked together in my capacity as link lecturer to her clinical placement for pre-registration student nurses. In view of this, I made sure that I stuck very closely to the interview schedule, in order to make sure that I followed through on the research process.

After going through the consent process, the interview began and Alice shared her story. She spoke with clarity and confidence. Her interview lasted for 62 minutes and 8 seconds. She answered all the questions fully. She used idioms to express herself.

“*Ummm…And it was interesting because…I just fell apart really…I felt like I’d been kicked in the teeth a bit…It was so…it was a…it was a shock!*” (Lines 300-302)
“Ummm…it was…it was shock I think… Ummm…and I think, maybe I’d…with retrospect I think…maybe I sort of found…was finding my feet as a CPN…finding my confidence a little bit more…and then it was just crushed….” (Lines 513-516)

“You have to put your face on and get back out there….” (Line 647)

“Mmmm…I think they ummm…obviously cancelled all my visits the day they found out…ummm…and…yeah…the next it was bam! Back out there seeing patients that had no idea what I was feeling…coz you don’t do that, do you? You know, you put your smile on and as best you can…and you get on…you put your protective armour back up…ummm…” (Lines 649-654)

“Pop my face back on… [Laugh out loud]…I find crying does help…I cry…so don’t worry…I’m not like in bits all the time…But occasionally, it is…just a way for me to release… Or laughter! I’ll…I’ll make…I’ll have a laugh…have a giggle…A good belly laugh! I laugh…that helps! It just gets rid of that…thing really…so…” (Lines 867-877)

There were times in the interview when she expressed feelings of guilt because she was talking about people who I had known professionally, in another context. However, I reassured her that I was interested in hearing her story from her perspective and that it was not my intention to judge anyone. Stating this was reassuring to Alice and she fluently shared her life experience. She had experienced two patient suicides and had experienced work-related burnout as a consequence.

Alice’s Interview was unique because of:

- Her commitment to sharing her story, despite having experienced anticipatory anxiety about engaging in the research interview. She said that she felt apprehensive before
the interview and was worried that she would be re-traumatised if she shared her story with me. However, after the recorder had been switched off at the end of the interview, she said that she had really appreciated the interview, because I had asked her questions about her life experience and She was able to tell me how she really felt. She told me that she really needed it and she wished she’d had this interview when she had her experience of her patient suicide.

- Her willingness to lean into the discomfort of talking about her experiences of patient suicide loss. She disclosed that the memories which she’d repressed about the patient suicides has come back, but they were not as painful or as scary as she thought they would be.

- Her pride in her profession as a community mental health nurse. She described it as something that she aspired to become, and she was proud to still be engaging in this work. The table below lists Alice’s emergent themes:

<table>
<thead>
<tr>
<th>Alice’s Emergent Themes</th>
</tr>
</thead>
</table>
| 1 | What is involved in being a CPN – “It was something everyone aspired to be…”  
“ I wanted more time with the patients”. “I do people things…human things…” |
<p>| 2 | High levels of autonomy &amp; accountability. |
| 3 | Working collaboratively, against a background of shifting landscapes. |
| 4 | Time management: “It’s quite a lot of juggling daily… as a team in anticipating and responding to risk and other urgent issues: We do it all…” |
| 5 | Mentoring mental health student nurses in the community: Role modelling the therapeutic use of self in the therapeutic relationship. |
| 6 | The lived experience of losing two patients to suicide: “Some of the memories have been coming back to me…” |
| 7 | The first patient suicide loss story: “I only met her the once” |
| 8 | Trauma after the first suicide: The ripple effects. |</p>
<table>
<thead>
<tr>
<th>9</th>
<th>Questioning self: “What did I miss?”</th>
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<tbody>
<tr>
<td>10</td>
<td>Guilt.</td>
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<td>11</td>
<td>Shame.</td>
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<tr>
<td>12</td>
<td>Trauma after the first suicide: “Horrific visualisations of the death”</td>
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<tr>
<td>13</td>
<td>The little debrief: “Led by people who may not have known what to do…”</td>
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<tr>
<td>14</td>
<td>The effect of the first suicide: “I just fell apart from the shock”</td>
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<td>15</td>
<td>Support from managers and peers.</td>
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<td>16</td>
<td>Coping after the first patient suicide: “I talked and I talked and I talked”</td>
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<tr>
<td>17</td>
<td>Making sense of the suicide: “She did what she wanted to do…”</td>
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<tr>
<td>18</td>
<td>The levels of scrutiny and fault-finding: “It was all about ticking boxes…”</td>
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<tr>
<td>19</td>
<td>Carrying on after the first patient suicide: “Put your face on and get back out there…”</td>
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<td></td>
<td>Crying and laughing as catharsis.</td>
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<tr>
<td>20</td>
<td>The second patient suicide story: “I only met her a couple of times”</td>
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<tr>
<td>21</td>
<td>Trauma after the second suicide: The ripple effects</td>
</tr>
<tr>
<td>22</td>
<td>Questioning self: “What have I done?”</td>
</tr>
<tr>
<td>23</td>
<td>The effect of the second suicide: “I remember feeling devastated!”</td>
</tr>
<tr>
<td>24</td>
<td>The meaning of a patient to suicide: “A mark of failing as a nurse…”</td>
</tr>
<tr>
<td>25</td>
<td>Lessons learned: “Personal growth and sharing the burden of risk with the wider team…”</td>
</tr>
<tr>
<td>26</td>
<td>Moving forward with courage, confidence and bravery when assessing people experiencing suicide thoughts and behaviours. Improved questioning technique and documentation of higher levels of intent.</td>
</tr>
<tr>
<td>27</td>
<td>Appreciation for participating in the research interview: “I was doubting if I could go through with it!”</td>
</tr>
<tr>
<td>28</td>
<td>“After a patient dies by suicide, nurses are important too…”</td>
</tr>
</tbody>
</table>

As planned in the methods chapter and in an attempt to capture all the emergent themes which capture the voice of all the ten participants, I created a visual representation that would give the reader an overview of what the participants had said about their lived experiences. Using online software called ‘WordItOut’ (2019), I created a word cloud by uploading the anonymised and pseudonymised version of the emergent themes that were generated from all participant interviews. The word clouds were stored securely in a password protected computer, along with all the other data.

This visual representation of the emergent themes can be seen in Figure 5 below. The larger
words represent words frequently used while those of smaller font size were used less often. My interpretation is that surviving a patient suicide is complicated and that the participants did very well to find words to describe a situation which is sometimes very difficult to articulate.

![Word Cloud](image)

Figure 5: A Word Cloud showing the emergent themes from all ten participants

9.2. The convergent themes resulting in the development of superordinate themes.

This section presents the resulting convergent themes, which led to in the development of the ordinate and superordinate themes. Table 22 illustrates the final themes which emerged from the IPA analysis. An audit of the data analysis process which I adhered to was carried out through regular discussions with my PhD Supervisory Team. I also enlisted the help of a fellow
qualitative researcher, who was undertaking a Professional Doctorate at the University of Wolverhampton and took on the role of a moderator of the emergent themes and how they all interrelate. This was carried out in the form of a face-to-face interview, where I discussed the data analysis process and I shared my evidence as discussed in Chapter 8.

### Table 22: Superordinate and Ordinate Themes

<table>
<thead>
<tr>
<th>Superordinate Theme</th>
<th>Ordinate Themes</th>
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<tbody>
<tr>
<td>The experiential significance of a therapeutic relationship ending unexpectedly for the mental health nurse.</td>
<td>Dealing with suicide distress against a shifting landscape of mental health nursing care in the community.</td>
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<tr>
<td></td>
<td>Forming, establishing, sustaining and coping with the prematurely ending therapeutic relationship with the suicidal patient.</td>
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<tr>
<td>Searching for the meaning of the patient suicide in the face of public scrutiny.</td>
<td>The interface between feelings of failure and responsibility in the face of public scrutiny after the suicide.</td>
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<td>The levels of scrutiny, inquiry and fault-finding after a patient suicide.</td>
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<tr>
<td>After the suicide, the experience of intense grieving, learning, growing and moving on.</td>
<td>The lived experience of coping after the suicide.</td>
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<td>The journey of growth following patient suicide loss.</td>
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9.2.1. *The experiential significance of a therapeutic relationship ending unexpectedly for the mental health nurse.*

The findings described in this section highlight the significance of the therapeutic relationship that nurses develop in relation to the work that they do with patients experiencing suicide thoughts and behaviours. Community mental health nurses apply the principles outlined by Peplau (1952) in the formation of therapeutic relationships with
patients, where the desired outcome is the recovery from mental distress and the restoration to an optimum level of functioning. Barbara stated this in her interview:

“I’m…we wouldn’t be in this business if we weren’t interested in trying to help people…ummm…recover from…ummm…mental illness and to…you know…to have motivation…ummm…to live well etcetera…you know…to have a reason to live…have a reason to keep going…” (Lines 618-622)

In their interviews, all ten participants voiced their experience of existential distress when the therapeutic relationship ended suddenly by suicide on the patient’s terms and not on mutually agreed terms as is often expected in the therapeutic nurse-patient relationship. The death of a patient by suicide challenged each participant’s identity as a registered nurse, an existential challenge which left them questioning their clinical competence in relation to their skills of suicide risk prediction as well as strong feelings of responsibility after the patient death. The narratives indicated that each participant was very committed to their work with their patients and equated a reduction in the patient’s levels of distress to mean a reduction in levels of ideation and intent to die by suicide. Participants articulated that they were surprised and shocked when a patient who had appeared to be getting better had suddenly died by suicide. This was quite a strong theme which ran through the stories which were shared by the participants, who desired to remain authentic to the tenets of promoting recovery within the context of community mental health nursing practice.
9.2.1.1. Dealing with suicide distress against a shifting landscape of mental health nursing care in the community

The participants’ stories open up hidden spaces within their lifeworld and allowed me to view the world of community mental health nursing through the lens of the community mental health nurse. Whilst listening to the stories, I had a partial insider perspective on what care in the community is like. It is often seen as providing mental health care in the real world, as opposed to providing care within an institution or a mental health hospital. The philosophy of care in the community has been influenced by the principles of social inclusivity, reduction of mental health stigma and recovery-oriented practice. Practising in people’s homes brings with it freedoms and social connections which are not attainable in an in-patient setting. When sharing their stories about how they became community mental health nurses, all participants spoke in a positive and enthusiastic manner, which indicated that they felt grounded in what they do. Working within a community setting gave them freedom away from a mental health hospital and they felt confident in their practice. However, with these freedoms there come some challenges. One challenge is that, unlike a hospital ward environment, the community setting does not remain stagnant, it is constantly shifting and changing in response to changes in the real world. For example, their stories reveal that their field of practice is constantly fluctuating with increased workloads resulting in even bigger caseloads, and increased numbers of referrals into the service. This means that they have many high-risk distressed patients to try and manage in the community, against a background of reduced hospital beds and reduced staffing levels. This aspect is captured in Barbara’s narrative:

“Or…someone who has been referred by the GP…as they’re suicidal, so they want them to be seen in seven days…but in the meantime… This has happened actually, in the meantime, who contains those risks, if there’s risks within those seven days?” (Lines 569-573) …” Should be the GP…but we tend to take it on…and we’ve had
suicide within that time as well...even though, we haven't really...officially assessed them yet." (Lines 575-577)

“And then from...you know, the local Emergency Psychiatry Department...they will make recommendation...so it will to be to them because they are suicidal...ummm...be seen by the AMHT [Adult Mental Health Team] within three days. They don't even always communicate that to us... Ummm...and then suddenly again... So, we...we in the Team take...we just hold all this risk...all the time...” (Lines 581-588)

The participants shared their experiences of this shifting climate and related it to how it had a significant impact on their personal and liminal space. The community nurses shared their stories about being endlessly busy, working at top speed, juggling, managing heavy caseloads whilst anticipating, predicting and responding to risk, crisis and distress. Their narrative also revealed that there is an unspoken expectation that when they respond to patients' high levels of distress, they are expected to do so with equanimity and with fewer and fewer resources.

Hannah talked about her experience of being expected to do more with less and how this had a significant impact on her work with distressed people experiencing suicide thoughts and behaviours.

“Ummm...you know...so...within that time...other than, sort of trying to find somewhere to park...ummm...and then getting calls to say, ‘You’ve double parked, can you move your car?’ Coz we do that. We have to move our cars within...even in the time we're sitting and talking to a patient, even if they are suicidal...” (Lines 124-129).

Liz spoke about her experience of managing a large caseload in her interview. She stated: 

“you know...obviously you've got a caseload...that you are managing. Sometimes it’s
quite a large caseload.” (Lines 50-51)

“we might be doing…one of the days we might be doing an assessment clinic and ummm…seeing new people to the service. Ummm…You know, assessing them, making recommendations, or you know…keeping them within the service. And the rest of the time you would be seeing patients out in their…in their homes.” (Lines 55-60)

Mary also described the demanding and busy nature of her role in her story about working as a community mental health nurse. She reported:

“On a normal care co-ordinating day…so. I've got about 20 people on my caseload…and…ummm…I might be doing sort of routine reviews…ummm…initial assessments…or attending an outpatient appointment with a doctor with my patient. Or, I might be sat in the Duty Room…it's almost like a Virtual Ward really…so, we'd have a handover; work out what's to be done during the day…maybe go on urgent visits.” (Lines 63-69)

Hannah's description revealed that she perceived herself as working at top speed, in order to try and keep up with the demands of her work by saying:

“there's no typical day…ummm…it is always…full on, top speed!” (Lines 61-62)

“Like, top of the end…. busy! And it’s always been that way. Even more so…now!” (Lines 69-70)

“Ummm…and it will vary from meetings with other professionals…ummm…either within your organisation or outside of it. Multiple calls…you know…emails or telephone
calls…alongside various visits, or sessions…therapy sessions with your clients.” (Lines 63-67)

Emily’s comments give some insight into how she feels about her job. She says:

“your job is every…I absolutely love my job…even though it’s very stressful… [soft laugh] …It’s incredibly rewarding! You know, you want to…you come into work to do the right thing don’t you? To try and save lives…to make people’s lives more meaningful and…and be happy! That’s what our job…. that’s what our job role is for. …” (Lines 561-566)

“I know we have to…ummm…be held accountable…that’s part of our job role as a nurse isn’t it…or a clinician? Of course, you have to be accountable to the NMC, but…also…you know…ummm…to the…to families and carers…of course we do…we’re accountable to patients…of course we are…we must be…it’s very important to have that integrity… Ummm…but I think…it’s a balancing act…with it all…” (Lines 581-587)

9.2.1.2. Forming, establishing, sustaining and coping with the prematurely ending therapeutic relationship with the patient.

The participants all talked about their experience of being in a therapeutic relationship with the distressed patient and explained how they used it as a platform for mitigating suicide distress. In their narratives, they reflected on their lived experience of willingly forming therapeutic relationships with distressed patients from their initial encounter. They recognised that some therapeutic relationships were turbulent and, at times, there was a struggle to engage with
some patients experiencing suicide thoughts and behaviours. However, there was a general consensus that community mental health nurses make emotional investments in their relationships with their patients which results in a shared experience of deep human connection within that therapeutic relationship. They acknowledged the experiential significance of being in a therapeutic relationship - it meant that they could act as caring mental health nurses, who wanted to help people and make a difference in their lives.

Peter’s comments reveal how he worked at engaging with a patient who had been newly referred to him, but was very reluctant to engage with the mental health services:

“Within our service, and I suppose like in all CMHT type roles, where there is a need, we try and build up that rapport and we try to gain access. Where possible we try to kind of establish that therapeutic relationship.” (Lines 146-149)

“I…I…met with him at least twice a week initially, just to slowly build up a rapport with him.” (Lines 165-166)

“I remember on my initial visit, ummm…we had to kind of skirt round slightly, the idea of him…if he’s feeling depressed. Ummm…it was more about general conversation and just gaining a feel of how he is living and his experience of going into hospital was…and maybe what his…how he saw his future in the next week or so.” (Lines 168-173)

“In the comfort of his own living room…and often it would just be trying to establish this rapport…that he had someone to really talk to.” (Lines 255-257)

Emily’s narrative revealed her strong commitment to working within the therapeutic
relationship:

“You know...you are in close contact with the patient on a regular basis...so, of course, you build up a relationship with these people...with all our patients in there...because that's obviously our essential way of getting in there...assessing and supporting and part of the whole care approach, isn't it?” (Lines 123-128)

In line with this theme, Barbara commented:

“But...but overall...it’s...it’s more sadness because of the therapeutic relationship...and wishing that you’d found a way...not necessarily even done more...but just found a way...you know...” (Lines 680-683)

“Well, I mean, that’s what makes us...err...who we are in this profession really...you know...and I think the day that we don't feel sad...or, you know...upset...or...you know...whatever it is...if someone dies...or [dies by] suicide...or anything happens to them...ummm...you know, if we don't feel something...then we certainly haven't formed any sort of bond with that person...” (Lines 1068-1074)

“but my most important thing is ummm...patient care...you know...the rapport and the therapeutic alliance that you have with that patient...because that is what's going to help if they... Sometimes, nothing will help...but if anything, ...that's gonna help.” (Lines 1116-1120)

Olivia felt that she had managed to engage with a patient who had previously struggled to engage with other members of the multi-professional team. She stated:
“I’d been seeing him for ummm…about a year and ummm…felt that I knew him really well and had a good therapeutic relationship with him.” (Lines 189-191)

“He was somebody who…ummm…ummm…as a most recent patient, he hadn’t been terribly well-known to the wider team. Ummm…although the Psychiatrist, who was around at the time, knew him reasonably well. So, it felt helpful for her to have…ummm…[sigh]…I guess a good understanding of him…rather than kind of holding out alone.” (Lines 202-208)

Having invested so much into the therapeutic relationship, some participants experienced the suicide as a surprise. For example, this surprise is reflected in Liz’s narrative:

“Absolutely devastated. Ummm…because we hadn’t…you know…the Crisis Team felt that he was really improving, ummm…and…you know, the plan was that he was going to be discharged back to my care…” (Lines 133-136)

“They were planning to discharge him…they felt that things were much better…that they decided over the Christmas period it would be really inappropriate to do that…and they decided to keep him on…and you know…and visit him still. And on the Boxing Day, they couldn’t get hold of him.” (Lines 109-113)

“Actually, they deemed he needed to be discharged really…but they were deciding out of good practice to keep him on over…you know…quite an isolating time…you know…so…ummm…that’s probably for me…it’s about that sort of thing.” (Lines 186-189)
The participants perceived the premature ending of the therapeutic relationship as a human tragedy which often triggered feelings of grief, sadness and concern for the welfare of the deceased, their family and significant others who were left behind.

9.2.2. Searching for the meaning of the patient suicide in the face of public scrutiny.

The experiential significance of being asked to give an account of one’s clinical practice in the face of public scrutiny was strongly reflected in the participants’ narratives. Understandably, after a patient dies by suicide, a serious investigation is triggered with a view to finding the answers to the questions around the suicide. Whilst this legal and ethical process is required and it is an established process, it does bring with it an element of scrutiny which heavily infiltrates into a community mental health nurse’s personal and professional space. The scrutiny process - with its attention to detail, observation and examination - left each participant feeling scrutinised for every little detail regarding their clinical practice prior to the death of their patient. Many of the participants revealed that the investigative process was often dealt with in a climate of fear and not compassion. In her story, Liz stated:

“We weren’t supported very well by the Psychiatrist, who actually rang the Coroner and said, “It’s nothing to do with me”. (Lines 141-143)

“I think that would be her [the psychiatrist] or their way of dealing with that sort of thing.” (Lines 149-150)
“Mainly how it was handled... because when there was an investigation, you know... they did the investigation... we did it as a group... you know... it wasn't individual. And the person who was doing the investigation had rung and said... you know, this is going to be a really supportive thing... so I was feeling quite positive about it. And then I was asked a question of... ummm... "Do you think if you hadn't been on leave that he wouldn't have ended his life? ... And I was really floored by that... for a very, very long time..." (Lines 228-236)

“Yeah... I think it felt like [blame]... I don't think it was intentional... I just think that it was a poorly worded question...” (Lines 641-642)

9.2.2.1. The interface between feelings of failure and responsibility in the face of public scrutiny after the suicide.

The participants' narratives revealed that, when a patient dies by suicide, the death is automatically seen as a failure and the community nurses are left feeling responsible a long time after the death. They report on the lived experience of binary conflict, the tension between existentialism and personal ontologies.

Peter said,

“So immediately after that, it's just trying to... I think... myself and my colleague were obviously trying to understand the circumstances.... Immediately thinking about... how are we accountable for this? ... In what way are we accountable?” (Lines 231-234)

“Ummm... professionally it makes me feel (heavy sigh) that we ummm... I haven't been
able to do my job as effectively as I wanted to.” (Lines 394-396)

“Ummm…and I think that’s a huge thing…that we…we take on as CPNs. You know, that whole feeling of leaving the patient on their own, to do whatever they want to do. Ummm…it’s a difficult thing to walk away from, when you know the situation is really risky.” (Lines 448-452)

In addition to the binary conflict between existentialism and personal conflict, participants reported on external pressures which heightened the internal conflict which they were experiencing. For example, Mary’s involvement in the clinical case involving a patient suicide was reported on in the local newspaper. She said:

“And soon after, the Inquest was actually in the local paper…and actually named me in the paper…Lines 524-525)… Ummm…something that it highlighted was that a risk…a thorough risk assessment wasn’t undertaken…something like that…and that actually put my name in the paper…and I think that…I felt that was very unfair!” (Lines 527-530)

“Ummm…ummm…once it’s out there…it’s out there…I think people felt it was very unfair…that someone could be named. I wasn’t even at the inquest…and what are “comms department” doing to stop things like that? I suppose there would be some reporter there…who, you know…they exercised free will to report things…ummm…” (Lines 539-544)

Hannah’s story also revealed that the patient suicide was reported on in the local and national news, however she had never actually met the patient but got to see images of his face on the news media. Hannah said,
“Errm…it [the suicide] was in papers…it was….it was on the news (nervous laugh) …” (Lines 145-146)

“Yeah…yeah…so…not only did you as the nurse have your own feelings to deal with, but then you had it through the hospital, you had it on newspapers…local newspapers…then regional news…and…it’s like…” (Lines 148-151)

“I think…think it was…ummm…I can’t remember actually…but…you know…‘young person found in toilets’…you know…in BIG HEADLINES! In Black headlines!” (Lines 153-156)

9.2.2.2. The levels of scrutiny, inquiry and fault-finding after a patient suicide.

The participants described how they lived and worked through an investigation after the patient suicide. They described this as being a time of uncertainty, with the process often triggering feelings of anticipatory anxiety, self-doubt and uncertainty. The critical nature of the investigative process tended to trigger feelings of shame and blame.

Peter said,

“I think it was because it felt more…errr…almost like a Police Interview really…” (Lines 550-551)

“Ummm…it’s probably partly my imagination…ummm…but yeah…it was much more of a formal process…rather than, “How has this made you feel?” It was more about, “What exactly happened?” “Were you kind of doing this?” “What time?” “Ummm…where…”was there a gap?” And they sifted through all the notes
and...ummm...were able to show any kind of...any errors that occurred. Ummm...so that was difficult...that really did highlight...if...if...if anything...or where I did go wrong at points. I think there was one error...of the date that I saw him...ummm...literally around the first time...the first week that I started to know the chap...there was an error of a date and time...when I saw him. It didn't correspond to my notes. So, we were looking at things in finer detail. ..... Yeah...and I suppose they had to...” (Lines 553-567)

Barbara also stated:

“The problem is that...if...if it [our suicide prevention intervention] doesn't succeed...there are...we...we just feel that we've have failed and...you know...we haven't managed...we've...you know...and...there is a risk that there will be...you know...fingers will point at us...and...” (Lines 443-447)

“They are just sort of, popping up... [soft laugh]...they are bringing to mind...there’s just far more than I even care even to remember...but...they...they...they’re all weight...aaah...sadness! Sometimes, sense of failure...particularly in the ones I’ve told you about where I’ve actually been led to believe that of being a failure.” (Lines 673-678)

9.2.3. After the suicide, the experience of intense grieving, learning, growing and moving on.

Emily relates her experience of grief and how it affected her:

“Ummm...the first one...So, I’d started in November...so it was July...July the ninth actually...2013...I don’t think I’ll ever forget it...it’s ironic how you remember the death
to the day…when the first phone call comes in…” (Lines 114-117)

“It was just heart-breaking! And I still…I am getting upset now…because I just feel…I feel desperately upset and sad for her…ummm…and it was awful…” (Lines 194-196)

“And it doesn’t just leave you. I mean I don’t think about these situations all the time…(Lines 443-445)…But the others…you know…it’s not with you all the time…but now and again…” (Lines 449-450)

“I can’t even claim to even know what it would feel like…so you can only use your imagination as to how absolutely dreadful it would be. But you know…it sort of impacts how you are outside work. You worry…you know…you worry a lot…you think you…I can’t stop thinking about that person…and it takes a long time.” (Lines 602-607)

Hannah stated that she had learned the following personal and professional lessons after the patient suicide:

“So, if your gut instinct says something, go for it! And just keep doing it! And keep repeating and going through the process.” (Lines 543-544)

“As a result of her death, actually…we made massive changes to…the Crisis Criteria.” (Lines 545-546)

“So, if you’re in errm…Crisis Intervention, we MUST be seeing you at least once a week. We can’t have someone who is saying they are suicidal or self-harming or whatever…and we are not actually, physically seeing you!” (Lines 551-555)
Mary acknowledged that she had grown after the suicide:

“I think I’m a better clinician after it…really…even though it’s a terrible thing to happen…I think probably, you can get complacent about these things not happening to you…” (Lines 558-560)

9.2.3.1. The lived experience of coping after the suicide

The lived experience of coping after a patient suicide was of great existential significance to the participants. The expectation that nurses should cope with equanimity after a patient suicide was recognised as an unwritten rule within the profession and, in some cases, it was a personal rule to which the nurses themselves subscribed. The professional identity of the mental health nurse was bound up with the personal, human emotions associated with forming close therapeutic alliances with the patients who died and their families. This theme was further developed by the participants who had experienced more than one patient suicide, who talked about how they publicly carried on with the work of engaging with patients experiencing suicide thoughts and behaviours whilst privately grieving over the loss of the patient(s) that had died. Alice reflected this in her narrative:

“You have to put your face on and get back out there….” (Lines 647)

“Mmmm…I think they ummm…obviously cancelled all my visits the day they found out…ummm…and…yeah…the next it was bam! Back out there seeing patients that had no idea what I was feeling…coz you don’t do that, do you? You know, you put your smile on and as best you can…and you get on…you put your protective armour back
Peter’s narrative reveals how he was realistic about the situation he was in and how this had enabled him to cope after his patient had died by suicide:

“Ummm….it…it…but being realistic, I know that there are…there are no…we cannot stop people doing what they want to do…but it is…it’s ummm…as a reflective practitioner…I try and…I try and kind of cover everything…I try to look at all of the risk involved…ummm… (long pause)…and I like to…I pride myself in being quite a creative practitioner as well. So, when it’s beyond your control, and people do take their own life, it’s ummm…on one side, we have to be realistic and say that that person had the choice…or they took responsibility over their life…” (Lines 396-404)

“…it was very fortunate that the family…who knew him well and like I said, lived next door…ummm…were completely understanding of why he ended his life. And actually, they just said that he wanted to end this way. We didn’t really think it would happen, but he…you know…we’re not totally surprised. Again, that’s kind of a strange thing…” We’re not totally surprised.” So, could there have been something that could have prevented it. But actually, they were kind of relieved for him…” (Lines 601-609)

“Although we want to protect life…he made his own choice. And ummm…and I have to be realistic about that.” (Lines 428-430)

9.2.3.2. The journey of growth following patient suicide loss

Olivia talked about how she had grown after the patient suicide:
“I think it kind of builds you as a clinician…it gives you another layer of insight into what we do…and yeah…it helps with your…the kind of…it does inform your decision making…” (Lines 787-790)

“Growing…which seems weird…given that it’s a loss that you’re growing from… A loss…” (Lines 811-812)

“I think in the short-term and in the long-term. ummm… [long pause]…Yeah…you kind of feel like you’ve gained…its gained something…in terms of…you know…in terms of understanding. Ummm..” (Lines 790-794)

Jessica talked about the growth on a personal level:

“Yeah…and I think…you know…that…you I’m never…to my dying day…I’m never gonna forget this man…” (1175-1177)

“You know…you know…it’s…and I suppose that grief…you know…OK…he wasn’t my uncle or brother, but he was still a…he was still part of my life…” (Lines 1179 – 1181)

“Ummm…you know…and it’s still a loss and you know…you can’t just forget that, can you…you know? And I wouldn’t wanna forget him, he was a nice chap…you know? He was…he was a nice chap…why would I wanna forget him…” (Lines 1183-1187)
9.3. Chapter Conclusion

The participants’ stories which were highlighted in this chapter have revealed the cognitive and emotional experiences after a patient suicide. The experience of losing a patient to suicide is multifaceted and has many layers of meaning. The ordinate and superordinate themes that have been presented in this chapter confirm that when a patient dies by suicide they symbolically never leave the nurse’s psychological caseload. This chapter has also shown that all mental health nurses, even the most experienced nurses, do react emotionally to a patient suicide and they also need help with coping after the suicide.
Chapter 10: Discussion

As presented in Chapter 1, this thesis posed a question which aimed to investigate the experiences of mental health nurses after a patient dies by suicide in the community within the context of UK-based mental health services. The scoping review presented in Chapter 6 informed the design of the study and the pilot study presented in Chapter 7 gave me the opportunity to test out the research instruments and to begin the process of exploring how and whether factors such as gender, culture, levels of training, clinical supervision and the individual nurse’s experience of personal loss may affect mental health nurses’ experiences of patient suicide. The main study presented in Chapter 8 and the in-depth IPA analysis presented in Chapter 9 show the findings from the semi-structured interviews which were carried out with ten community mental health nurses who had experienced a patient suicide. The purpose of this chapter is to present a discussion which will determine to what extent this thesis has answered the research question.

10.1. The experiences of community mental health nurses

After engaging in an interpretive analysis of my interviews with ten participants, I have developed a clearer understanding and appreciation of the lifeworld as experienced by community mental health nurses following the death of a patient by suicide. In the literature, I observed that mental health and social professionals in general experience significant cognitive and emotional reactions after a patient suicide. Researchers have reported on the experience of stress, distress, identity crisis and sometimes strong feelings of regret regarding the choice to enter into psychiatry or mental health practice. Although psychiatrists have their reactions after patient suicide widely documented, it can be argued that this is because of the higher levels of professional responsibilities that they carry, and that they perhaps carry a much bigger patient caseload covering a wider patient catchment area. There is also the traditional
idea that the medical model often dominates mental health practice, an historical perspective discussed in depth in Chapter 3. However, psychiatrists recognise that they cannot do the work single-handedly and that the mental health nurse also provides crucial therapeutic interventions. Therefore, when a patient dies by suicide, any mental health nurses involved in their care will also be affected, as evidenced by the studies which were discussed in the scoping review presented in Chapter 6. The stories that have been shared by these ten participants will be linked to literature regarding mental health nurses’ experiences of patient suicide and the next section will highlight the experiential significance of what it means to experience the death of a patient by suicide.

10.1.1 The tension between existentialism and personal ontologies

The most striking finding is the lived experience of the conflict and tension between existentialism and personal ontologies on the part of the community mental health nurse. The clinical practice of preventing suicides through the use of risk management strategies is a vital part of the work that mental health nurses undertake. In view of the fact that mental health nursing practice is traditionally rooted in the healing power of the therapeutic nurse-patient relationship (Peplau, 1952), it is recognised that mental health nurses engage in the ‘therapeutic use of self’ (Travelbee, 1971), where they consciously use their own character and knowledge to make a difference in the outcomes for the distressed patient (Mirhangi, 2017). In their qualitative study, Midence et al. (1996) surveyed the effects of patient suicide in an in-patient setting on 27 mental health nurses and report that nursing staff accepted that the suicide was the patient’s personal choice, even though they had experienced feelings of sadness, frustration, shock, fear, anger and guilt. To further add to the work by Midence et al. (1996), the participants that I interviewed provided an in-depth discussion about their experience of the tension between the person’s right to die versus the mental health nurse’s duty to prevent suicide. The participants respected the right of the patient to die by suicide,
but this meant that the patient suicide conflicted with their professional duty of care.

The ten participants demonstrated that they were authentic to their mental health practice, which has been and still is theoretically influenced by the work of Peplau (1952) who proposed the central nature of the therapeutic relationship. The essence of the therapeutic relationship is the creation of a shared experience between the nurse and the patient which would result in the meaningful process of experiential learning, improved coping and personal growth for both the nurse and the patient (Peplau, 1952; Jones et al., 2012). Therefore, communication and the use of nurse-patient interviewing are fundamental nursing tools which facilitate the development of this meaningful therapeutic relationship (Jones et al., 2012). The fostering of personality development towards maturity is a key function of the therapeutic relationship in nursing. Mental health nurses use Peplau's principles to guide the process towards a meaningful and sometimes life-sustaining resolution in interpersonal problems (Howk et al., 1998). However, among this group of participants, the premature termination of this therapeutic relationship as a consequence of suicide triggered emotional reactions in them and left them feeling stranded and standing alone after the patient terminated that therapeutic relationship by taking their own life.

As reported by Dziopa and Ahern (2009), Hawandeh and Fahy (2009), Wills (2010), Lecharrois,(2011), and Mirhagi (2017) the work of preventing patient suicides is emotionally taxing and draining and the death of a patient can have a weighty effect on mental health nurses because they invest so much in the therapeutic nurse-patient relationship which is an essential basis for of all approaches to mental health nursing treatment. Whilst elements of the life stories shared by the ten participants give evidence of this, their narratives also revealed how they make huge emotional investments in their clinical casework with patients experiencing suicide thoughts and behaviours and they equate their observation of outward reduction of symptoms of distress with the expectation that the patient also has reduced levels
of suicide ideation and intent. Among the participants there was a genuine belief that lives can be preserved through reaching out to their distressed patients and using therapeutic engagement skills (Peplau, 1952; Travelbee, 1971; Hammell-Bissell, 1985). Therefore, having made such a major investment in the therapeutic relationship, a patient suicide took participants by surprise, triggering emotional catharsis, some of which was played out during the face-to-face semi-structured interviews.

10.1.2. Experiencing existential crisis of identity

It was also striking to find out that an existential crisis of identity was triggered in all participants after a patient suicide. Hagen et al.’s (2017) qualitative study explored the way in which mental health nurses cope with suicide and attempted suicide. Findings from this study reported that along with feelings of guilt, failure, anxiety and sadness, the participants seemed to control their internal emotions by appearing outwardly to be confident and calm when reacting to a suicide, whilst they were internally distressed. The participants that I interviewed provided life stories which reflected the complexities of working within a community setting, where they tended to work more autonomously whilst carrying large patient caseloads. On the one hand, working with people in the community brought with it freedoms and social connections which are not attainable within an in-patient environment. However, the background against which the participants were practising continually changed and this added another level of stress when the participants experienced a patient suicide.

A key theme from this study, which adds to the work of Hagen et al. (2017), is the belief that mental health nurses must cope with a patient suicide with equanimity. However, given the opportunity, all participants voiced the need to share their stories and to receive support. As the interviewer, I observed that as soon as I had asked a nurse to share their story of a patient suicide, I saw their mask of coping with equanimity come off and the identity of a distressed
community nurse became present and played itself out in the room. It was also striking to observe that as a participant engaged in this unmasking, they conveyed the strong sense that the patient who had died by suicide was still alive in their psychological caseload, despite the passage of time.

One explanation for this could be that current mental health practice situates the needs of the patient as the main focus; there is little or no attention being paid to how mental health nurses may be experiencing that distress as they engage in work with people experiencing suicide thoughts and behaviours. Additionally, mental health nurses often experience an existential struggle and are distressed in response to patients experiencing suicide thoughts and behaviours (Nystrom, et al., 2007). Feelings experienced as a consequence of existential identity crisis have been attributed to the view that the work of preventing is not an exact science (De Leo and Postuvan, 2017) as there is no statistically proven effective approach when dealing with suicide risk (Andriessen, 2016). In view of the complex nature of suicide risk in relation to patients experiencing mental distress, the process of suicide risk assessment is also not an exact science (De Leo and Postuvan, 2017). This means that it is not always possible for mental health nurses to accurately predict when or how a patient is going to die by suicide. To unequivocally say that suicide can be prevented 100 per cent of the time would be erroneous and untrue. However, for mental health nurses to not respond and not prevent suicide is not an option. The safety of people at risk of suicide must be maintained at all costs and this is reflected in the legal and ethical frameworks which underpin nursing professional regulatory bodies all around the world, including the UK.

10.1.3. Experiencing personal and professional accountability whilst working in a system which is not always accountable

The participants in this study saw the role of being a care co-ordinator as more than just a
job description; it was significantly bound up with strong feelings of professional responsibility and accountability. Within the context of professional regulation in the UK, the principle of the preservation of patient safety is reflected in the Nursing and Midwifery Council (2015) Code of Professional Conduct, which directs that nurses must preserve patient safety. It states:

“You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.” (NMC Code, 2015, p. 13)

If nurses are found to be in breach of this professional guidance, they can be officially struck off the NMC Register, with no hope of ever practising as a registered nurse again. For example, in August 2018, a registered mental health nurse named Susannah Ajayi was struck off the NMC register after she failed to prevent a patient suicide in an acute in-patient mental health unit in England (British Broadcasting Corporation, 2018; NMC; 2018). Whilst such a public report can be alarming, it does show that mental health nurses have the professional responsibility to prevent suicide and that it would be unethical for them to encourage or recommend suicide. Even if the patient has tried and explored all alternatives, the mental health nurse should not support the patient with their plans to die by suicide, neither should they participate in assisted suicide. Robertson et al. (2010) conducted a discourse analysis which explored how two mental health nurses conceptualised their accountability when they engaged in a dialogue about the suicide of the same patient that they were caring for. The two mental health nurses had worked as colleagues on the same in-patient ward and they felt accountable for the suicide.

The participants that I interviewed did not hold unrealistic expectations regarding their ability
to engage in the work of suicide prevention, intervention and postvention. Instead, what the participants highlighted was the tension which they experienced between their lived experience of personal accountability whilst working in a system which was not always accountable. Some participants told stories of how patient suicides had taken place whilst patients were in transition from one mental health service to another, which was a significant system failure. Other participants, although being highly skilled and highly committed, struggled to meet the demands of co-ordinating care in the community against ever-changing and competing service demands with many staff shortages. As a consequence of some of these contextual factors, participants questioned their own levels of competence with regards to their work of suicide risk prediction, mitigation and prevention in a challenging work environment. The element of blame and shame featured strongly in their narratives, even though, at the conclusion of the interviews, all of the participants acknowledged that they had done the best that they could for the patient who had died.

10.1.4. The experience of being scrutinised after a patient suicide in the community

The experience of being scrutinised and fear of being criticised also featured strongly in the participants’ narratives. An element of this was reported in the qualitative study by Shanley (2012) with 15 mental health nurses from both in-patient and community settings in England. Shanley explored the effect of facing a patient suicide or the sudden death of a patient as well as the subsequent experience of going through professional investigation and inspection (Shanley, 2012). Unquestionably, professional scrutiny needs to happen; but the way in which it happens may inadvertently cause nurses to become second victims, even when no error has been made while working with patients experiencing suicide thoughts and behaviours. The participants that I interviewed added another dimension to the process of scrutiny and that included the experience of being blamed by the media as a consequence of journalists
reporting the suicide to the wider community. Other participants were directly blamed by their colleagues, who had been directly involved in working with the patient who died by suicide, with some participants being blamed for errors of omission when they had actually been off work on annual leave. The participants revealed that the more they were scrutinised and blamed, the higher their levels of distress and anger after the patient suicide.

10.1.5. The patient who died by suicide in the community never leaves your psychological caseload

The concepts of community mental health nursing space, personal space, and liminal space were all referred to in all the interviews. Even though the participants were describing a suicide death which had occurred in the professional care in the community space or arena, the reactions were deeply personal and distressing. Although the feelings of stress and distress were reported in the in-patient studies conducted by Valente (2002), Joyce and Wallbridge (2003), Bohan and Doyle (2008), Takahashi et al. (2011), Shanley (2012), Hagen et al. (2017), and Turkles et al. (2018), this study significantly contributes to what is known about the lived experience of distress from the perspective of community-based mental health nurses. This distress was played out in the interview spaces as participants told stories about how they had meticulously completed their care plans and all the risk assessment documentation, which revealed their high standard of suicide risk assessment and management, but that it did not spare them from experiencing stress and distress after the patient suicides. Other participants related experiences of how they had felt that they had failed to rescue their patient from the clutches of suicide because they perceived themselves as a safety agent. All participants talked about the suicide as being unwelcome and it was seen as an undesired outcome as participants fought against the attitude that the suicide of patients was an inevitable part of the job.
During each research interview, I observed that my interaction with participants enabled them to connect with the previously hidden meaning making process which had been triggered when their patient died by suicide. They voiced and articulated those meanings within the context of the research interview. By sharing their stories, the participants of various ages - both male and female - with different levels of clinical practice and training, formed a homogenous sample and were able to tell me about their lived experience of surviving a patient suicide in the community. It was amazing to see a similar dynamic process occurring in each interview, thus revealing some of the hidden stories and existential experiences about what it means to lose a patient to suicide within a community setting. Whilst the process of investigation and scrutiny tends to only focus on the hard facts, on what is seen, it does not consider the unseen turmoil which the mental health nurses may go through as they experience the investigative process.

For the participants, it was not all about feelings of failure, guilt or self-blame. Some took time to acknowledge the hard work that they had invested in the therapeutic relationship which they had developed with the patient who had died by suicide, including the evidence-based suicide postvention work which they had done with bereaved relatives. The nurses who volunteered to participate in this study still carried their patient suicide in their psychological caseload and the interview process gave them the opportunity to share that experience.

10.2. Conclusion

This chapter has presented a discussion of the study and it has highlighted the key ways in which the objectives which were set at the start of the study were met. Connections with current literature were made and the key contributions that this study has made were captured in the discussion which highlight that after a patient suicide, community nurses experience tension between existentialism and their personal ontologies when the therapeutic relationship
ends unexpectedly. They experience an existential crisis of identity, particularly when they respond to suicide distress against a shifting landscape of providing mental health care in the community. In their search for meaning of the suicide, the nurses experienced personal and professional accountability whilst working in a system which is not always accountable as they experienced the feelings of failure and responsibility after a suicide. They told stories which indicated that they struggled with the experience of being scrutinised post-suicide as a result of the high levels of inquiry and fault finding. From their perspective, the mental health nurses also experienced intense grieving, learning, growing and moving on, whilst recognising that their patient who died by suicide in the community never leaves their psychological caseload.
Chapter 11: Conclusions and Recommendations

This chapter presents a summary of the research study and a reflective statement. It also presents the limitations of the research and concludes by proposing some thoughts and suggestions for future exploration within the field of suicide loss survivorship for mental health nurses.

11.1. Summary of the strengths of the study

This study explored the experiences of mental health nurses after a patient dies by suicide in a community setting within the context of UK mental health services. It employed the use of IPA principles to explore the experiences of ten community mental health nurses who had experienced a patient suicide between 2002 and 2018. The study was divided into two main types of fieldwork, a pilot study and a main study as a way of training the novice IPA researcher in the process of conducting sensitive qualitative research.

11.1.1. What is new and novel about this study

What is new about this study is that it highlights three significant superordinate themes. The first theme highlights the significance of a therapeutic relationship ending unexpectedly for the mental health nurse. The second theme indicates that mental health nurses engage in a process of searching for meaning in the patient suicide in the face of public scrutiny. The third theme reveals that, after the suicide, mental health nurses go through a period of intense grieving, learning, growing and moving on.

What is novel about this study is its specific focus on the lifeworld experiences of community mental health nurses who are autonomous practitioners, experts in their work and provide compassionate suicide support and mitigation within a community setting against an ever-
changing health service landscape within the United Kingdom. It gives insight into the lifeworld experiences of community mental health nurses who make a significant contribution to the community care workforce and often formulate intensive therapeutic relationships with the person experiencing suicide thoughts and behaviours, as well as with their relatives, family, friends, carers and significant others. Awenat et al.’s (2017) study indicates that the participants who had worked with patients experiencing suicide thoughts and behaviours as professionals working within an inpatient setting became highly emotional as they were describing the event, even when the incidents had occurred several years ago in the past. The participants in this study gave a deeper insight into this experience when they gave descriptions which indicated that the patient who had died by suicide never left their psychological caseload.

11.1.2. What this study contributes to the suicide loss survivorship literature

In terms of contributions to the literature, this thesis adds to the findings from Shanley’s (2012) work on the experiences of mental health nurses after a patient suicide and other forms of sudden and unexpected deaths. The participants in this study included both inpatient and community-based mental health nurses and it revealed that they became second victims in the aftermath of the patient suicide.

This thesis also adds to Awenat et al.’s (2017) study, which sought to investigate the thoughts and perceptions of mental health professionals who had worked with patients with experience of suicide thoughts and behaviours in an inpatient setting. Although the study was designed to capture the perspectives of mental health professionals made up of psychiatrists, psychologists, mental health nurses, mental health nursing assistants, mental health support worker, occupational therapists and social workers, findings revealed that all participants had experienced an inpatient suicide as well as suicide attempts. Amongst its recommendations,
this study indicated that more research needed to be conducted with specific mental health professional groups, as some of the findings revealed general perceptions which may differ among the professional groups represented in the sample. This thesis adds to the literature by presenting the professional encounters and experiences, not just the perceptions, of community mental health nurses who are suicide loss survivors. This study also adds to the overall body of literature which aims to shed light on how mental health professionals can be supported after a patient suicide.

11.1.3. The unique contribution that this study makes

We know that a patient suicide significantly affects mental health nurses in both a personal and professional way. We know that, when a patient dies by suicide, mental health nurses struggle to cope. Empirically, we know that the experience of stress and distress is common, and this has been evidenced by many surveys which have employed the Impact of Event Scales (IoES). However, the study of the lived experience of patient suicide loss from the perspective of community mental health nurses is in its infancy. The findings presented in this study give us a unique insight into the lifeworld (Ashworth, 2003) experience of community mental health nurses after a patient dies by suicide. More than just confirming that it is distressing to have a patient die by suicide, this study presents their unique world view of patient suicide loss, their sensitive experience of what losing a patient to suicide means and how they personally make sense of patient suicide loss survivorship as they carry on working in the forefront of providing mental health care in the community in an ever-changing health and social care landscape.

11.1.4. Recommendations for policy

Findings from this thesis add to the suicide prevention, intervention and postvention health
policy that has been set out by the World Health Organisation (WHO) which has categorised suicide prevention as a global health imperative and acknowledged the crucial contribution that mental health and social care professionals make in working with people experience of suicide thoughts and behaviours. WHO suicide prevention policy has guided national UK health and social care policy as published by the Department of Health (DH), NHS England and Public Health England. National policy is then translated into local NHS Trust policy on suicide prevention, which advocates that health and social care professionals should engage in suicide prevention casework using the frameworks presented in National Suicide Prevention Strategies.

Within the context of mental health practice, a key recommendation in suicide prevention policy is that mental health nurses need to be able to engage in suicide risk assessment and management as part of their clinical role. Whilst this work in not an exact science, Bowers et al. (2016) recommend that suicide risk assessment and management policies should advocate for mental health nurses to be upskilled and educated to engage in idiographic suicide risk assessments, as opposed to nomothetic risk assessment. Idiographic risk assessments focus on the individual patient experience of suicide thoughts and behaviours as opposed to the nomothetic approach which has more to do with the completion of tick boxes and checklists. The findings from this thesis have the potential to influence the development of policies which are inclusive of an idiographic approach to supporting mental health nurses after a patient dies by suicide.

When a patient dies by suicide, policy tends to focus heavily on the process of investigating the cause of the suicide by means of the inquest process. Whilst this is understandable, little attention has been paid to how mental health nurses may experience a patient suicide and may be supported after a patient dies by suicide. In addition to this, there is the important practice of recording and documenting deaths by suicide by the Office for National Statistics.
(ONS)(2019) and the National Confidential Inquiry into Suicide and Safety (NCISS)(2019; DH, 2014) to help health and social care practitioners, including community mental health nurses, to understand suicide trends as part of suicide prevention. However, there is the softer, more human side to this policy: the people who have to come forward and contribute these stories and lived experiences which contribute to overall reporting about suicide whilst confirming death by suicide.

Findings from this thesis also have the potential to enhance policy development by acknowledging and recognising the need to set up processes and systems to support mental health nurses who have experienced suicide loss.

11.1.5. Recommendations for practice

The Mental Health Five Year Forward View (DH, 2016) includes current guidance that heavily influences the clinical practice of suicide prevention, intervention and postvention. Nursing professional bodies such as the Nursing and Midwifery Council (NMC, 2018) and the Royal College of Nursing (RCN), which is the voice of nursing across the United Kingdom and the largest union of nursing staff in the world, have provided guidance which specifically underpins mental health practice.

The NMC (2020) acknowledge that community mental health nurses are pivotal in providing mental health care in the community. Additionally, mental health nurses are experts in the work that they do, especially as they enter into the private and intimate lives of their patients in their homes, and in doing so become highly skilled at entering into the lifeworld of the patient. As has been outlined in this thesis, they engage in risk assessments and management as autonomous practitioners. However, when the community mental health nurse experiences patient suicide loss survivorship after a patient dies by suicide, this experience can add to the
strain of the work of being a nurse, increasing the weight of responsibility which may be complicated by the autonomous nature of the role of being a community mental health nurse. In addition to this, the RCN lobby for action on the improvement of suicide prevention on behalf of nurses, stating that nurses, as a professional group, are themselves considered a high suicide risk (Hawton et al.; ONS; 2018). Considine (2016) highlighted that nurses, including mental health nurses, are a ‘high suicide risk due to the strain and high levels of responsibility that is attached to their role’ (page 1). Nurses need to take care of their own physical health and mental wellbeing and the RCN advocate for stronger government policy and systems to make sure that there is support for mental health nurses (Considine, 2016).

This thesis has the potential to support the notion that the mental health and wellbeing of mental health nurses needs to be acknowledged generally and needs to be taken seriously, in a standardised way following a patient suicide. It has the potential to contribute empirical evidence that underpins the need for support after a patient suicide in the form of standardised quality mental health promotion in the nursing workplace as advocated by the Royal College of Nursing (RCN) (Considine, 2016). Although small in size, this study presents the lived experiences of participants who had differing experiences of the post-suicide process from the time they discovered that their patient had died by suicide through to the investigation and inquest. The participants’ lifeworld narratives tell us that they were distressed by a patient suicide and give us an insight into the lack of consistency in how the distress of being a suicide loss survivor is addressed in clinical practice.

It is crucial for mental health nurses to be able to know how to access standardised crisis support and for that support to give specific emphasis to supporting mental health nurses after a patient suicide by offering a variety of mechanisms that nurses can choose to engage with at different times after a patient suicide. Nurse participants in the study found that talking about suicide loss survivorship during the research interviews helped them to unburden themselves.
as they shared their lived experience. They suggested that there would be some clinical utility in having such a support system for all nurse suicide loss survivors.

11.1.6. Recommendations for UK Pre & Post Registration Nurse Education

Findings from this study have the potential to contribute to pre-registration nurse education by adding to the theme of suicide risk assessment and management within the context of suicide prevention, intervention and postvention. The current NMC Standards for pre-registration nurse education (NMC, 2018) are divided into three parts. Part 1 provides educators with a standards framework for nursing and midwifery education; Part 2 provides educators with standards for supervision and assessment in clinical practice; and Part 3 provides programme standards for nursing education, nursing associate education and for the nursing prescribing programme (NMC, 2018).

The standards framework for nursing and midwifery education in Part 1 explicitly states that approved education institutions and their practice partners who provide practice-based learning for students must ensure that public safety is at the centre of the education process. They acknowledge that student nurses, whilst working with registered nurses in their role as assessors and supervisors, will be in contact with patients, service users, their families, relatives, carers and significant others throughout their pre-registration education, hence it is crucial for practice-based learning to occur in a safe and effective way (NMC, 2018). In other words, it is highly likely that students will work with people experiencing suicide thoughts and behaviours who are in contact with mental health services and that they will also experience patient suicide loss survivorship at the same time as their registered nurse supervisors and assessors. The support provided after a patient suicide then becomes an important factor that needs to be taken into consideration during the education of nurses in their theory and clinical practice. To facilitate this process, practice-based learning must take place in learning
environments that promote honest, open and ethical cultures conducive to personal and professional development. Findings from this study have the potential to contribute to raising awareness about suicide loss survivorship not just in the mental health nursing field but across other fields such as adult learning disabilities and children’s nursing. There is also the potential for raising awareness in midwifery where both registered and student midwives may experience patient suicide as a consequence of perinatal mental distress.

Raising awareness about the experience of suicide loss survivorship could also support Part 2 of the NMC Standards (2018), as supervisors and assessors in clinical practice aim to facilitate learning in a safe and effective way, particularly in response to distressed patients who may be experiencing suicide thoughts and behaviours. The curriculum content as stated in Part 3 of the NMC Standards (2018) must be designed, delivered and assessed in a manner that helps students to achieve the standards of proficiency for registered nurses to be fit for purpose, award and practice. There is a requirement for all nurses responsible for general care to receive theoretical instructions on mental health awareness, how to identify mental distress and how to address mental illness. The findings from this thesis could make a significant contribution to theoretical instruction on suicide awareness and prevention through the delivery of content regarding suicide mitigation, safety planning and dealing with the aftermath of a suicide attempt and death by suicide. Theoretical content could explicitly include suicide postvention after the experience of suicide loss survivorship for the bereaved family, relatives, carers, significant others, as well as mental health nurses. Therefore, findings from this thesis have the potential to contribute to nurse education discourse about suicide and suicide loss survivorship in nurses in general, with more specialised curriculum content being delivered to pre-registration mental health student nurses.

11.2. Critique of current study – limitations
One limitation of this study is my status as a novice researcher, new to conducting primary qualitative research using IPA as the chosen methodology. Although I sought professional training, mentorship, support and advice from very experienced IPA researchers, my application of the IPA process reflects the abilities of a novice researcher. I recognise that this was my first experience of data transcription, analysis and writing-up, therefore there may have been some things that I have omitted. The process of data analysis was very demanding and intense. This will have influenced the quality of the hermeneutic interpretation of the transcripts.

The two phases of fieldwork in the form of a pilot study and a main study took place within the same host NHS Trust. Although this decision was taken for my convenience as the lead researcher, it would have been interesting to see if another NHS Trust could have been included in the catchment area for the research. This may have broadened the scope and experiences which the participants could have shared about what it means to experience a patient suicide.

11.3. Quality measures in qualitative research

In order to measure the value of qualitative research, Smith at al. (2009) suggest the use of criteria offered by Yardley (2000) which provided me with some guidance that I could follow as a developing IPA Researcher. This is important because, traditionally, qualitative research outputs have been appraised using the reliability and validity criteria which are often applied to quantitative research. Many qualitative researchers would argue that qualitative research studies must be assessed using standards which are acknowledged as being suitable for qualitative research (Smith et al., 2009).

Yardley (2000) suggested broad principles that inform the valuation of the quality of qualitative
research studies. This section will now present each key principle in turn to illustrate how this study has addressed these principles.

11.3.1. Sensitivity to the context

Yardley suggests that a good IPA study will demonstrate sensitivity to the context of the study. The researcher needs to be aware of and sensitive to the socio-cultural environment in which the study is situated (Yardley, 2000). As discussed in Chapter 1, my personal journey through this research process demonstrates how sensitive I have been to the context of this research as a registered mental health nurse who also has a partial insider perspective of being a suicide loss survivor. The researcher needs to have knowledge about the existing literature on the topic. I have demonstrated my knowledge about existing research as presented in Chapters 2, 3 and 6 of this thesis. Yardley also recommends that any material obtained from the participant needs to be dealt with sensitively. Throughout my research journey, I adhered to the principles of IPA as closely as possible, whilst taking into consideration the emotional nature of suicide research. I chose IPA as a methodology because I perceived that I needed to engage in this research sensitively, working with the idiographic and the particular (Smith et al., 2009). The idiographic pieces are very interesting, and I really enjoyed harnessing the idiographic as I wanted to ensure that all the valid and important aspects of the participants’ experiences were included.

Sensitivity to the context can also be demonstrated during the recruitment of a purposive sample of participants. From my experience of applying for permissions and ethics approval, I appreciated that this purposive sample is not easy to access. I needed to demonstrate sustained engagement with key gatekeepers who played a crucial role in helping me to get access to participants. Stakeholder engagement was central to the viability of the project at
the start. Yardley (2000) suggests that researchers should understand the collaborative nature of data collection within the context of the semi-structured interview, which requires essential skills of awareness and a strong dedication to the collection of good data. I believe that during the data collection of the main study, I did my best to pay disciplined attention and commitment to engaging in data analysis and giving critical attention to the lifeworld that the participants shared with me as I engaged in the double hermeneutic. Whilst this was a challenging process, I believe that I adhered to the principles of IPA research during the data collection phase of the main study. Yardley (2000) explains that researchers need to have a number of verbatim transcripts to support the arguments being presented. This shows commitment to participants’ lifeworld and it ensures that the participant voice is heard in the research. This gives the reader the chance to check and make sure of the interpretation that the researcher is making. Evidence of how I did this will be presented and discussed in the remaining sections of this thesis.

11.3.2. Commitment to rigour

My commitment to rigour in the application of the principles of IPA research was strengthened after I received training, guidance, and advice on how to plan and carry out IPA research. I attended a “Methodology, Expert Interviewing Technique Workshop, Data Collection and Analysis” workshop presented by London IPA Training and was facilitated by Hefferon and Gil-Rodriguez (2014). This gave me the opportunity to learn about IPA research and also to have developmental conversations with other experienced IPA researchers. I also had the privilege of attending the Dublin IPA Summer School in 2015 where I participated in workshops hosted by Dr. Virginia Eatough (PhD) on how to skilfully engage in IPA research (Eatough, 2015). My attendance at the London IPA Regional Group Meetings, and more recently the Gloucester IPA Regional Group, has given me the opportunity to receive further training, coaching and
support in the use of IPA methodology. I am registered as a member of the “IPA Online Interest Group”, an international network of IPA researchers who regularly share IPA research information under the skilful guidance of IPA authors Jonathan Smith, Paul Flowers and Michael Larkin.

11.3.3. Transparency and coherence

Yardley (2000) suggests that the research process should be transparent and that it should be possible for the reader to see how themes were developed and what tools were used in the process. My commitment to transparency was enhanced when I attended an IPA Analysis Workshop in Derby (Holland and Montague, 2019) and my transcripts were peer-reviewed by two very experienced IPA researchers. These IPA researchers were also conducting sensitive research within the context of mental health practice, which meant that we could all relate to the research studies under consideration.

11.3.4. Impact and importance

The final criterion in Yardley’s (2000) quality framework is the notion of the influence and significance of the research. As the lead researcher, I genuinely believe that this research study is important because it explores a sensitive subject regarding death and dying by suicide and how such an experience can have significant cognitive and emotional effects on community mental health nurses, who make a significant contribution to the nursing workforce.

11.3.5. Validity

In addition to Yardley’s (2000) framework, Smith et al. (2009) suggest another very important
quality indicator, which is to do with the validity of the study. One method that can be used to ensure the validity of the research is engaging in an independent audit of the IPA research process to make sure that data analysis steps have been adequately followed. I engaged in independent auditing during all phases of my study. When I designed the pilot study interview schedule, I engaged in an audit of the initial semi-structured interview before I used it during the pilot study. I enlisted the help of a fellow IPA researcher, a registered adult nurse by background, who had undertaken a PhD study using IPA methodology at Cardiff University. As stated in Section 8.2.4 above, we had attended the same IPA training together, so I felt that she had extensive understanding of the IPA process. My colleague gave me extensive constructive feedback on the IPA semi-structured interview schedule. Once we had reached an agreement, the same IPA research colleague allowed me to test out the interview schedule on her, to check the quality of the questions. I arranged a face-to-face interview session with her and carried out a mock interview. We agreed that this interview schedule met IPA requirements.

After doing this preliminary work, I then discussed it with my PhD Supervisory Team during my supervision sessions and there was an agreement that I could use the interview schedule. I applied the same process regarding the development of the semi-structured interview schedule for the Main Study after incorporating the lessons learned from the pilot study. I approached a different qualitative researcher who was undertaking a Professional Doctorate at the University of Cardiff and was a registered mental health nurse by background. She had also experienced a patient suicide within the context of an inpatient setting and volunteered to help me with the audit of the semi-structured interview schedule for the main study. We had a face-to-face session where I tested out the interview schedule and she gave me constructive feedback regarding the quality of the interview. After following this process, I presented the updated version of the semi-structured interview schedule to my PhD Supervisory Team and we agreed that it would be appropriate for me to use this refined semi-structured interview
In order to audit transcripts for the main study, I enlisted the help of a fellow IPA researcher who I had met through the Derby IPA Data Analysis Workshop (Holland & Montague, 2019) and they engaged in a detailed audit of the data analysis process. We were introduced to each other by the facilitators of the workshop, as we were undertaking similar research studies. My colleague was undertaking her PhD at Greenwich University in London and she was exploring the experiences of burnout among General Practitioners (GPs) working in the Thames Valley Region. I submitted my first IPA transcript with details of the interview that I undertook with a participant who I have chosen to call Rachel. (I discussed the evidence which I submitted to fellow IPA Researchers as part of the audit trail in section 8.5.) By engaging in this audit of the data analysis process, the iterative nature of my data analysis improved, and I was able to develop more confidence in my ability to move on from analysing Rachel's transcript to analysing Liz’s transcript as shown in Chapter 9, Table 8.

11.4. Reflective Statement

In January 2012, I officially enrolled onto a part-time PhD programme with the University of Bedfordshire because I wanted to learn how to become a nurse researcher. My focus was going to be on the concept of suicide loss survivorship for mental health nurses. During this seven-year journey, I have been through my own version of metamorphosis, where I have transformed from being a mental health nurse to being a qualitative researcher. In Chapter 1, I gave a narrative of my lived experience of being a suicide loss survivor. I have been engaging in reflection and in reflexive thinking throughout the PhD research journey.

11.4.1. My reflections on the research process
I had an idea about qualitative research at the start of my study, but it was merely superficial and based on limited perceptions rather than the lived experience. I took my time to learn about the fundamentals of research. I discovered my epistemological and ontological position and I learned how to align this to the research methodology. With guidance from my supervisory team, I began to develop deeper insights into these fundamentals. The qualitative paradigm came to life as I engaged in learning about IPA and my interest in interpretative phenomenology grew.

11.4.2. My partial insider-outsider perspective

In order for me to answer the research question, I started the study from the perspective of a registered mental health nurse who had worked as a community mental health nurse and had experienced patient suicide loss within in-patient settings as well as community mental health settings. I knew that this experience is what motivated me to keep going with the study because it meant so much to me to make sense of my own lived experience of patient suicide. As a mental health nursing lecturer, I was also driven by my experiences of teaching my pre-registration student nurses about the labour-intensive work of suicide prediction, assessment, prevention and postvention. The experience of undertaking this study helped me to strengthen my ability to navigate published literature and to develop the essential quality appraisal skills which helped me to retrieve the most up-to-date relevant evidence-based research which then informed my teaching and learning activities.

When engaging in fieldwork, I shared my partial insider-outsider perspectives with my participants. Even though some of the participants had met me in my role as link lecturer for their clinical placements, they did not know about my lived experience of patient suicide loss. Therefore, by disclosing my partial insider-outsider perspective, I was able to connect with the participants in a manner which resulted in the quick development of rapport at the start of each
research interview. After each interview, I reflected by recording my initial thoughts on an audio recording device. Listening to those recordings reminded me of how much emotional labour I had invested into the research process, especially in the way in which I had made the time to travel to visit community mental health nurses within their place of work and to listen to them as they shared their stories. I believe that by consistently engaging in reflexivity after each single interview, I was learning how to gather interview data in a manner that yielded high-quality information.

11.4.3. Time

One of the most challenging things about conducting this research was time. I embarked on the research journey as a part-time PhD student whilst I was juggling a full-time job as a senior lecturer in mental health nursing. I was also a project lead for an externally funded research project. Doing this study has helped me to learn to make and take time to develop my skills as a researcher, something which I felt would be an investment in myself. With competing demands, I realised that I was spreading myself too thinly, which resulted in less time being devoted to my research. However, as time went on, I developed an appreciation of my time and how much it mattered to me. I made some significant changes in my professional working life which meant that I could reclaim some lost time and make progress with my research.

11.5. Future research: Recommendations

During the recruitment phase of the main study, it attracted interest from community-based social workers, occupational therapists and psychologists who were employed as generic workers or mental health care coordinators by the host NHS site. They expressed an interest in participating in the interview because they had experienced a patient suicide in the community and they had been the main key worker for that patient, as opposed to it having
been a nurse. When I informed these allied health and social care professionals that they did not meet the study inclusion criteria, they expressed deep disappointment at not being included, as they felt that they had a worthwhile story to contribute to the qualitative research evidence. Therefore, an important recommendation for future study would be to explore the experiences of community care coordinators, a role which can be fulfilled by health and social care practitioners and not just mental health nurses. For example, social workers, occupational therapists and clinical psychologists can be employed as care coordinators in community-based service. It would be beneficial to elicit their experiences of a patient suicide, irrespective of their professional registration.

During the recruitment stage of the main study, I was also approached by registered mental health nurses who were based in in-patient settings and had experienced patient suicide. According to the literature, the last in-patient focused research involving mental health nurses was done by Cutcliffe et al. (2008). Even though mental health wards are now supposed to be safe and the reduction in ligature points in many hospitals has resulted in the reduction of the number of inpatient suicides (Appleby et al., 2018), there are still some instances where suicides in in-patient settings have taken place. Therefore, another recommendation from this research would be to conduct a qualitative study focusing on in-patient ward-based nurses after a patient suicide.

11.6. Conclusion

To conclude, the experience of suicide-loss survivorship as a community-based registered mental health nurse creates conflict as well as tensions between existentialism and personal ontologies. Sometimes patients will experience suicide thoughts and behaviours as a consequence of distress which is triggered by the experience of mental illness. When this happens, mental health nurses will continue to hold the genuine belief that lives can be
preserved through reaching out to their distressed patients and using therapeutic skills. In response to increased suicide risk, they will continue to work skilfully and collaboratively with the person experiencing suicide thoughts and behaviours. Even if the patient terminates the therapeutic relationship by choosing to die by suicide, the community mental health nurse can be secure in the knowledge that they fully lived up to their part in the therapeutic nurse-patient relationship.
References


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Appendices

Appendix 1 – Confirmation of University of Bedfordshire Institute for Health Research (IHR) Ethics Approval for Pilot Study

13 June 2014

Melsina Makaza
Student number: 90121088

Dear Melsina Makaza

Re: IHREC Application No: IHREC097

Project Title: Exploring the experiences of mental health nurses in the aftermath of a patient suicide in the community – Pilot Study

The Ethics Committee of the Institute for Health Research has considered your application and has decided that the proposed research project should be approved with no amendments.

Please note that if it becomes necessary to make any substantive change to the research design, the sampling approach or the data collection methods a further application will be required.

Yours sincerely

[Signature]

Dr Yannis Pappas
Head of PhD School, Institute for Health Research
Chair of Institute for Health Research Ethics Committee
Appendix 2 - Confirmation of Permission from Director of Nursing for Pilot Study

Oxford Health NHS Foundation Trust

Oxford Health NHS Foundation Trust
Trust Headquarters, Warneford Hospital
Warneford Lane, Headington
Oxford, OX3 7JX
10th March 2014

Melsina Makaza
PhD Research Student
Institute for Health Research
Putteridge Bury Campus
University of Bedfordshire

Dear Melsina,

Your PhD Research Study

Having consulted with Ron Alstead, Director of Nursing and Clinical Standards, I can confirm that, subject to the required ethical approval, you have permission to contact and recruit registered nurses working within community settings of the Trust for a pilot study as part of your PhD research study: ‘Exploring the experiences of mental health nurses in the aftermath of a completed patient suicide’. Once you have approval to commence the study, please can you contact me to confirm how you plan to contact, recruit and support staff as they contribute to your research.

Yours sincerely,

Mike Foster
Acting deputy Director of Nursing
Appendix 3 - Confirmation of NHS Ethics Approval for Pilot Study

Dear Melina,

RE: Exploring the Experiences of Mental Health Nurses in the Aftermath of a Patient Suicide in The Community – A Pilot Study.

PID No: OxH 1038

I am pleased to confirm that Oxford Health NHS Foundation Trust will grant NHS Permission (management approval) for this research study until the study end date of 27th February 2015, as described in your application to the University of Bedfordshire Research Ethics Committee. NHS Permission is granted as of the date of this letter. This confirmation is dependent on formal approval from the University of Bedfordshire Research Ethics Committee.

Every NHS Trust is required to meet and report on performance standards, one of which is first participant recruited to a study within 30 days of receiving NHS Permission. In addition to this, a study is expected to recruit its sample size within its recruitment period. In your University ethics application it is stated that Trust involvement will end on 27th February 2015 and that 5 participants are required.

I must remind you of your responsibilities as a researcher including adherence to the principles of the Research Governance Framework (RGF), Good Clinical Practice (GCP) and the Data Protection Act. Please note that the Trust is required to monitor research to ensure compliance with the RGF and other legal and regulatory requirements. This is achieved by random audit of research.

NHS Permission is dependent upon submission to the R&D Department of:

- date of first participant recruited
- quarterly response to request for recruitment figures
- any amendments to the conduct of the study
- final report on completion of the study

I wish you every success with the study.

Yours sincerely,

Professor John Geddes
Director of R&D
Appendix 4 - Consent Form for Pilot Study Participants

Consent Form

Study title: Exploring the experiences of community mental health nurses in the aftermath of a completed patient suicide.

Please tick box

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information and ask questions and I have had these answered satisfactorily. □

I understand that my participation is voluntary, and that I am free to withdraw from the study at any time without giving any reason, without any effect on my employment. □

I understand that the interview will be recorded on a digital recording device. □

I understand that direct quotations and the data which is collected from the interview may be used in any publications arising from the study. I understand that the quotations will be anonymous with no person, workplace, NHS Trust identifiable. □

I agree to take part in the above study. □

__________________________  ____________________________  ____________________________
Initials of participant        Date                      Signature

__________________________  ____________________________  ____________________________
Name of researcher            Date                      Signature

When completed: 1 for participant, 1 for researcher

Consent Form for Suicide Postvention Study – Version 5 – 22nd May 2014
Appendix 5 - Information Sheet for Registered Mental Health Nurses

Study title: Exploring the experiences of community mental health nurses in the aftermath of a completed patient suicide

You are invited to take part in the above study by attending an individual interview. Before you decide if you would like to take part, please read the following information and feel free to discuss it with others. The Lead Researcher’s contact details are at the end of this information sheet. Please do not hesitate to make contact with any enquiries you may have.

What is the research about?

This research is designed to find out about the experiences of registered mental health nurses after a patient that they have been caring for in the community has died by suicide. As part of their job description, preventing suicide is a core competency and a major clinical responsibility. Therefore, this research aims to look into nurses’ experiences as survivors and how they may make sense of a completed patient suicide. It also explores how nurses carry on with their daily clinical practice after such a significant event.

Why is the research being undertaken?

There is a lot of research that investigates how relatives and family may feel after their relative dies by suicide. However, there are few research studies about the experiences of mental health nurses as survivors of a patient suicide. This study aims to build on what is currently known about nurses as suicide survivors. The results from this study will provide some insight into the experiences of mental health nurses working in the community setting.

It will find out what it means for mental health nurses to lose a patient by suicide, the support they received after a patient suicide and will explore what support mental health nurses may need after a patient dies by suicide. Such knowledge will contribute to the development of suicide postvention for mental health nurses which can be incorporated into daily clinical practice on a personal and professional level.

Why have I been chosen?

You have been chosen because you are a registered mental health nurse working in a community setting within Oxford Health Foundation NHS Trust and have experienced a patient suicide from 2002 until the present day. If the suicide occurred while you were working for a different Mental Health NHS Trust during this time period, then you are eligible to participate in this study. Your experiences and views will be very valuable to this research study.

Do I have to take part?

No. Your participation in the study is entirely voluntary and it is up to you to decide if you wish to take part. Your employment with Oxford Health Foundation NHS Trust and your role as a registered mental health nurse will not be affected if you decide not to take part in the study.

What will happen to me if I take part?
You will be invited to take part in an individual interview with the Lead Researcher. The interview will take up to 60 minutes but could possibly last longer. The interviewer will ask you about your experiences of a patient suicide, the support that you received at the time and what could be developed to support registered mental health nurses in the future. The interview will be audio-recorded, transcribed and then analyzed by the Lead Researcher.

**What are the potential benefits or advantages of taking part?**

You may find it interesting to be involved in this research study and to be able to contribute to developing the future support mechanisms for mental health nurses who are survivors of a patient suicide, for the benefit of the profession and future patient care.

**Are there any risks or disadvantages of taking part?**

The interview will take up some of your time (probably up to 60 minutes). You will also be discussing sensitive information about your experiences after your patient died by suicide. Therefore, you may become distressed when talking about and making sense of your experience. However, you will not be left alone to deal with this. You will be guided towards obtaining additional support should you feel that you need it after you complete the interview.

**Can I withdraw from the study?**

If you decide to take part, you can withdraw from the study at any time without giving a reason. Any information you have already given will be included in the study unless you inform the Lead Researcher that you do not wish it to be used.

**Will the information I give be kept confidential?**

Yes. All information collected will be treated confidentially and the data will only be reviewed by the research team. Your contact details will not be kept with the data, which will all be anonymised. The Lead Researcher will also ensure that the patients who have died by suicide cannot be identified in any publication which may result from this study.

The research report, publications and presentations arising from the research will include anonymised quotations from the interview. Any quotations used will not include the workplace or any information that could identify you or your NHS Trust.

**Where will the information be kept and who will have access to it?**

All the information will be stored in a locked filing cabinet and on university password protected computers. Only the Lead Researcher will have access to the information. The information will be kept until the study has been completed and the necessary reports have been written, after which all information collected will be destroyed and deleted from electronic files.

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

The study’s results will be presented to the Institute for Health Research, the University of Bedfordshire and Oxford Health Foundation NHS Trust Education Leads. The research results will also be presented at conferences and submitted for publication in journals for healthcare professionals. Should you wish to discuss anything further about your experience of a completed suicide and/or the research process you are welcome to contact the Lead
Researcher at any time.

You will have the opportunity to view the transcript of your interview and copies of publications as they are produced. You are also most welcome to attend any of the presentation seminars as the results are disseminated to the Institute for Health Research. This approach is based on Liamputtong’s approach to sensitive research that aims to minimise the likelihood of you as a participant experiencing the research process as a “hit-and-run” event. Rather, it demonstrates that the Lead Researcher aims to deal with the potentially emotive subject matter of suicide with dignity and sensitivity (Liamputtong, 2009*).

Who is funding the study?

There is no funding for this study as it is being undertaken by the Lead Researcher in order to meet the requirements of a PhD programme with the Institute for Health Research, University of Bedfordshire

Who has approved the study?

The study has been approved by the University of Bedfordshire’s Institute of Health Research Ethics Committee.

What do I do now?

If you are interested in taking part, please respond via email or phone (details of both provided below). The Lead Researcher will then contact you to discuss the study and answer any questions, and arrange a mutually convenient date, time and venue for the interview. You will then be asked to read and sign an informed consent form to take part in the study prior to the interview.

Who can I contact if I have any concerns or questions?

If you have any questions or queries, please feel free to contact the Lead Researcher:

Melsina Makaza  
Lead Researcher & PhD Student  
Institute for Health Research  
University of Bedfordshire  
Buckinghamshire Campus  
Oxford House  
Oxford Road  
Aylesbury  
Buckinghamshire  
HP21 8SZ

Email: melsina.makaza@beds.ac.uk  
Telephone: 07476 286061

Director of Studies & PhD Supervisor  
Dr Chris Papadopoulos  
Senior Lecturer in Public Health
Department of Clinical Education and Leadership  
Faculty of Health & Social Science  
Putteridge Bury Campus  
Luton  
Email: Chris.papadopoulos@beds.ac.uk

Director of Institute for Health Research & Second PhD Supervisor  
Professor Gurch Randhawa  
Professor of Diversity in Public Health  
Institute for Health Research  
University of Bedfordshire  
Putteridge Bury Campus  
Luton  
Email: gurch.randhawa@beds.ac.uk  
Telephone: 01582 743797

Thank you for reading this information sheet.

Reference List:  
Appendix 6 - Invitation Letter for Pilot Study Participants

Melsina Makaza
PhD Researcher
Institute for Health Research
University of Bedfordshire
Putteridge Bury Campus
Luton
Bedfordshire
LU2 8LE

(Insert date)

Dear (insert person’s name),

This letter is an invitation to participate in a research study. I am a part-time PhD student with the Institute for Health Research at the University of Bedfordshire under the supervision of Dr. Chris Papadopoulos and Professor Gurch Randhawa. My study aims to explore the experiences of mental health nurses in the aftermath of a completed patient suicide. I am also an employee of the University of Bedfordshire.

The death of a mental health patient by suicide can have a profound and complex effect on families, relatives and friends. There is much research that looks into the experience of suicide survivorship for this group. However, there is little research that looks into the experiences of registered community mental health nurses who may have formed a close therapeutic relationship with the patient prior to suicide.

Finding out about the experiences of community mental health nurses as suicide survivors will provide some insight about how suicide prevention and intervention can be further developed in community care.

The research will be carried out in two stages. First, I want to undertake a pilot study with up to five participants in order to review, adapt and refine the research process and the interview schedule that is going to inform the main study. The findings and lessons learned from the pilot study will then lead into the main study.

I would like to talk to registered mental health nurses working in a community setting within Oxford Health Foundation NHS Trust who have survived a patient suicide in a community setting in the United Kingdom between January 2002 and 2014. As a nurse working in the community, you play a very important role in the prevention of suicide and your input would provide key information and opinions to this study. I would therefore like to invite you to participate in an individual interview.

This research study is qualitative in nature and as such will use a semi-structured conversational interview approach. I will ask you to tell me about your experiences as a patient suicide survivor. If you agree to participate, I will contact you to set up the interview at a mutually convenient time. The interview will probably last about an hour but could possibly last longer. To ensure the accuracy of your input, I would ask your permission to audio record the interview.
Participation in this interview is entirely voluntary. You may decide to withdraw from this study at any time, without negative consequences, simply by letting me know your decision. All information you provide will be considered confidential and the data collected will be kept in a secure location and confidentially disposed of once the research study has been completed. I can also confirm that this study has been reviewed and received ethics clearance through a University of Bedfordshire Institute for Health Research Ethics Committee.

If you are interested in participating in this study and you would like to know more, please contact me by email: melsina.makaza@beds.ac.uk or by my phone number: 07476 286061

Thank you in advance for your interest and assistance with this research.

Yours sincerely,

Melsina Makaza
PhD Research Student
Appendix 7 – Semi-structured Interview Schedule for Pilot Study Interviews

Semi-Structured in-depth interview Schedule for Interpretative Phenomenological Analysis (IPA)

Theme: Exploring the experiences of mental health nurses in the aftermath of a patient suicide in the community.

1. Can you tell me how you came to be a community mental health nurse?
   Possible prompts: when did you start? What made you start?

2. Please tell me about the nature of the work that you currently do in the community?
   Possible prompts: the nature of your community team? What things are involved? Describe a typical day?

3. As you know, my study is about surviving suicide. Since joining the community, can you tell me about your experience of a patient dying by suicide?
   Possible prompts: When did it happen? What happened? Can you describe how you felt at that time?

4. What does losing a patient to suicide mean to you?
   Possible prompts: What does it mean to you as a mental health nurse? What does it mean to you personally?

5. Can you tell me what happened to you after the patient completed suicide?
   Possible prompts: Can you describe how you felt at that time? What did you do to cope? Was there anything else that helped you to cope?

6. How has this experience affected your current practice in the community?
   Possible prompts: Is there anything that you are now doing differently? Can you give me some examples?

7. What are your views about the support that you received at the time of the completed suicide?
   Possible prompts: What was the source of the support? How long did it last? Can you describe how you felt at the time?

8. What does this experience of a completed patient suicide mean for your future practice in the community?
   Possible prompts: Can you think of anything that you will do differently in the future?

9. Do you have anything else that you wish to add?

Thank you for participating
Appendix 8- Confirmation of Support Arrangements for Participants Immediately After the Pilot Study Interview

Oxford Health NHS Foundation Trust

Melsina Makaza
PhD Research Student
Institute for Health Research
Putteridge Bury Campus
University of Bedfordshire

6th August 2014

Dear Melsina,

"Exploring the experiences of mental health nurses in the aftermath of a patient suicide in the community" – Provision of support for participants who may become distressed after an interview

Karen Lascelles (Suicide Prevention Lead) has informed me that you are a PhD Student with the University of Bedfordshire’s Institute for Health Research who is doing a pilot study about the experiences of mental health nurses after a patient dies by suicide.

I understand that for your pilot study you will be interviewing 6 mental health nurses who have survived a patient suicide and that there is a possibility that your participants may experience emotional distress after the interview. Having met with Karen, we have agreed that, on behalf of the Department of Spiritual and Pastoral Care, I will be the named person that the nurses can contact, should they require extra support. Therefore, please go ahead and add my name to the information sheet that you give to your participants.

Yours sincerely,

Guy Harrison (The Revd)
Head of Spiritual & Pastoral Care
Appendix 9 - Information to Support Participants after Pilot Study Interview

Information to Support Registered Mental Health Nurses after Participating in a Research Interview

Study title: Exploring the experiences of mental health nurses in the aftermath of a patient suicide in the community – A Pilot Study.

Thank you for sharing your experiences about surviving a patient suicide in the community. The Lead Researcher appreciates the time that you have taken to participate in the individual interview.

As you have been discussing sensitive information about your experiences after your patient died by suicide, you may become distressed when talking about and making sense of your experience during or after the interview. This information sheet is designed to guide you towards obtaining additional support should you feel that you need it after you complete the interview.

Internal Support within Oxford Health Foundation NHS Trust

Immediate Telephone Support.
Should you require immediate telephone support after the interview, please contact:

Guy Harrison (Head of Spiritual & Pastoral Care).

The Spiritual and Pastoral Care Service offers spiritual and pastoral care, confidential listening, short-term counselling and team support.

Telephone number: 0845 219 1145.
Email: guy.harrison@oxfordhealth.nhs.uk

Occupational Health
You can self-refer to the Occupational Health Team who offer advice and support to manage your health and wellbeing. The service can also offer fast track access to counselling.

Contact: 0845 219 1150

Improving access to Psychological Therapies (IAPT)
The Improving Access to Psychological Therapies service can help through offering a range of short-term talking therapy treatments. You can self-refer to this service.

Contact numbers:
0844 225 2400 (Healthy Minds, Buckinghamshire)
01865 325 777 (Talking Space, Oxfordshire)
01793 836836 (LIFT, Swindon & Wiltshire)

External Support

Royal College of Nursing
The professional body provides free short-term counselling and psychological support for members. National contact: 0845 7726100 or email: counselling@rcn.org.uk

**Primary Care Support. - Your General Practitioner**

Should you feel that you need extra support, it is possible for you to obtain it from your local General Practitioner (GP) via your local GP Surgery. Your GP may be in the best position to signpost you to Counselling Services that you can access.

**Online Support**

You can also access self-help websites such as:

**Healthtalkonline**

This is an online resource with reliable information on a variety of health care topics, including Bereavement by Suicide. It has been developed by a Charity called DIPEx working in partnership with the Health Experiences Research Group at Oxford University’s Department of Primary Care. It has life experiences about suicide survivorship that are presented in text and audio-visual format.

It can be accessed on the internet via the following web link: [http://healthtalkonline.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics](http://healthtalkonline.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics)

**Survivors of Bereavement by Suicide**

National Helpline ~ Open from 9am to 9pm daily: 0300 1115065
Website: [http://uk-sobs.org.uk/](http://uk-sobs.org.uk/)

This website has information about suicide survivorship which includes a section for health care professionals. It signposts you to more information about how suicide bereavement is different; support available for survivors; postvention; education and training; national and local suicide prevention strategies as well as resources for professionals.

**Department of Health Document:** "Help is at Hand: A resource for people bereaved by suicide and other sudden death" by Hawton et al. (2008).

This document was designed by Professor Keith Hawton (Oxford Centre for Suicide Research) in 2008. It is a resource that provides information for people who have survived a suicide, including professionals. A hard copy of this Guide is attached to this information sheet for you to read after the interview.

**Who can I contact if I have any concerns or questions?**

If you have any questions or queries, please feel free to contact the Lead Researcher:

**Melsina Makaza**
Lead Researcher & PhD Student
Institute for Health Research
University of Bedfordshire
Buckinghamshire Campus
Oxford House
Oxford Road
Aylesbury
Buckinghamshire
HP21 8SZ

Email: melsina.makaza@beds.ac.uk
Telephone: 07476 286061

Director of Studies & PhD Supervisor
Dr Chris Papadopoulos
Senior Lecturer in Public Health
Department of Clinical Education and Leadership
Faculty of Health & Social Science
Putteridge Bury Campus, Luton
Email: Chris.papadopoulos@beds.ac.uk

Director of Institute for Health Research & Second PhD Supervisor
Professor Gurch Randhawa
Professor of Diversity in Public Health
Institute for Health Research
University of Bedfordshire
Putteridge Bury Campus, Luton
Email: gurch.randhawa@beds.ac.uk
Telephone: 01582 743797
Appendix 10 - University of Bedfordshire Personal Safety Guidelines for Researchers – Used for Pilot & Main Study.

Personal safety guidelines for researchers

The measures outlined below may help ensure the personal safety of researchers/interviewers undertaking fieldwork in potentially challenging or unsafe situations. The following must, however, be borne in mind.

- Many fieldwork situations pose few risks and it is not necessary to observe guidelines when they are not appropriate.
- Conversely, such guidelines cannot cover every eventuality and, indeed, in some situations may not by themselves be adequate.
- Alternatively, however, there can be circumstances in which, notwithstanding the presence of some element of risk, observing these guidelines could compromise the objectives of the research involved.

The guidelines should, therefore, be interpreted flexibly. However, it is of paramount importance that in the planning and preparation of any interviews or observational fieldwork, the foreseeable and inherent risks to the personal safety of the interviewers or researchers undertaking that fieldwork should be considered and assessed. Any necessary protocols or safety procedures should be carefully negotiated with and agreed to by the researchers/interviewers in advance. Observing some of the following precautions may involve additional costs and might even impact upon the staffing levels required for a project. In such circumstances, they need to be explicitly factored into the costings of research proposals.

1. Researchers should always carry some accredited form of identification, such as a university ID card and/or letter signed by the staff member supervising the project.
2. Researchers would not be expected to approach any location or enter any premises if they have uncertainties about safety, or else without considering how best they could extricate themselves from the situation in an emergency. Although not every risk can be foreseen, researchers should try and assess what risks might be posed to their own safety by the people they are observing or interviewing, by other people or animals who may be present, and/or by the physical environment in which their investigations are being conducted.
3. Researchers should be offered the opportunity to have a personal alarm and/or a mobile ‘phone when undertaking fieldwork. It should be remembered, however, that effective though such devices can be, the protection they by themselves provide is limited and, in certain circumstances, they may themselves hold dangers (for example, the possession of a mobile ‘phone may expose a researcher to the risk of being robbed). It is important to consider in advance how and in what circumstances they would be used.
4. If it is appropriate - for example, because the research involves social groups or
physical locations that may be subject to police surveillance or where some risk of violence can be anticipated – the police in the locality where the research is to be conducted should be notified in advance in writing. The notification should explain the broad purpose and nature of the research and should specify the period of time during which the fieldwork will take place.

5. If it is appropriate, researchers while they are in the field should establish a call back system. A reliable call back contact – such as the research supervisor, a colleague, a friend or a contact in the fieldwork locality – should be identified; each fieldwork session should be planned and agreed in advance between the researcher and the call back contact; the researcher should report when they are starting and when they have finished the session and, possibly, at pre-arranged points during the session. This procedure will not be effective if the nature of the research does not permit the researcher to precisely plan her/his itinerary in advance or where the call back contact would have no practical way of intervening in the event that the researcher should not report in when expected.

6. Where research necessarily involves ‘cold-calling’, researchers should not enter anyone’s home if they have any uncertainties about safety. If appropriate, an appointment should be made to return and conduct an interview at a specified time (and, if any doubts remain, the interview should be foregone).

7. In certain kinds of fieldwork, it is possible for researchers to work in pairs or in teams. In such situations, it is possible for colleagues to accompany each other into fieldwork situations and/or to wait for one another while interviews are conducted. This is a good way of ensuring the safety of researchers. However, the presence of more than one researcher may on the one hand inhibit the co-operation of research participants while on the other, if a researcher were covertly to rely on the presence of a colleague, this could raise ethical objections.

8. If researchers do not travel to fieldwork locations in their own cars, they should make use of taxis where appropriate (for example, if the fieldwork concludes late at night and/or public transport is unreliable).

https://in.beds.ac.uk/healthandsafety/university/part2/4/412person_safety_research
Accessed 21st July 2014
Appendix 11 – My experience of Data transcription & Analysis During the Pilot Study – A narrative

Data Transcription for the Pilot Study

From my knowledge about qualitative research, I was aware that the process of data transcription is essential to the qualitative research process, which uses audio data that has been collected. To the inexperienced researcher, the transcription process may appear to be a straightforward process where the researcher listens to the audio recording of the interview and they type it up into a document. I certainly had this impression until I actually embarked on the process of data transcription, I was shocked as I discovered that there is much more work that is involved, much more than what generic qualitative research textbooks tend to report. From my first experience of transcribing 6 qualitative data interviews, I learned that transcription is an intense time consuming process which requires great skill, patience and resilience on the part of the researcher, who is sitting on the edge of analysis but cannot start analysis until all transcripts have been completed (Braun & Clarke, 2013). Transcripts that are used in the academic community can verify the validity of the claims and observations made in an empirical study. By engaging in transcription, I learned that human communication is a multifaceted phenomenon, which involves pauses that are carefully timed, with gestures and speech which are designed to convey meaning in different contexts (Jenks, 2011). In IPA, a verbatim transcription is required so that the words that are said by the interviewer and the participant is recorded to allow for a descriptive, linguistic and conceptual analysis of the data. Usually, the words are spelt conventionally, unless the participant uses non-conventional words. Notable non-verbal expressions which include the use of para-language, expression of emotions through laughing or crying or any pausing within the conversation are included in the transcription (Smith et al., 2009). With regards to the formatting of the document, the transcripts should have wide margins to enable the researcher to code themes with ease and
physical space should be left in between each turn in the conversation between the researcher and the participant (Smith et al., 2009, Braun and Clarke, 2013). After consulting this IPA guidance on transcription, I applied it to my own research activity as I diligently engaged in the process of data transcription. I quickly discovered that although the task and process of transcription was not so simple, I managed to complete the transcription of all six pilot study interviews, and I developed a much deeper understanding of the participants world view.

Looking back, I recognise that it was a real challenge for me to transcribe my first interview and it was a steep learning curve. However, I persisted with learning the skill as I was determined to see it through. I allowed myself the time to learn and make mistakes until I finished my first transcript. I came to realise that for 1 hour of audio data, it took me 12 hours to transcribe. However, as I systematically worked through each transcript, I began to speed up a little bit, until it took me approximately 10 hours to transcribe one hour of data, which I thought was a major achievement. Braun and Clarke (2013) recommend that new researchers must develop patience as they develop this really good skills that is essential for any qualitative researcher working with audio data. Initially, I did find transcribing to be anxiety-provoking, because this was my first experience of transcribing audio recordings, and I was keen to do my best. Prior to this, I had read and analysed transcripts that were written by other researchers and was overwhelmed by how well their finished version looked, without fully appreciating that these researchers also had to learn how to transcribe in their research journey. The sample transcript provided by Smith et al. (2009) provided a visual example of what an IPA transcript should or could look like, so this this gave me a framework that I could follow. I found that once I started to listen and transcribe, I began to immerse myself into the data and consequently, into the participants’ lifeworld (Ashworth, 2003). By the time that I had transcribed the sixth interview, I had learned so much from the participants, I had learned about
my own style of interviewing and I got to appreciate the importance of preparing audio data for analysis after completing the challenging but rewarding task of transcription.

**Data analysis for the Pilot Study**

Once data had been transcribed, I analysed it using Interpretative Phenomenological Analysis (IPA) which has set of shared procedures such as moving from the particular to the shared whilst using thematic analysis that moves from the descriptive to the interpretative (Smith et al., 2009). IPA is also characterised by principles which demonstrate the researcher's commitment to understanding the participants’ point of view with a psychological focus on how the participants makes sense of experiences within particular contexts (Brocki and Wearden, 2006; Smith et al., 2009). My understanding of IPA was enhanced when I attended a two-day training workshop which introduced me to the key principles of IPA research and it gave me the opportunity to work alongside other IPA researchers (Hefferon and Gil-Rodriguez, 2014). This IPA workshop was facilitated by experienced IPA researchers who had been supervised by Jonathan Smith and it gave me the opportunity to engage in developmental conversations with other IPA researchers. I also attended the London IPA Regional Group Meetings which were held every 2 months at the Tavistock Clinic in London and were facilitated by experienced IPA researchers. I also found it helpful to learn about IPA methodology by being a member of an “IPA Online Interest Group” which is an international network of IPA researchers, including novice PhD research students and is facilitated by IPA authors Jonathan Smith, Paul Flowers and Michael Larkin. In order to begin the stages of IPA analysis, I engaged in a close and detailed reading and re-reading of one transcript at a time and I made initial notes. Next, the I identified, and gathered initial themes which I then clustered into emergent themes. Those themes are then refined and then I moved on to the next transcript. After I had engaged in the
analysis of all the transcripts, the superordinate themes were identified and I created a narrative account of how these themes interconnect (Smith et al., 2009; Finlay 2011).

It was at this stage of analysis that I began to fully appreciate the benefits of having transcribed the data myself because I became fully immersed in the data. In other words, I began to understand and experience the complex nature of analysis qualitative research. I followed IPA guidance and I read through each transcript and I made descriptive, linguistic and conceptual notes in order to become more familiar with the data (Smith et al., 2009; Parys et al., 2014). This initial pilot study analysis gave me the opportunity to begin to develop essential and valuable qualitative research methodology skills and to gain an insight into what it is like to seek the answers to the research question, based on the pilot study interviews which I had conducted. The next section will describe the findings from the pilot study and will outline the lessons that I learned.
Appendix 12 – Confirmation of HRA Approval for Main Study

Miss Melina Makaza
Senior Lecturer in Mental Health Nursing
University of Bedfordshire
University Square
Luton
Bedfordshire
LU1 3JU

19 July 2018

Dear Miss Makaza

Study title: Exploring the experiences of community mental health nurses in the aftermath a patient suicide.
IRAS project ID: 243576
Sponsor: University of Bedfordshire

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales? You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should formally confirm their capacity and capability to undertake the study. How this will be confirmed is detailed in the “summary of assessment” section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a ‘green light’ email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.
How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The attached document “After HRA Approval – guidance for sponsors and investigators” gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:
- Registration of Research
- Notifying amendments
- Notifying the end of the study
The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Chris Papadopoulos
Tel: 01582 743273
Email: chris.papadopoulos@beds.ac.uk
Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 243576. Please quote this on all correspondence.

Yours sincerely

Beverley Mashegede
Assessor

Email: hra.approval@nhs.net

Copy to: Dr Chris Papadopoulos, Sponsor Contact

Mr Gordon Riddell, Oxford Health NHS Foundation Trust, Lead NHS R&D Contact
Appendix 13 - Confirmation of Permission from Director of Education & Development for Main Study

Oxford Health NHS Foundation Trust

Oxford Health NHS Foundation Trust
Unipart House
Garsington Road
Oxford
OX4 2PG

1st May 2018

Melsina Makaza
PhD Research Student
Institute for Health Research
Puttenridge Bury Campus
University of Bedfordshire

Dear Melsina,

Your PhD Research Study

Having consulted with Ros Alstead, Director of Nursing and Clinical Standards, I can confirm that, subject to the required ethical approval, you have permission to contact and recruit registered nurses working within community settings of the Trust for a pilot study as part of your PhD research study: ‘Exploring the experiences of mental health nurses in the aftermath of a completed patient suicide’. Once you have approval to commence the study, please can you contact me to confirm how you plan to contact, recruit and support staff as they contribute to your research.

Yours sincerely,

[Signature]

Helen Green
Director of Education and Development
Appendix 14 - Confirmation of University of Bedfordshire Institute for Health Research Ethics Approval for Main Study

07 September 2018

Melisina Maka
Student number: 95121068

Dear Melisina Maka

Re: IHREC Application No: IHREC876

Project Title: Exploring the experiences of community mental health nurses in the aftermath of patient suicide – An Interpretive Phenomenological Analysis (IPA) Study.

The Ethics Committee of the Institute for Health Research has considered your application and has decided that the proposed research project should be approved with no amendments.

Please note that if it becomes necessary to make any substantive change to the research design, the sampling approach or the data collection methods a further application will be required.

Yours sincerely

[Signature]

Dr Yannis Pappas
Head of PhD School, Institute for Health Research
Chair of Institute for Health Research Ethics Committee
Appendix 15 - Confirmation of Support Arrangements for Participants Immediately after the Main Study Interview

Oxford Health NHS
NHS Foundation Trust

Spiritual and Pastoral Care
Corporate Services Building
Littlemore Mental Health Centre
Littlemore, Oxford, OX4 4XN
Tel: 01865 932760
Mobile: 07786 843676

guy.harrison@oxfordhealth.nhs.uk
Web: www.oxfordhealth.nhs.uk

25th April 2018

Melia Makaza
PhD Research Student
Institute for Health Research
University of Bedfordshire
Putt-end Bury Campus
Hitchin Road, Luton
LU2 8LE

Dear Melina,

Re: “Exploring the experiences of mental health nurses in the aftermath of a patient suicide in the community – an Interpretative Phenomenological Analysis (IPA) Study” – Provision of support for participants who may become distressed after an interview.

Karen Lascelles (Nurse Consultant for Suicide Prevention) has informed me that you are continuing with your part-time PhD with the Institute for Health Research at the University of Bedfordshire. I understand that after successfully completing a Pilot Study in 2014, you are now undertaking the main study about the lived experiences of community mental health nurses after a patient dies by suicide in a community setting.

I understand that for your main study, you are looking to interview 10 mental health nurses who have experienced a patient suicide and there is a possibility that your participants may experience emotional distress after participating in an interview. I have consulted with Karen and we agree that, on behalf of the Department of Spiritual & Pastoral Care, I will be the named person that the nurses can contact, should they require extra support. We have also agreed that if for any reason, I am not available to provide such support; Karen will be the alternative contact for participants.

Therefore, please go ahead and add the contact details for Karen and myself to the information sheet that you give to your participants.

Yours sincerely,

Guy Harrison (The Revd)
Head of Spiritual & Pastoral Care
Oxford Health Foundation NHS Trust

Page 1 of 1
Study title: Exploring the experiences of community mental health nurses in the aftermath of a patient suicide in the community – An Interpretative Phenomenological Analysis (IPA) Study.

Thank you for sharing your experiences about surviving a patient suicide in the community. The Lead Researcher appreciates the time that you have taken to participate in the individual interview.

As you have been sharing sensitive information about your experiences after your patient died by suicide, you may become distressed when talking about and making sense of your experience during or after the interview.

This information sheet is designed to guide you towards obtaining additional personal and professional support should you feel that you need it immediately after you complete the interview.

Internal Support within Oxford Health Foundation NHS Trust

Immediate Telephone Support:

Should you require immediate telephone support after the interview, please feel to contact:

Karen Lascelles (Suicide Prevention Consultant).

Telephone number: 07920 275 028

Email: Karen.lascelles@oxfordhealth.nhs.uk

Karen has many years’ experience in working with mental health nurses and supporting them to develop their skills in the practice of suicide prevention, intervention and postvention. Karen is aware of this study and is willing to talk to you after you have been interviewed by the Lead Researcher.

If Karen Lascelles is not available for whatever reason, an alternative person that you can contact is:

Guy Harrison (Head of Pastoral Care & Staff Support).

Telephone number: 0845 219 1145.
Email: guy.harrison@oxfordhealth.nhs.uk

Guy is the head of staff support and pastoral care. As part of this role, he offers confidential listening, individual short-term counselling and team support for members of staff who may require it. He is aware of this study and is willing to talk to research participants after they have been interviewed by the Lead Researcher.

**Oxford Health Staff Wellbeing Services - Occupational Health Team**

You can self-refer to the Occupational Health Team who offer advice and support to manage your health and wellbeing. The service can also offer fast track access to counselling. For more details, please see: [https://www.oxfordhealth.nhs.uk/careers/staff-wellbeing/](https://www.oxfordhealth.nhs.uk/careers/staff-wellbeing/)

Contact: 0845 219 1150

**Improving access to Psychological Therapies (IAPT)**

The Improving Access to Psychological Therapies service can help through offering a range of short-term talking therapy treatments. You can self-refer to this service.

For more details regarding IAPT Services and contact details, please see the table below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Healthy Minds, Buckinghamshire</td>
<td>0844 225 2400</td>
<td><a href="https://www.oxfordhealth.nhs.uk/healthyminds/">https://www.oxfordhealth.nhs.uk/healthyminds/</a></td>
</tr>
<tr>
<td>2 Talking Space Plus Oxfordshire</td>
<td>01865 325 777</td>
<td><a href="https://www.oxfordhealth.nhs.uk/talkingspaceplus/">https://www.oxfordhealth.nhs.uk/talkingspaceplus/</a></td>
</tr>
<tr>
<td>3 LIFT Psychology Service</td>
<td>01793 836836</td>
<td><a href="https://lift-swindon.awp.nhs.uk/">https://lift-swindon.awp.nhs.uk/</a></td>
</tr>
</tbody>
</table>

**External Support**

**The Royal College of Nursing**

The professional body provides free short-term counselling and psychological support for members.

Please see: [https://www.rcn.org.uk/get-help/member-support-services/counselling-service](https://www.rcn.org.uk/get-help/member-support-services/counselling-service)

National contact number: 0845 7726100 or email: counselling@rcn.org.uk

**Primary Care Support - Your General Practitioner (GP)**

Should you feel that you need extra support, it is possible for you to obtain it from your local General Practitioner (GP) via your local GP Surgery. Your GP may be in the best position to signpost you to Counselling Services that you can access.

**Online Support**
You can also access self-help websites such as:

**Healthtalkonline**

This is an online resource with reliable information on a variety of health care topics, including Bereavement by Suicide. It has been developed by a Charity called DIPEx working in partnership with the Health Experiences Research Group at Oxford University's Department of Primary Care. It has life experiences about suicide survivorship that are presented in text and audio-visual format.

It can be accessed on the internet via the following web link:  
http://healthtalkonline.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics

**Survivors of Bereavement by Suicide**

National Helpline ~ Open from 9am to 9pm daily: 0300 1115065  
Website: http://uk-sobs.org.uk/

This website has information about suicide survivorship which includes a section for health care professionals. It signposts you to more information about how suicide bereavement is different; support available for survivors; postvention; education and training; national and local suicide prevention strategies as well as resources for professionals.

**Department of Health Document: “Help is at Hand: Support after someone may have died by suicide”** by Hawton et al. (2015).

This document was designed by Professor Keith Hawton (Oxford Centre for Suicide Research) supported by Public Health England in 2015. It is a resource that provides information for people who have survived a suicide. A hard copy of this Guide is included in this information pack for you to read after the interview. For an electronic version, please see:  
http://supportaftersuicide.org.uk/support-guides/help-is-at-hand/

**Royal College of Psychiatrists Leaflet: Help is at hand: Post-Traumatic Stress Disorder,** edited by Dr. Philip Timms.

This leaflet was designed for anyone who has been though an unexpected, traumatic and overwhelming experience that was beyond their control. A hard copy of this leaflet is included in this information pack for you to read after the interview. For an electronic version, please see:  
https://www.rcpsych.ac.uk/healthadvice/problemsanddisorders/posttraumaticstressdisorder.aspx

**Suicide Bereavement UK:** [https://suicidebereavementuk.com/](https://suicidebereavementuk.com/)

A key area of action in England's Suicide Prevention Strategy is to 'provide better information and support to those bereaved or affected by suicide,' (DH, 2017). Increasing pressure is being placed on the NHS and Public Health to develop suicide bereavement services locally. However, evidence suggests most professionals, in the UK, who come into contact with this vulnerable population, are often anxious and uncertain how to respond to and care for them. This website provides UK based information which addresses some of the complex issues that arise after the experience of a suicide.

This website provides practical advice on how you can take care of yourself after someone dies by suicide.

Books:


Who can I contact if I have any concerns or questions?
If you have any questions or queries, please feel free to contact the Lead Researcher:

Melsina Makaza
Lead Researcher & PhD Student
Institute for Health Research
University of Bedfordshire
Putteridge Bury Campus
Hitchin Road
Luton
Bedfordshire
LU2 8LE

Email: melisina.makaza@study.beds.ac.uk
Telephone: 07476 286061

Director of Studies & PhD Supervisor
Dr Chris Papadopoulos
Principal Lecturer in Public Health
School of Healthcare Practice
Faculty of Health & Social Science
Putteridge Bury Campus,
Hitchin Road,
Luton, Bedfordshire, LU2 8LE
Email: Chris.papadopoulos@beds.ac.uk

Director of Institute for Health Research & Second PhD Supervisor
Professor Gurch Randhawa
Professor of Diversity in Public Health
Institute for Health Research
Appendix 17 – Letter of Invitation for Participants – Main Study

Melsina Makaza
PhD Researcher
Institute for Health Research
University of Bedfordshire
Putteridge Bury Campus
Hitchin Road,
Luton
Bedfordshire
LU2 8LE

Date: ______________________________

Dear ______________________________,

This letter is an invitation to participate in a research study. I am a part-time PhD student with the Institute for Health Research at the University of Bedfordshire under the supervision of Dr. Chris Papadopoulos and Professor Gurch Randhawa. My study aims to explore the experiences of community mental health nurses in the aftermath of a patient suicide.

The death of a mental health patient by suicide can have a profound and complex effect on families, relatives and friends. There is much research that looks into the experience of suicide survivorship for this group. However, there is little research that looks into the experiences of registered community mental health nurses who may have formed a close therapeutic relationship with the patient prior to the suicide.

Finding out about the experiences of community mental health nurses as suicide loss survivors will provide some insight about how suicide prevention and intervention can be further developed in community care.

The research is being carried out in two stages. First, I undertook a pilot study in 2014, where I was able to interview six participants. This pilot study helped me to review, adapt and refine the research process and the interview schedule. I am now using what I learned from the pilot study in order to inform this main study.

I would like to talk to registered mental health nurses working in a community setting within Oxford Health Foundation NHS Trust who have survived a patient suicide in a community setting in the United Kingdom between January 2002 and 2018. As a mental health nurse working in the community, you play a very important role in the prevention of suicide through risk assessment and management. Your input would provide key information to this study. It will provide your valuable insights and opinions about the lived experience of being a suicide loss survivor after the death of a patient.

Thank you for agreeing to participate in an individual face-to-face interview on ______________ at your Community Mental Health Team Base in

_______________________
This research study is qualitative in nature and as such it will use a semi-structured conversational interview approach. I will ask you to tell me about your experiences as a patient suicide loss survivor. If you agree to participate, I will contact you to set up the interview at a mutually convenient time in a location that is suitable for you. The interview will probably last about an hour but could possibly last longer. To ensure the accuracy of your input, I would ask your permission to audio record the interview.

Participation in this interview is entirely voluntary. You may decide to withdraw from this study at any time, without negative consequences, simply by letting me know of your decision. All information you provide will be considered confidential and the data collected will be kept in a secure location for 5 years after the study has been completed in July 2019. It will then be destroyed after the 5-year time period has ended. I can also confirm that this study has been reviewed and received ethics clearance through a University of Bedfordshire Institute for Health Research Ethics Committee and the National Health Service (NHS) Health Research Authority (HRA).

Should you require more information about this study, please feel free contact me by email: melisina.makaza@study.beds.ac.uk or by my phone number: 07476 286061

Thank you in advance for your interest and assistance with this research.

I look forward to meeting with you on ________________________________.

Yours sincerely,

Melsina Makaza
PhD Research Student
Institute for Health Research
University of Bedfordshire
Information Sheet for Registered Mental Health Nurses

Study title: Exploring the experiences of community mental health nurses in the aftermath of a patient suicide – An Interpretative Phenomenological Analysis (IPA) Study.

You are invited to take part in the above study by attending an individual interview. Before you decide if you would like to take part, please read the following information and feel free to discuss it with others and also with the Lead Researcher.

What is the research about?

This research is designed to find out about the experiences of registered mental health nurses after a patient that they have been caring for in the community has died by suicide. As part of their job description, preventing suicide is a core competency and a major clinical responsibility which falls under the practice of suicide risk assessment and risk management. Therefore, this research aims to look into mental health nurses’ experiences as suicide loss survivors and how they may make sense of a patient suicide. It also explores how mental health nurses carry on with their daily clinical practice after such a significant event.

Why is the research being undertaken?

There is a lot of research that investigates how relatives and family may feel after their relative dies by suicide. However, there are few research studies about the experiences of mental health nurses as survivors of a patient suicide. This study aims to build on what is currently known about nurses as suicide loss survivors. The results from this study will provide some insight into the experiences of mental health nurses working in a community mental health setting.

It will find out what it means for mental health nurses to lose a patient by suicide, the support they received after a patient suicide and will explore what support mental health nurses may need after a patient dies by suicide. Such knowledge will contribute to the development of suicide postvention for mental health nurses which can be incorporated into daily clinical practice on a personal and professional level.

Why have I been chosen?

You have been chosen because you are a Nursing and Midwifery Council (NMC) Registered Mental Health Nurse working in a community setting on a part-time or full-time basis within Oxford Health Foundation NHS Trust and you have experienced a patient suicide from 2002 until the present day. You have indicated that you are willing to be interviewed about your experiences of surviving a patient suicide. If the suicide occurred while you were working for a different Mental Health NHS Trust during this time period, then you are also eligible to participate in this study. Your experiences and views will be very valuable to this research study.

Do I have to take part?
No. Your participation in the study is entirely voluntary and it is up to you to decide if you wish to take part. Your employment with Oxford Health Foundation NHS Trust and your role as a registered mental health nurse will not be affected if you decide not to take part in the study.

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

You will be invited to take part in an individual face-to-face interview with the Lead Researcher. This interview will be arranged at a location of your choice and also at a mutually convenient time. The interview will take up to 60 minutes but could possibly last longer. The interviewer will ask you about your experiences of a patient suicide, the support that you received at the time and what could be developed to support registered mental health nurses in the future. The interview will be audio-recorded, transcribed and then analysed by the Lead Researcher as part of the study.

**What are the potential benefits or advantages of taking part?**

You may find it interesting to be involved in this research study and to be able to contribute to developing the future support mechanisms for mental health nurses who are survivors of a patient suicide, for the benefit of the profession and future patient care. By participating in this research, you may also find that you will have the opportunity to share your untold story in a manner that will provide insight into this under-researched aspect of the work that community mental health nurses experience.

**Are there any risks or disadvantages of taking part?**

The interview will take up some of your time (probably up to 60 minutes). You will also be discussing sensitive information about your experiences after your patient died by suicide. Therefore, you may become distressed when talking about and making sense of your experience. However, you will not be left alone to deal with this. You will be guided towards obtaining additional support should you feel that you need it after you complete the interview.

**Can I withdraw from the study?**

If you decide to take part, you can withdraw from the study at any time without giving a reason. Any information you have already given will be included in the study unless you inform the Lead Researcher that you do not wish it to be used.

**Will the information I give be kept confidential?**

The University of Bedfordshire is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Bedfordshire will keep identifiable information about you until the end of the study. It will keep the research data for 5 years after the study has finished in July 2019.

Your rights to access, to change or to move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information [https://www.beds.ac.uk/about-us/our-university/public-information/gdpr](https://www.beds.ac.uk/about-us/our-university/public-information/gdpr) The Lead Researcher's contact details are at the end of this information sheet. Please do not hesitate to make contact with any enquiries you
may have.

**Where will the information be kept and who will have access to it?**

All the information will be stored in a locked filing cabinet and on university servers that can only be accessed through password protected computers. Only the Lead Researcher will have access to the sensitive information. The information will be kept for 5 years after the study has been completed and the necessary reports have been written, after which all information collected will be destroyed and deleted from electronic files.

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

The study’s results will be presented to the Institute for Health Research, the University of Bedfordshire and Oxford Health Foundation NHS Trust Education Leads. The research results will also be presented at conferences and submitted for publication in journals for healthcare professionals. Should you wish to discuss anything further about your experience of a patient suicide and/or the research process you are welcome to contact the Lead Researcher at any time.

You will have the opportunity to view the transcript of your interview and copies of publications as they are produced. You are also most welcome to attend any of the presentation seminars as the results are disseminated to the Institute for Health Research. This approach is based on Liamputtong’s approach to sensitive research that aims to minimise the likelihood of you as a participant experiencing the research process as a “hit-and-run” event. Rather, it demonstrates that the Lead Researcher aims to deal with the potentially emotive subject matter of suicide loss survivorship with dignity and sensitivity (Liamputtong, 2009*).

**Who is funding the study?**

There is no funding for this study as it is being undertaken by the Lead Researcher in order to meet the requirements of a PhD programme with the Institute for Health Research, University of Bedfordshire

**Who has approved the study?**

The study has been approved by the University of Bedfordshire’s Institute of Health Research Ethics Committee and National Health Service (NHS) Health Research Authority (HRA).

**What do I do now?**

If you are interested in taking part, please respond via email or phone (details of both provided below). The Lead Researcher will then contact you to discuss the study and answer any questions, and arrange a mutually convenient date, time and venue for the interview. You will then be asked to read and sign an informed consent form to take part in the study prior to the interview.

**Who can I contact if I have any concerns or questions?**

If you have any questions or queries, please feel free to contact the Lead Researcher:

**Melsina Makaza**
**PhD Research Student**
Institute for Health Research  
University of Bedfordshire  
Putteridge Bury Campus  
Hitchin Road,  
Luton. LU2 8LE  
email: melsina.makaza@beds.ac.uk  
Telephone: 07476 286061

Director of Studies & PhD Supervisor  
Dr Chris Papadopoulos  
Principal Lecturer in Public Health  
Department of Clinical Education and Leadership  
Faculty of Health & Social Science  
Putteridge Bury Campus  
Hitchin Road,  
Luton  
LU2 8LE  
email. Chris.papadopoulos@beds.ac.uk

Director of Institute for Health Research & Second PhD Supervisor  
Professor Gurch Randhawa  
Professor of Diversity in Public Health  
Institute for Health Research  
University of Bedfordshire  
Putteridge Bury Campus  
Hitchin Road,  
Luton  
LU2 8LE  
Email: gurch.randhawa@beds.ac.uk  
Telephone: 01582 743797

Thank you for reading this information sheet.

Reference List:  
Appendix 19 – Consent Form – Main Study

Consent Form

Study title: Exploring the experiences of community mental health nurses in the aftermath of a patient suicide – An Interpretative Phenomenological Analysis (IPA) Study.

Please sign each box

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information and ask questions and I have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving any reason, without any effect on my employment. I understand that I can ask for my data to be withdrawn from the study should I decide to withdraw.

I understand that the interview will be recorded on a digital recording device.

I understand that direct quotations and the data which is collected from the interview may be used in any publications arising from the study. I understand that the quotations will be anonymous with no person, workplace or NHS Trust identifiable.

I agree to take part in the above study.

_________________________  __________  __________________________
Initials of participant     Date          Signature

_________________________  __________  __________________________
Name of researcher         Date          Signature

When completed: 1 for participant, 1 for researcher
Biographical Data Form

Study title: Exploring the experiences of community mental health nurses in the aftermath of a patient suicide – An Interpretative Phenomenological Analysis (IPA) Study.

Thank you for agreeing to take part. Before we start the interview, please can you tell the Lead Researcher a little bit about yourself by completing this form? This background information about you will be kept confidential. It will be used during the analysis phase of this research study.

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  What is your age?</td>
<td></td>
</tr>
<tr>
<td>2  What is your gender?</td>
<td></td>
</tr>
<tr>
<td>3  What is your ethnicity?</td>
<td></td>
</tr>
<tr>
<td>4  What type of work setting do you work in?</td>
<td></td>
</tr>
<tr>
<td>5  How long have you worked as a registered mental health nurse?</td>
<td></td>
</tr>
<tr>
<td>6  How many years have you worked in your current role?</td>
<td></td>
</tr>
<tr>
<td>7  How many instances of patient suicide have you experienced?</td>
<td></td>
</tr>
<tr>
<td>8  How many days off sick have you had in the last 12 months?</td>
<td></td>
</tr>
<tr>
<td>9  Have you had any experience of work-related stress after the patient suicide?</td>
<td>Yes</td>
</tr>
<tr>
<td>10 Have you had any experience of work-related burnout after the patient suicide?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Thank you for taking the time to complete this form.
Appendix 21 – Semi-Structured Interview Schedule – Main Study

Semi-Structured in-depth interview Schedule for Interpretative Phenomenological Analysis (IPA)

Theme: Exploring the experiences of community mental health nurses in the aftermath of a patient suicide.

1. Can you tell me how you came to be a community mental health nurse?
   Possible prompts: When did you start? What made you start?

2. Please tell me about the nature of the work that you currently do in the community.
   Possible prompts: The nature of your community team? What things are involved? Describe a typical day?

3. As you know, my study is about experiencing patient suicide loss. Since joining the community, can you tell me about your experience of a patient dying by suicide?
   Possible prompts: When did it happen? What happened? Can you describe how you felt at that time?

4. What does losing a patient to suicide mean to you?
   Possible prompts: What does it mean to you professionally as a mental health nurse? What does it mean to you personally?

5. Can you tell me what happened to you after the patient died by suicide?
   Possible prompts: Can you describe how you felt at that time? What did you do to cope? Was there anything else that helped you to cope?

6. How has this experience affected your current work as a community mental health nurse?
   Possible prompts: Is there anything that you are now doing differently? Can you give me some examples?

7. What are your views about the support that you received at the time when your patient died by suicide?
   Possible prompts: What was the source of the support? How long did it last? Can you describe how you felt at the time?

8. What does this experience of losing a patient to suicide mean for your future practice in the community?
   Possible prompts: Can you think of anything that you will do differently in the future?

9. Do you have anything else that you wish to add?

Thank you for your participation.
Excerpt from Rachel's Interview Transcript with Emergent Themes & Quotes

<table>
<thead>
<tr>
<th>Emergent Theme</th>
<th>Rachel's Interview Transcript Comments from the transcript including the line number</th>
</tr>
</thead>
</table>
| 1 The time spent working with the patient. | “….he had come in for an assessment with me and ummmmm…I hadn’t actually realised…or I hadn’t remembered…until I got back and looked at the notes that how short a time that we had actually worked together?” (Lines 52-54)  
“So it was only about 3 weeks….” (Line 56)  
“I met him on the 12th March and he died on the 31st…and……ummmm…I felt actually like it was a lot longer” (Line 58-60)  
“And I felt, I felt like I couldn’t mourn because it wasn’t my place to. And also because I hadn’t known him that long. It felt like quite a strange grieving process…it was a strange grieving process…and strange to miss someone I hardly knew.” (Lines 595-598) |
| 2 Evaluation of the therapeutic relationship: “I was happy with the standard of care that I had given” | “built a good therapeutic relationship.” (Line 66)  
“I think one of the…one of the biggest things was…ummmm…something that was actually quite helpful…and made me ummmm…cope a little bit better…was that my paper work was “shit hot”. It was all in order, it was exactly…and like…up to date…everything was documented exactly how I thought of it…”  (Lines 345-349)  
“all the different people that needed to be involved were involved and I was happy with the standard of care that I had given. And I was happy that I had documented everything! And there was nothing that I could have physically done…and there was nothing more that anyone could have physically done.”  (Lines 349-353)  
there wasn’t like…Oh, I should have done that a while ago and I never got round to it…or…why haven’t I thought of…getting that team involved because I had done it all. And I felt quite confident in that…and that’s what…er…yeah…that made it a little bit easier…” (Lines 355-358) |
| 3 The element of surprise: I thought he was getting better, then he died suddenly. | “a lot of other things that were going on in his life…he’d changed schools ummm…due to his behaviour…ummm…and…was feeling suicidal. And we had concentrated on our sessions in coping skills and things like that. He’d responded really, really well to those…ummm…was implementing a lot of them within a couple of weeks”. (Line 67-71) |
“…his mum said, “After your last session, he was in the best mood we’d seen him in a long time!” She said…ummm…” He sang all the way home to me! [laughs out loud] and “he seemed to be in pretty bright spirits…and then he’d had a really good weekend, gone out with his mates skating for the first time in ages.” (Lines 76-80)

“the way that it all came about was…Monday morning…umm…we’d got a phone call at 5 minutes past 9…and I hadn’t got to my desk yet because I was in the kitchen making coffee….ummm….got another phone call…at quarter past 9 and…and….mum said, “Just calling to let you know that Sam’s jumped off a building and we are about to switch off the life support.”

4 Absolute shock.

“it was a shock to them as well…as to me…” (Lines 80-81)

“my….colleague who was…who is an administrator had that message [about the suicide] told to her…(raised voice) and she was in such a state of shock….she had a massive grin on her face….as she came into the office and told me that. And I was like, “You’re joking?” and she was like, “No!!”… I was like, “You are joking!!” She said, “No!!” ….just this massive smile. And I was like, “You are joking!!” and just burst into tears!”

I was in absolute shock!! Ummm…I bawled my eyes out….for the entire day…umm (long pause) and I just felt….really responsible and really guilty…..for quite a long time. (Line 101-103)

“When it [suicide] does [happen], I think when it does, that’s when people are shocked. Ummm…and also feel a little bit…ummm….I’ve heard other people say it recently…sort of, “I know I shouldn’t because obviously I’m a mental health nurse and this sort of thing happens…but I’m really shocked…and upset that this has happened to me. Or the person I am working with. Ummm…but I almost feel like a little bit embarrassed…like they should be able to cope with it.” (Lines 505-510)

“it’s probably something that we put on ourselves…ummm…I don’t remember anyone ever telling me that I should be able to cope…ummm…but it was very much the thing that I felt.” (Lines 513-515)

5 Overwhelming feelings of guilt

“I remember feeling like the next few days…really guilty that…that day, he would never have experienced that thing and he wouldn’t have grown up”… (Lines 113-114)

…”as I kept thinking of these opportunities that he’d missed out on, I just felt more guilty and upset.” (Line 116-117)

“Umm…yes, I think ummm….the guilt was probably the most, well…obviously the sadness…and sort of regret, but that was
| 6 | My identity and responsibility as a nurse | “I remember just thinking that it was [becomes tearful] my responsibility.....[soft sobbing].....to make him feel better....[sobbing]....” (Lines 136-137)  
“I just sat…err…crying uncontrollably…” (Line 254-255)  
“Yeah, I just remember really feeling responsible. That I should have made him feel better.... Not so much now, but very much in the first 6 months…” (Lines 144-145)  
“And also, that feeling of responsibility! And I really think that in the nursing culture, and I don't know whether it’s part of our training or part of who we are…that we go in to become nurses…but we take on so much for other people and we would put other people before our own health, before our own families, before our own bladders and stomachs! You know like, if you need that, I'll do it for you…it doesn't matter that I am sacrificing myself…” (Lines 167-172)  
“So, there is always that “what if?” in the back of my mind….ummm…and that responsibility sharing and ummm...things like that…. Ummm…I think I was a little bit more cautious…for the first few months…and a little bit unsure…of myself…. and ummmm...double checking things…” (Lines 365-369) |
| 7 | Unwritten rules: nurses should be able to cope with equanimity. | “I would say that most people do feel like that…ummm…there are a lot of “shoulds” in nursing…you know…unwritten rules….ummm… I think probably…you should put yourself first…you should just be able to cope with it…you should just get on with it...(laughs out loud)…..ummm…probably conscious that we probably put this upon ourselves.” (Lines 520-524)  
“you've done something wrong…or you're not a good nurse…or good enough…or like other colleagues…or… And I think especially in mental health, you know….ummm…i always find it a little bit ironic of how…not everywhere or everyone… but how there can still be a huge stigma around mental illness in mental health nurses or staff who work in mental health services.” (Lines 530-534)  
“It’s not talked about and it is looked down upon as, “You can’t do your job if you’ve got anything from stress to depression…anxiety or more severe…ummm…illnesses…ummm….so I do think there’s this element of, “You should be able to handle it!”. Ummmm…and if you can't, then you can’t do your job…or anything. Now, I am not saying that’s what happened in this situation, but there is that
culture and I still find it SO surprising…that we are telling everybody else…“It’s OK…to not be OK…and it’s OK to just talk about it…ummm…and ummm…that’s not what we are telling each other or ourselves.” (Lines 535-542)

“Or it’s tolerated to a certain degree. “You’re stressed…ok….what can we do?” …Ummm…but then at some point…you are just not cut out for this job. That is the worst statement, like you are expected to be some…super resilient human being…or not even being a human being…because that wouldn’t exist…to be a mental health nurse. And yeah…you do have to be resilient because of the things that you have to do and to be and to hear…people’s projections onto you…ummm…but it’s still OK to feel…” (Lines 554-560).

8 Self-blame
“I feel I should have done something more”

“In these situations, you do…. you do and you do blame yourself and you think: “What else could I have done?” (Line 105-107)

“learning what it’s like first-hand has…taught me what you need in that moment…how you might feel…ummm…and really understanding what it’s like to feel that, “I am to blame”. Because I think a lot of people talk about it…a lot of people brush it off…” …No, you don’t! No, you don’t! No, you’re not!” And it’s like…”No, they are not (to blame)….but they really feel they are…so err…knowing that saying that, “No you’re not [to blame]” isn’t going to fix that for that person.” (Lines 458-463)

“Rationally, I knew that if he wanted to end his life he would have been determined enough to…to find a way around that…And, you know, that even if I had known that and even if I had spoken to him, just before…there would have…if he was in that frame of mind then there wouldn’t have been anything that I could have said. Ummm…but I still felt like there could have been something…that I should have done something”. (Line 107-112)

9 Failure

“I think…. ummm…very much at first it felt like I had failed” (Line 127)

“…feeling like I have really failed him ummm…and I think, I think earlier on….my feeling of making statements to myself or other people of…ummmm…

I have failed as a nurse and I…I couldn’t keep him safe and that was my job…ummm very much in the beginning…but then obviously as time goes on, you do…. you are able to rationalise it.” (Lines 145-150)

“You feel like a failure [when you don’t cope, or you break down after a patient suicide]” (Line 526)

10 Reality versus imagination:

“a friend that I had trained with…ummm…who’d had…ummm…the same experience about a month before…ummm…I actually said
<table>
<thead>
<tr>
<th>Concern for the deceased: “Did he meant to die? I will never know”.</th>
<th>“I didn’t realise how bad it feels to lose a patient to suicide”.</th>
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</thead>
<tbody>
<tr>
<td>to her, “God, I’m sorry I wasn’t there for you a bit more…I didn’t realise it would have felt this bad! Like I knew it would have felt bad, but I should have checked in more…” (Lines 156-160)</td>
<td>“How I’d felt a month before when my friend had told me about her patient…ummm…that sort of helped me understand…that you don’t really realise how bad it feels until it happens to you.” (Lines 195-197)</td>
</tr>
<tr>
<td>“like friendships, relationships, experiences, independence, ummmm….rites of passage…all sorts of things….so…personally, I just…I just felt really sad that he’d missed that.” (Lines 210-212)</td>
<td>“I’m surprised that I got upset about it today.” (Line 576) “I thought I’d come to terms with it a lot more…” (line 578)</td>
</tr>
<tr>
<td>“It’s just all really sad.” (Line 583)</td>
<td>“Another thing that I thought about quite a lot was…did he…did he really want to?” (Lines 214-215)</td>
</tr>
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<td>“I’ve always wondered…did he…did he mean to die?” (Lines 218-219)</td>
<td>“I just would hate the idea that he…err…was filled with regret as well.” (Lines 223-224)</td>
</tr>
<tr>
<td>“Never really knowing…ummm…I mean…none of us know…none of us will know…but I thought about that quite a lot…ummmm…not wanting him to feel like burdened or anything…” (Lines 226-228)</td>
<td>“We concentrate so much on the bad things that happen”</td>
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<td>“Some of our colleagues…you know…..try to say…but think of how many people you could have tried to save and you don’t even know it. Because of…you know…we concentrate so much on the bad things that happen, we don’t really celebrate all the achievements…that we make and that’s kind of a model that we have in health care that we…really concentrate on those rare massive bad things but we don’t celebrate the hundreds of achievements that we achieve each week…”</td>
<td>“Yeah…so…that day…I stayed at work, but I didn’t have any clinical work to do…my colleagues just took it all….and I think I”</td>
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<td>“so…it’s hard to know which people you’ve made that sort of a difference to…..but…that’s a more positive way of looking at it.” (Lines 238 – 245)</td>
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the suicide. just sat with different people in their offices for a little while” …(Lines 251-253)

“Like I just went to the park just around the corner and called my mum…” (Line 253-254)

“I had a week off work…and in the middle of that week, my then Deputy Manager was working part-time, so she said, “Would you like to meet for hot chocolate in the middle of the week?”…Ummm…so we met up and she…we just talked about it and ummm…she’d had a patient and umm…had died I think a couple of years before that…and so we were just talking about that and shared experiences really…normalising some of what I was feeling….ummm…but that was really helpful…I really valued that…” (Lines 263-269)

“I thought it (the support) was brilliant. It was just what I needed at the right time to be honest with you”.

“Ummm…I felt supported by my team…my managers, also the Trust.”

Umm…Even like later on, when it came to writing up Coroner’s reports and things….I had someone who came and met me here…ummm…they talked me through what I needed to do…they talked me through the process…answered any questions…told me about like the legal side of things and what it all meant….ummm…talked about what to expect at Coroner’s or what would happen…and then ummm…at Coroner’s, my manager went with us.” (Lines 398-405)

“and then afterwards, in terms of sort of my caseload and day to day work…and…ummm…the counselling that I got…from the Trust. Ummm…yeah, I don’t think there could have done anymore to be honest.” (Lines 407-410)

“I remembered the support that I got and what was important to me then…and so I could do that do that for someone else then. Ummm…and they said that it was really helpful.” (Lines 419-421)

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<tr>
<th>14</th>
<th>Courage to reconnect with clinical work.</th>
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<td>“I’m glad I didn’t take longer…because I would have found it hard to come back to work and my manager recognised that at the time. So said, “Just have a week…come back”…and I think I did like a phased return just to ease me back into things and some…some of the scarier things like big assessments and stuff…were taken off and I just did a little bit.</td>
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<td>Ummm…and….so obviously there lots of big meetings going on…lots of liaison reports and stuff…and my manager just took all of that off me…ummmm…errr….and then…like the next day…or like the next week…maybe when I was back rather…so fed back</td>
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| **15** Funeral attendance - seeking closure | “errr….and…they also…the doctor and my manager…they also supported me and we went to his funeral.” (Line 300-301)  
“I wanted to go…err…for closure…but also…ummm…to show that I was really sorry to the family. But at the same time…I felt like…errr….now…what’s the word…[long pause]…ummm…I’m not sure of the words…not an intruder…but like how…I wasn’t really welcome there. That is not what the family said or did—or anything…they were so consumed by grief…they wouldn’t have noticed anybody else…ummm…bit I…I felt like everyone was looking at me and it was…..ummm….I think it was my fault….probably looking at me because I was just crying unconsolably……outside…” (Lines 305-313)  
“it was just strange being at a funeral for someone so young as well and all these young people and like they had all his favourite music!” (Lines 316-318)  
“I was glad I went…Ummm…but I think I also felt embarrassed about being there…and crying so much. (Laughs softly)” (Lines 333-334) |
| **16** Moving forward with empathic understanding: “Waking up after every mental health nurse’s worst nightmare!” | “We always think it won’t happen to me. Ummm…you know that’s something that people have been talking about recently…you know with this incident. Ummm [long pause]…I think…practice wise is about that empathy for other people who are in that position.” (Lines 449-452)  
“Obviously it is a risk of mental health nursing…that people will hurt themselves or other people. Ummm…there is always that risk of working with people…that unpredictable things will happen…And we talk about suicide and self-harm with every patient we have…and we risk assess every patient we have…ummm…and we try and determine…based on what they have said how likely that would be…what their intent is…and we see so many… So for most people (nurses), they’ll assess two new people every week…you see so many young people in a year…and ummm…you know that it can happen…but you just don’t think it will happen to you!”  
“it’s err…I guess it’s a…it’s….it’s a mental health nurse’s worst nightmare! It’s the thing you dread the most, ummm…that someone will come to harm or…and end their life because of their mental health. Ummm…It’s a risk that we all carry every day potentially with every patient…” (Lines 497-501). |
“my role has changed a little bit...so a more managerial role, I still have a clinical caseload, I still see patients...but I think that is more...ummm...from what I've taken from it...of, “How can I support other people if this happens to them?”.” (Lines 454-457)

17 Lessons learned: “It taught me to have empathy and to support other nurses after their patient dies by suicide”.

“At least it taught me...it taught me a lot.” (Line 439)

“in terms of my clinical practice, (long pause) ...again it’s difficult because there wasn’t really any learning from his death in terms of what could have prevented it.” (Lines 465-467)

“because everything that should have been done was done. Everything that could have been done was done...and it wasn’t appropriate to do anything else like admit [him to hospital] or anything else like that. So even though in hindsight it would never have been appropriate or met the threshold. So it was kind of hard to know...ummm...what to learn or what to do differently next time. Ummm...But I think I’ve been on a bit more training and done a lot of sort of ummm...there like a suicide prevention day that they do and conferences...ummm...and I go to those.” (Lines 469-475)

“...there wasn’t one particular learning point. I think it’s more about the empathy and support for other people...rather than the clinical...the clinical points.” (Lines 483-485)
Rachel's Transcript – Page 10 & 20
CPNO1: Ummm... because when positions change... my role has changed a little bit... so a more managerial role... I still have a clinical case load... but... I think that is more... Ummm... from what I’ve heard from it... or? How can I support other people if that happens to them? That’s been the biggest change in that... learning what its like first hand has taught me what you need in that moment... how you might feel... you’re not a mental health nurse. - It’s like being in a moment and understanding what it’s like to be in that... I am to blame... because I have a lot of people talk about if a lot of people have a lot of... I don’t think... you don’t... no you don’t! No you don’t! And it’s like... no, they’re not... they’re not... they’re not... in that... it’s not a blame game... but they’re really... they’re... so... err... knowing that paying that...
Appendix 23: Images showing how I undertook data analysis and clustered ordinate themes based on IPA process suggestions as published by Gee, (2011)
357
Appendix 24 – Master Table for Superordinate Theme 1 - “The experiential significance of a therapeutic relationship ending unexpectedly for the mental health nurse” – Developed after a cross case analysis.

<table>
<thead>
<tr>
<th>Participant Name &amp; Emergent Theme</th>
<th>Supporting Quote</th>
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<tbody>
<tr>
<td>Absolute shock (Rachel)</td>
<td>“it was a shock to them as well...as to me...” (Lines 80-81)</td>
</tr>
<tr>
<td>Overwhelming feelings of guilt (Rachel)</td>
<td>“Umm...yes, I think ummm....the guilt was probably the most, well...obviously the sadness...and sort of regret, but that was probably the...one of the biggest, most overwhelming feelings.” (lines 119-121)</td>
</tr>
<tr>
<td>Absolute tragedy and devastation (Liz)</td>
<td>“Absolutely devastated. Ummm...because we hadn’t...you know...the Crisis Team felt that he was really improving, ummm...and...you know, the plan was that he was going to be discharged back to my care...” (Lines 133-136)</td>
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<td>“Ummm...I think it’s just the tragedy of that.” (Line 296)</td>
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<td>“she found him. Which was pretty tragic” (Lines 224-225).</td>
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<td></td>
<td>“it was really...really sad...it was really a tragic...” (Lines 243-244)</td>
</tr>
<tr>
<td>After the suicide: Tragedy! (Peter)</td>
<td>“But at the same time, very tragic that they couldn’t engage, or I couldn’t reach them.” (Lines 406-407)</td>
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<tr>
<td>Shock (Peter)</td>
<td>“the Coroner’s Inquest said that it was alcohol related death [by suicide]. Ummm...and that came as a shock for both...myself and my colleague” (Lines 114-116)</td>
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<td>“That was my first initial...apart from the sss...the...the shock...and how tragic it was...but also potentially, how understandable it could have been for him...to feel like this..” (Line 234-237)</td>
</tr>
<tr>
<td>The lived experience of</td>
<td>“Yes, this is the only person that I have ever experienced this with....” (lines 77-78)</td>
</tr>
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</table>
| Having a patient die by suicide: “This is the only person that I have ever experienced this with.” | “I worked with [the patient] for about eight months” (Line 135)  
“And it does make you…you know…I still cover the patch where he lives…lived…and I drive up that road a lot….and I drive up past that train station a lot…you think of it every time…” (Lines 630-632) |
| --- | --- |
| He lives in my psychological caseload (Mary) | After the suicide: Shock! (Mary)  
“….because I was on leave, but his wife rang in to admin…to reception…and spoke to our admin…and told admin what he’d done [died by suicide]…so of course it was a shock for them…” (Lines 272-273)  
“you know, from looking outward, you know, he was doing all these things…and…ummm…so, it was a shock really.” (Lines 142-144) |
| Strong emotion of Guilt (Hannah) | “Ummm…and I think primarily because I had a very strong emotion of guilt. I thought, “Oh, my god, If I had actually seen you…could have I stopped it?”.” (Lines 123-125) |
| Feelings of absolute shock! (Hannah) | “Ummm…how did I feel? Just gutted! She was beautiful…she was pretty, and she was bright…and ummm…you know…and stubborn and all of these things…and umm…you know…just, just shock…shock…absolute shock….and just gutted!” (Lines 284-287)  
“Yeah, with both of them, it’s a very physical sensation…it’s like…I wanna…I wanna be sick…ummm…of just shock.” (lines 312-314) |
| After the suicide – Feelings of shock, sadness & tears (Jessica) | “Initially, I didn’t know what to think of it…apart from…apart from having that gut wrench as soon as I heard…like…like…yeah…. A lot of shock! [Nervous laugh] But ummm…yeah, you sort of go through all sorts of emotions…really… [Long pause]…yeah…” (Lines 614-620)  
“It’s really sad…[becomes tearful]… It’s really sad…because…I…you think….I don’t know…even if he’d given a little bit away…that might have made a difference…Yeah…sad [tearful]” (492-494) |
| Anger (Jessica) | “I found this very confusing…and then I did feel quite angry… [Long pause]” (Lines 600-601)  
“And I suppose it was a bit…yeah, I was a bit angry coz it…it…you know…every… There are gonna be questions we never get answers to…” (Lines 603-605) |
<table>
<thead>
<tr>
<th>Experience</th>
<th>Text</th>
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<tbody>
<tr>
<td>The lived experience of losing a patient to suicide for the first time:</td>
<td>“Ummm… the first one… So, I’d started in November… so it was July… July the ninth actually… 2013… I don’t think I’ll ever forget it… it’s ironic how you remember the death to the day… when the first phone call comes in…” (Lines 114-117)</td>
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<tr>
<td>“And that call that had come through… on my god, my skin is going… just thinking about it now…” (Lines 186-188)</td>
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<tr>
<td>“It was just heart-breaking! And I still… I am getting upset now… because I just feel… I feel desperately upset and sad for her… ummm… and it was awful…” (Lines 194-196)</td>
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<tr>
<td>Trauma after the first suicide: Horrendous visualisations about the death.</td>
<td>“And I had absolutely horrendous visualisations… it was the first one… you know… it’s just like everyone remembers their first one… of seeing… I just almost fantasize… almost that I can see her hanging! It was horrible!” (Lines 196-200)</td>
</tr>
<tr>
<td>“when I was in… on my own… a few times when the kids were outside… I could almost… I was having almost these weird thoughts of seeing her and it was just… I was SO traumatised by it and it was awful!” (Lines 202-205)</td>
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<td>After the first Suicide: Feeling numb…</td>
<td>“I was feeling a bit… kind of… numb… about it… ummm… [long pause] …. trying to kind of process how you feel… but not really being sure…” (Lines 435-456)</td>
</tr>
<tr>
<td>Shock (Olivia)</td>
<td>“Ummm… I have to say, I [long pause]…. I didn’t disbelieve… or maybe I did believe him a bit actually… but I was quite shocked that he actually had been able to do it… he’d actually done what he’d said.” (Lines 423-426)</td>
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<tr>
<td>The lived experience of losing many patients to suicide:</td>
<td>“And that there was one after that… that happened… well… I mean there have been a few [suicides] after that actually… ummm…” (Lines 271-273)</td>
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<tr>
<td>(Barbara)</td>
<td>“we do have someone in the Trust coming in and so on… but… you know… I think… at a local level… ummm… We had a Staff Support Group recently and somebody’s patient had died… and… she said, ‘I feel terribly guilty because one of my first thoughts was… That’s one less person’…” (Lines 428-432)</td>
</tr>
<tr>
<td>Anger towards the person who has died by suicide (Barbara)</td>
<td>“I have felt anger… towards… I can’t think who specifically… but I remember feeling anger… towards somebody who has… has committed suicide…” (Lines 764-766)</td>
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</table>
Questioning self after the first patient suicide: “What did I miss?” (Alice)

“And all I kept getting off people was, ‘Most...most CPNs never have a suicide in their experience...in their...in their...’ And that’s all I kept hearing...and I thought, ‘Oh...poor me then! What have I done that’s so, so bad...’ But, I think as well, I had no gut feeling...coz...I didn’t know her...” (Lines 304-308)

“And she wasn’t presenting and saying, ‘Oh I am going to do something...I am going to do X, Y and Z...’ Or...’I’ve ever tried in the past...to do anything...’ This was ALL new...” (Lines 310-312)

Guilt (Alice)

“Guilt...ummmm...Why didn’t I pick up on cues that...weren’t even there...now I know...they were...you know...I couldn’t have...but...you feel at that time... ‘What did I miss?’ ‘What did I miss?’” (Lines 388-391)

“I didn’t know what to do with it...Because...[long pause]...because of the...the...the comment...’Its unfortunate Alice that some people don’t have any [suicides] [raised voice]...it’s stuck with me...you know...that...’Most people don’t have any suicides, and unfortunately you’ve had one already’...and I...I’d only been [new] in the post...” (Lines 404-410)

“What have I done? I’ve let this happen.... yeah...” (Line 619)

Ordinate Theme 2: Forming, establishing, sustaining & coping with prematurely ending therapeutic relationship with the patient

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<thead>
<tr>
<th>Participant Name &amp; Emergent Theme</th>
<th>Supporting quote from participant transcript</th>
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<tbody>
<tr>
<td>He was getting better (Rachel)</td>
<td>“a lot of other things that were going on in his life...he’d changed schools ummm...due to his behaviour...ummm...and...was feeling suicidal. And we had concentrated on our sessions in coping skills and things like that. He’d responded really, really well to those...ummm...was implementing a lot of them within a couple of weeks”. (Line 67-71)</td>
</tr>
<tr>
<td>The suicide affected my identity and responsibility as a mental health nurse (Rachel)</td>
<td>“I remember just thinking that it was [becomes tearful] my responsibility.....[soft sobbing]....to make him feel better....[sobbing]...” (Lines 136-137)</td>
</tr>
<tr>
<td>He was getting better (Liz)</td>
<td>“he’d been talking about how much better he was feeling...ummm...that he didn’t have these thoughts at that time” (Lines 2018-220)</td>
</tr>
<tr>
<td>I was away from the office</td>
<td>“it was a bit of a shock. One of my colleagues rang me whilst I was out on leave...to tell me...that...”</td>
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<tr>
<td>Scenario</td>
<td>Quote</td>
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<td>when the patient died by suicide: Annual Leave (Liz)</td>
<td>he’d…he’d ended his life.” (Lines 220-222)</td>
</tr>
<tr>
<td>The element of surprise: &quot;Things were actually improving – then all of a sudden, there was this change in behaviour&quot; (Peter)</td>
<td>“worked very intensively with her…and things were actually improving and then…all of a sudden, there was this sudden change in behaviour.” (Lines 116-118)</td>
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<td>“And err…there was a really good point where she engaged very well. Actually, she started to have her life probably more in order and have some plans for the future. She wanted to return to some kind of work.” (Lines 344-348)</td>
</tr>
<tr>
<td>Deep reflection about my practice: the lived experience of feeling mixed emotions ranging from insightful realism to real tragedy! (Peter)</td>
<td>“yeah…a lot of…a lot of reflection…which changed over time…as well. That’s the interesting part. You have moments where you feel quite insightful about it all and quite realistic and practical about it all…and other times when you feel…you… actually this was just…this was really tragic. You know…and for the family to find him…and…ummm…all these kinds of images were there…” (Lines 489-495)</td>
</tr>
<tr>
<td>The patient was getting better: They were “an absolute Model Patient” – Then all of a sudden…(Mary)</td>
<td>“And [the patient] seemed very open. [The patient] wasn’t somebody that was shy about talking about their feelings…you know…[the patient] would….[the patient] would do all the homework that the therapist would set for them. All the…[the patient] was engaging in the CBT. [the patient] would rate his mood…You know, you sort of told [the patient] to try and increase [their] exercise and set a routine every day…” (Lines 137-142)</td>
</tr>
<tr>
<td>I was away from the office when the patient died by suicide: Annual Leave (Mary)</td>
<td>&quot;I was off on leave for a week and then when I come back from leave…ummm…on the first Monday back, my manager called me to the office…and said that [the patient] had…ummm…gone onto a train track and committed suicide. And I sort of had a feeling the week before…ummm…just reading a local newspaper…and they mentioned a person in the area where [the patient] lived…had done this…and I just…I just knew that it was [my patient] ….&quot; (Lines 117-123)</td>
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<td>“And you sort of think…we were talking about PTSD earlier…you know, I don’t have flash backs or anything like that as such…but whenever I go off on leave now, if I have a week’s leave…you sort of think, what’s going to happen when I come back?” (Lines 634-637)</td>
</tr>
<tr>
<td>My first experience of a patient suicide: “Someone who was referred to me, but I had never met them” (Hannah)</td>
<td>Ummm…OK…so, one….one of ummm…the first suicides that I experienced was when I was in a Crisis Team…an Adult Crisis Team. And it, quite interestingly, this was someone, I actually had never met…but had one of the most profound effects on me as a mental health nurse” (lines 75-79)</td>
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<td>“And so, I put, like a sticky note with his name in my diary, just so that I could remind myself…that you...” (Hannah)</td>
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</table>
| The last time that I saw him, he was doing OK (Jessica) | *know...I'll keep track of this. And...and then, three days later...ummm...his body was found in...ummm... (Lines 104-107) ... in a [nearby] toilet and he had suffocated himself and cut his wrists. (Lines 109-110)*

> “Ummm...and I think primarily because I had a very strong emotion of guilt. I thought, “Oh, my god, If I had actually seen you...could have I stopped it?”.” (lines 123-125)

> “Ummm...went out to see him...and ummm...and there was...there wasn’t really anything out of character. There wasn’t anything. I was very like, you know...the bins were where they would normally be...ummm...the bins had been emptied...the...the...the grass had been cut...Ummm...the curtains were open...there was nothing unusual outside. He answered the door in a timely manner...ummm...he...ummm...didn’t show any signs of being paranoid or wasn’t irritable...or anything like that. There was nothing out of the ordinary.” (Lines 394-403)

I was away from the office when the patient died by suicide: “It was my day off” (Jessica)

> “I think they heard via the GP I think... Ummm...so I was on a day off...ummm...like I say...Like I say...I had been on a Spa Day all day...ummm...and I think there was some discussion around...do they phone me and let me know? Or do they wait until I come into work and let me know? Ummm...and I think that’s one good thing...that my...that my managers do know me quite well...is that I wouldn’t wanna walk into it...that I would want to know so that I’ve got a bit of time to process...” (lines 539-548)

> “Ummm...so...when my manager phoned... Instantly when she phoned, I knew there was something wrong...because...you know...you don’t just get a phone call like that... Ummm...so, I’m like, “What’s happened?”... And you know like how mind goes straight to the dozen [nervous laugh]...and I was sort of thinking of my caseload and I was thinking......ummm...and actually he didn’t register.... He didn’t register... and I thought...ummm...I thought it was one of my other clients... ummm...I thought it was one of my other clients...and that it was...an overdose or something that I might remember. But not a death! And then she told me...and I was just gutted!” (Lines 550-564)

Trauma after the third suicide: The ripple effects...(Emily)

> “I mean...the...ironically...ummmmm...this girl...that errrm...that jumped in front of the train...shortly afterwards...probably less than...[sigh]...about a week later...ummm...I had a referral for one of her friends...who, then wanted to kill herself...because she felt...because they both went to the same college together...and she could not forgive herself for the fact that she missed...she felt that she was to blame...that this girl had jumped in front of a train...and she’d not...she’d not realised...that she should have done more... So, then I was now left with the next issue...with trying to keep this other young girl alive! And...and...and that was horrendous!” (Lines 393-403)
| Questioning self (Emily)                                                                 | “you think...did I miss something? That’s all you are ever left with...what didn’t I do? What could I have done? What should I have done?” (Lines 382-384)  
“I think there’s that pressure of worry...If I’ve done some...If I have haven’t...You know...will I be? Lose my job? Will I lose my PIN Number? You know, for the job that I absolutely love...” (Lines 558-561) |
| Looking back: The events leading up to the first suicide...He was getting better... (Olivia) | “I’d been seeing him for ummm...about a year and ummm...felt that I knew him really well and had a good therapeutic relationship with him.” (Lines 189-191)  
“Ummm...he was someone that **struggled with trusting relationships**...ummm...so trying to ummm...**initiate a relationship**...having not met him...him not having been particularly happy with his admission...he was quite disgruntled about the way he’d been bought into hospital.” (Lines 308-312)  
“I saw him on the Monday...and had one of those meetings with him [and his probation officer]...and then...so he was then found hanging on...the Wednesday...at home [deep sigh]...” (Lines 331-334) |
| The struggle to initiate a therapeutic relationship (Olivia) | “I think...I certainly experienced that sense and other people have told me that we...if...if...if something went tragically wrong, we automatically feel that we have failed or that we have done something wrong. Ummm...and that’s definitely the thing...you know...for...that I’ve heard other colleagues talk about...as well as that experience that I have had...” (Lines 256-262)  
“Ummm...he was someone that **struggled with trusting relationships**...ummm...so trying to ummm...**initiate a relationship**...having not met him...him not having been particularly happy with his admission...he was quite disgruntled about the way he’d been bought into hospital.” (Lines 308-312)  
“I saw him on the Monday...and had one of those meetings with him [and his probation officer]...and then...so he was then found hanging on...the Wednesday...at home [deep sigh]...” (Lines 331-334) |
| We automatically feel that we have failed or done something wrong (Barbara) | “This is...this was all planned... Ummm...**the Blue Bell Wood**, which always felt very, kind of poignant to me actually. Ummm...I’ve still got these images of her...and I forgot...perhaps because I don’t talk about it...ummm...and then she hung herself... [becomes tearful]” (Lines 195-203)  
“I just remember my...my colleague the Psychiatrist, having to call...ummm...her mum...and...they were...her mum and I’ve worked with...a wonderful woman...just...you know...I think because I had...[sob]...you know...she worked like me...in mental health...community...you know...I kind of...just my heart went out to her. How...you know...how do you reconcile with that, really?” (Lines 195-203)  
“Any, ummm...so that was the Thursday I saw her and it was my last visit of the day... So, I finished at quarter-to-five and I remember ringing in and saying to whoever was on...coz we ring...as the Lone Worker Policy...ring in [to the main base] to let people know we are fine and well. And I remember saying, *No...she’s fine! I’m going to see her Monday or Tuesday*”...everything...” I suppose it
was...ummm...and “I'll be in tomorrow”. [clears throat] ... It came to be Friday...nothing...everything else was fine...busy day! Busy Friday...I think... I came in on the Monday...and she'd...killed herself on the Saturday...” (Lines 258-268)

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<th>Shame (Alice)</th>
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<td>“And all I kept getting off people was, ‘Most...most CPNs never have a suicide in their experience...in their...in their...’ And that’s all I kept hearing...and I thought, ‘Oh...poor me then! What have I done that's so, so bad... ’ But, I think as well, I had no gut feeling...coz...I didn’t know her...’” (Lines 304-308)</td>
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<td>“I also remember being lo...shut in the room at the end...you know...at the end of a corridor... So...she shut...yeah...she shut me in there and said, ‘Right...you have some quiet time...get on...get the notes done.’ And I just remember sitting there...thinking...’OK...let me think...with all of this going on in one part of my brain... ‘Oh my god, she's dead...oh my god, she's dead...oh my god, she's dead!’... 'What's she done? ... What's she done? ... What's she done?’ “ (Lines 1002-1009)</td>
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