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School after suicide: child and young person's experience in education after losing a parent to suicide

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Acknowledgments

I would like to dedicate this research to the memory of my father Richard Baxter who died by suicide on the 14/11/89 aged just 43; may your struggle not be in vain.

I would like to thank the very brave participants for taking part in this research and being open and honest with me about their experiences.

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Abstract

This research aims to highlight child and young people's (CYP) experience in education following the suicide of a parent. Research suggests that children and young survivors of suicide continue to be profoundly affected long after the suicide itself. They are more at risk from the effects of complicated grief such as, but not limited to, poor academic performance, depression, self-harm and indeed suicide. Children and young people who have experienced suicide are part of a vulnerable group who can feel marginalized. Nevertheless, research surrounding their experience is minimal. The research hopes to raise awareness and shape how education professionals support and respond to children and young people after being bereaved from suicide.

This study employed a narrative approach from a social constructionist perspective to hear and give power to the young voice. Participants were enrolled with the help and support of a well-known UK charity who support bereaved children. There were 3 participants: a 16-year-old female who was 15 and in year ten just starting her GCSEs when her mother died by suicide; a 19-year-old male who was 16 and in his final year of GCSEs when his father died by suicide; a 20-year-old male who was 18 and in college when his father died by suicide. All three had individual charity support workers who were available to be in the room with the participants throughout the research for support if needed.

The research aimed to represent each experience and so stories were analysed and presented separately in episodes of 'life before,' 'the discovery' and 'the aftermath. Themes were generated for each story which highlights the complexities of suicide bereavement. There were similar themes throughout all three stories which are also discussed. Also, participants highlighted what support they would like to see put in place to help other children who are bereaved by suicide. This research gives an insight into the complexities regarding grief and distress surrounding suicide bereavement. It highlights positive and negative experiences in education following the bereavement, and the detrimental implication suicide can have upon education attainment. The current research argues there is a need for professionals specifically education professionals to have an awareness of the complexities throughout all episodes of the child/young person experience. To illuminate this the web of complexities was developed highlighting factors that may lead to feelings of isolation, and entrapment (two things that arguably contribute to suicide). The aim to help professionals develop individual postvention support with specific areas to focus. This alone may arguably help prevent a further tragic cycle of unnecessary deaths and devastation from suicide.

It should be noted that this was a small study and difficulties due to ethical approval limited access to participants of 16 and above. Further studies exploring a wider range of ages and experiences would be beneficial. In addition to other research to help evaluate the effectiveness of postvention for young survivors of suicide.

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Introduction to the researcher

I have both personal and professional interests surrounding the subject of suicide. However, in my experience, the topic is still considered taboo and is rarely discussed openly.

I lost my father to suicide at the age of 14. I was in year nine at the time and the loss of my father impacted me not only socially and emotionally, but also educationally and it is only later in life as an adult (32) that I went to university and achieved my potential gaining a first-class honours in psychology.

I am now working as a 3rd year trainee Educational Psychologist determined to help remove barriers to education and influence positive change so that children and young people can meet their educational potential while in school. Society has evolved since 1989, and I would like to think that things have improved regarding support for those that have been bereaved by suicide. I am aware that it is part of a national agenda and that there are support groups for adults that were not available in 1989.

In my second year as a trainee I was given my first Educational and Health Care Plan assessment of needs to carry out. The case was for a year two boy who was described as having severe behaviour difficulties and as a result, was spending most of his time in isolation with the risk of being permanently excluded. It was while gathering information for this case that I discovered that only two years prior (when he was in reception class) that he found his mums' body and that she had died by suicide. The child then witnessed his father trying to resuscitate his mum and could not understand why his dad was hurting his mum. The young dad was left with the aftermath of the suicide while trying to raise two children under the age of 5 and finish his full-time degree course. Despite this, and the school being aware of the family's background, the child was labelled as having behaviour and learning difficulties which resulted in an Education Health Plan request.

I now strive to help professionals with understanding the complexities and to help improve support for CYP bereaved by suicide.

Chapter1 Literature Review

1.1 Introduction to literature

Suicide is defined as ‘the act of killing one’s self intentionally’ (Scowcroft, 2017). In England, Wales and Northern Ireland, a coroner can give a verdict of suicide for those as young as ten years old. Thus, all suicide data is for persons aged 10 and over (Scowcroft,2017). There are many reasons for suicide including depression, mental illness, hopelessness, feelings of entrapment, peer pressure, a loss, major life change, illness, bullying, and issues with sexual orientation; often, suicide results from a combination of variables (O’Connor & Kirtley, 2018; Powell & Matthys, 2013). However, even when a suicide note is left or the victim verbalized intentions, the reasons for suicide can remain unanswered. Thus, the grief experienced by those left behind can be intense and unique compared with other losses (Powell & Matthys, 2013). It could then be said that rather than using a within person or medical model to explain and understand suicide and suicide bereavement it is more useful to use a systemic framework such as that of Bronfenbrenner’s bio-ecological theory (1998).

Suicide is a serious and growing problem, and estimates indicate that the number of individuals affected by suicide each year is considerable. The U.S.A suicide (2015) official final data suggests that for each death by suicide 147 people are exposed (6.5 million annually) and more than 6 experience a major life disruption (those who have lost a significant other to suicide are classed as survivors of suicide). Thus, in the U.S.A. alone there are over 250,000 survivors of suicide a year. Based on the 851,660 suicides from 1991 through 2015, the number of survivors of suicide in the U.S.A is more than 5.1 million. It is estimated that in the U.S.A, there were 121.1 suicides every day or one suicide every 11.9 minutes. This results in more than six new survivors of suicide every 11.9 minutes (McIntosh & Drapeau, 2016). However,

it is commonly acknowledged within the field of suicide research and prevention that official statistics underestimate the 'true' number and, therefore, the rate of suicide (Scowcroft, 2017). Thus, numbers may be much higher.

In the United Kingdom (UK) and Republic of Ireland (ROI), The Samaritans collate figures from all the national statistical agencies on reported suicides to provide details of national suicide rates. According to the Samaritans' Suicide Statistics report, there were 6,213 suicides in the UK and ROI in 2017 (Samaritans, 2018). Although suicide figures have decreased in males, men remain around three times more likely to take their own lives than women in the UK and four times in the ROI. It is believed the decrease in male suicide correlates to the focus on suicide prevention in males over recent years (Samaritans, 2018). However, suicide rates are increasing in young people in the UK and Ireland, and it is argued that more research into the understanding of why young people take their own life is needed (Samaritans, 2018).

Risks in both genders are thought to be associated with social and economic factors connected to inequality affecting the most vulnerable and disadvantaged in society (Samaritans, 2018). Negative life events, early life adversity, and disruption to attachment relationships (impacting on cortisol functioning and emotional dysregulation) and exposure to suicide are also risk factors (O'Connor & Williams, 2014) all of which places suicide within a systemic and ecological paradigm (Bronfenbrenner & Morris, 1998). Behind every death from suicide, there are survivors of suicide devastated by their loss. Indeed, the death of a loved one from suicide is a negative life event which profoundly affects the surviving family unit. Suicide can have repercussions across generations and affects children and young people still in education; who often face increased adversity as well as significant disruption to attachment relationships. Evidence suggests that children and young people that have lost a parent to suicide are at a higher risk of depression, self-harm and indeed suicide (Botha et al., 2008; Melhem et al., 2011; Mitchell and Terhorst, 2017). Therefore, a better understanding of the support needed for this vulnerable

group of suicide survivors is vital in preventing further suicide. Nevertheless, knowledge about their experience is minimal, with scant available research which explores the voice of the child or young person recently bereaved by suicide (Sethi & Bhargava, 2003).

1.2 Grief from suicide

Simone (2009) points out that one of the most traumatic experiences for children is the death of a parent and death by suicide further complicates bereavement adaptation. Suicide is intentional, but reasons for the suicide can remain unanswered. Therefore, the grief experienced by survivors is arguably unique and more complicated compared with other losses, because of the level of uncertainty and suddenness of the death (Powell & Matthys, 2013). Powell & Matthys (2013) carried out qualitative interviews with survivors of suicide and found that even if a letter was left behind, they often felt the need to search for additional information to reduce lingering uncertainty. Participants reported questioning co-workers, friends, or anyone who may have interacted with their sibling in the days or hours leading up to the suicide. This highlights the importance of the relation between the bereaved and the systems that they are embedded within as being useful in trying to understand suicide. One participant in this study explained how she found information that suggested her brother was very depressed which was a reason to take his own life. However, she then felt more sadness knowing that things were so bad for him and that he did not approach her for help (Powell & Matthys, 2013). In the same study, another participant who lost her twin regarded her gathering information to reduce uncertainty as somewhat hopeless.

“I got the information I wanted, but with the information comes the pain of knowing, without it comes the pain of not knowing” (Powell & Matthys, 2013 p 332).

Research supports an association between bereavement by suicide and a range of complicated grief reactions (a heightened and extended state of grief which can have a permanent disruptive effect on a normal day to day living) which can lead to adverse health outcomes (Botha et al., 2008) which in turn could have implications

upon the ecological systems the bereaved individual is embedded within (Bronfenbrenner & Morris, 1998). Childhood exposure to parental suicidal behaviour is associated with many negative behavioural and health-related outcomes (Lunde et al., 2018). Survivors of suicide are more likely to experience more frequent feelings of confusion, blame, guilt, shame, anger, rejection, intense emotions of embarrassment, or perceived stigmatisation and responsibility (Bailey et al. 1999; Botha et al., 2008; Simone, 2009; Hung & Rabin, 2009). For a child, there is additional uncertainty and fear surrounding the concept that a primary caregiver can choose to die and leave (Lunde et al., 2018). Consequently, this can affect the ability to reorganise and cope, which can lead to poor social adjustment and internalising symptoms such as depression and post-traumatic stress disorder (Simone, 2009). However, caution should be taken with such a generalised statement based heavily upon one theory such as attachment.

Mitchell and Terhorst (2017) suggest that a death by suicide may lead to the development of Post-Traumatic Stress Disorder (PTSD) symptoms, and is associated with lower mental health, quality of life and complicated grief responses. However, this study was small scale with 60 Caucasian participants, with 47 females; thus, generalisability is questionable. Nevertheless, outcomes such as these can result in barriers to communications and interactions, leading to feelings of isolation, inhibiting the grief process further (Simone, 2009). Children who have experienced the suicide of a close family member are a vulnerable group who can feel marginalised and are at risk of delinquency and higher than average psychological difficulties (Simone, 2009) including bipolar disorder (Tsuchiya et al., 2005). Mc Menamy (2008) found that survivors of suicide experienced elevated symptoms of depression, guilt, anxiety, and trauma, in addition to social difficulties. which again all arguably impact upon the ecological systems of the individual (Bronfenbrenner & Morris, 1998). In this study, many participants found professional help beneficial, and many informal sources of support were also seen as helpful.

Brent et al. (2009) found that children and young people who lose a parent through suicide are most vulnerable to depression and alcohol or substance abuse during the

second year after the loss. It is therefore argued that optimum prevention of depression in bereaved children and young people is shortly after the parent's death (Brent et al., 2009). In contrast, Pfeffer et al. (2000) found relatively low levels of psychological distress reported by children bereaved by both suicide and cancer. They argue that most of the children exhibited what appeared to be a high level of resilience following their loss. Further, Melhem et al. (2011) found that more than half of children and adolescents bereaved by sudden parental death (including suicide) experienced resolution of grief within one year of the loss of their parent. Melhem et al. (2011) argue that it is those children with a prior history of personal depression who experience prolonged, complicated grief. However, Powell & Matthys (2013) qualitative research found that some participants who lost siblings from suicide, but who had also battled depression sometimes felt that their sibling's death acted as a wake-up call to address their issues. One participant suggested her brother's suicide;

“helped me deal with many my problems because I understood that he felt the same thing I did and I was able to actually talk to my dad about it, and he has changed the way he deals with things as well” (Powell & Matthys, 2013.p. 329)

This then in contrast to the notion that suicide exposure contributes to the risk of suicide. Indeed, for some individuals such as this participant, the suicide may become a protective factor from them acting upon their suicide ideation.

Sveen and Walby (2008) carried out a systematic review of suicide survivors' reactions compared with survivors after other modes of death. They identified studies using PsychINFO and MEDLINE databases and performed data analysis using 41 studies. They found no significant differences between survivors of suicide and other bereaved groups regarding general mental health, depression, PTSD symptoms, anxiety, and suicidal behaviour. However, results regarding the overall level of grief depended on whether general grief instruments or suicide-specific instruments were used. Several studies stated that those who died by suicide had suffered poor mental health before death, and many of these disorders had a genetic

component. Arguably then there is a higher risk that suicide survivors who are relatives of the deceased, may have higher levels of mental health disorders antedating exposure. Taken together with the stress that many suicide survivors have been exposed to before bereavement, suicide survivors would be expected to be more vulnerable than other groups. It was then surprising in this study that higher levels of group differences were not found. The study did find that suicide survivors reported higher levels of rejection, shame, stigma, need for concealing the cause of death and blaming than all other survivor groups (Sveen and Walby 2008).

It should be noted there were several limitations to this study, such as a multitude of samples, recruitment methods, lack of control groups, time passed since bereavement, and differences between instruments employed in the studies reviewed; most of the studies had methodological limitations (Sveen and Walby 2008). Further, all the studies were vulnerable to confounding variables and researcher bias (Sveen and Walby, 2008). In addition, selection bias, due to convenience sampling based on bereavement groups or obituaries, low response rate, or a low follow-up rate was also problematic (Sveen and Walby 2008). Therefore, the validity and thus the confidence level of these findings are questionable and may go some way to explaining the low difference outcome between types of death.

Sethi & Bhargava (2003) addressed the impact of a recent suicide death of a family member on children and adolescents. However, although this research involved children and young people themselves, it did not include their voice. The study evaluated a range of psychiatric problems and social adjustment of child and adolescent survivors of suicide. Child participants included 15 (63%) males and 9 (37%) females. The children ranged from 6 to 16 years old (mean age 12.20 ± 3.6 years). The 20 suicide victims included 12 (60%) fathers, 4 (20%) mothers, 2 (10%) brothers, and two sisters (10%). Poisoning/overdose accounted for 9 (45%), hanging for 6 (30%), jumping from a height and drowning for 2 (10%) each, and shooting for 1 (5%). Almost all the children immediately knew about the nature of suicide death in

the family. Three children discovered the bodies of the victims. The children entered the study 6 to 24 months (mean 9.2 months) after the deaths in the family. For comparison, the researchers selected an age-matched control group of 26 “normal” school children having no history of suicide in the family. Findings show that about half of the child survivors (53% of males and 44% of females) met criteria for major depressive disorder and five children (21%) met criteria for (PTSD). One male met the criteria for panic disorder, and three males met the criteria for conduct disorder. It should be noted that all these are within person medical model explanations. Comparisons between the child survivors of family suicide death and control subjects found that suicide survivors were significantly more likely to have school problems, spare-time problems, peer problems, and sibling problems. The researchers state that their findings imply the need for heightened awareness of the possibility of social problems and psychiatric disorder developing among children and young adolescents in the aftermath of familial suicide. There is a need for early recognition, treatment, and management of psychiatric and social problems in this population, both to address the immediate impact of the death and reduce risks of long-term maladjustment (Sethi & Bhargava, 2003). This highlights the complexities of suicide and the negative impact the death can have within the ecological systems of the bereaved. Arguably then this raises the question of how useful a within person explanation/intervention is and instead could be seen to highlight the need to take a more systemic approach for support (Bronfenbrenner & Morris, 1998). It should be noted that in this study the sample size was small (20 families) and was not carried out in western society (participants from urban Rohtak, India,) thus results cannot be generalised to western society.

Hung & Rabin (2009) suggest bereavement by parental suicide is a continuous process which is different from adult grief that diminishes over time. Instead, the death of a parent shapes the child’s personality, identity, and world-view. Thus, grief from parental loss is a new way of life, which at times it is triggered by some external cue (Hung & Rabin, 2009). As children mature the focus of grief can evolve from longing for the parent to coming to terms with the parent’s agency and the need to understand. Also, prolonged feelings of isolation, feelings of guilt,

responsibility, and abandonment or rejection by the deceased can affect the ability of the child to regain a sense of stability and safety (Hung & Rabin, 2009)

Evidence suggests that survivors of suicide are more likely to suffer complicated grief, depression and may need specialised mental health care (Mitchell et al. 2004). Also, studies also show that individuals enduring complicated grief can demonstrate lower attention and lower global cognitive performance (Hall et al., 2014). Patton et al. (2000) suggest that Attachment Theory explains perspectives on the relationship of the social environment to the emotional wellbeing of children and young people. Anxiety and depressive symptoms are more likely to occur in children when interpersonal bonds are threatened, which would arguably be a consequence of parental suicide. Further, Patton et al. (2000) argue that their work on the effects of life events, social support and disruption of social relationships supports the view that experiences of loss, adversity and disruptive life events are associated with emotional distress and mental disorder. This could negatively impact social relationships, physical health, academic achievement and have a long-term detrimental impact on future life outcomes underlying socioeconomic status (Lendrum et al., 2012). Also, mental health problems in childhood can increase the risk of further psychopathology and functional impairment; this can occur throughout life and contribute to substantial economic costs to society for treatment (O'Connell et al., 2009). Debatably this may become a vicious cycle because low socioeconomic status and poor mental health are both contributing factors to suicide itself (Scowcroft, 2017). This again all supports the relevance of a systemic ecological system approach in understanding the immediate and Long-term implications of suicide (Bronfenbrenner & Morris, 1998).

In summary literature suggests that suicide is a complex phenomenon which although has historically been seen as a within person concept can be better understood using a systemic framework both in relation to cause and impact upon the survivors . Although research highlights that suicide is rarely caused by a single factor, evidence does suggest that a contributing factor to suicide, especially in young people is the bereavement by suicide itself, which again arguably strengthens

the need to use a systemic frame work to explore suicide and the support of survivors (Lunde et al., 2018; O'Connor & Kirtley, 2018; Hung & Rabin, 2009). It should be acknowledged however, that much of the research exploring suicide has limitations and the level of quality, thus confidence level is questionable.

1.3 Postvention

It is suggested that to prevent further suicides and other long-standing psychological related difficulties in child and young survivors of suicide it is essential to put in effective support strategies to support their emotional and psychological needs; something that suicidologist Edwin Shneidman (1972) termed postvention. In addition to prevention by raising awareness and intervention with the suicidal person, postvention has been highlighted as one approach to help reduce suicide rates (Hung and Rabin,2009; Mitchell et al.,2017). However, within the suicide prevention field it has been highlighted that postvention does not get the same attention as prevention strategies (Hung and Rabin,2009; Mitchell et al ,2017), despite recommendations that a full postvention response for people exposed to a suicide fatality must be a core element of all suicide prevention (Hung & Rabin, 2009). Children and young people who have lost a parent to suicide are a population more at risk of suicide (O'Connor & Kirtley, 2018; Chapple et al., 2015). This then should arguably prompt researchers, health care providers and policymakers to focus on identifying and offering intervention to this large and highly vulnerable group (Lunde et al, 2018)

Encouragingly wellbeing and mental health surrounding children and young people have being considered using an ecological system approach. Education have recently been topics of political concern and in January 2017 Prime Minister Theresa May announced new plans to address mental health in schools (Dent, 2017). In 2018 The Department of Education mental health and behaviour in schools document identified risk factors associated with mental health difficulties in CYP; parent's psychiatric illness or personality disorder, parent's alcoholism, loss through death and academic failure are amongst those listed (The Department of Education, 2018). The document also states:

“Negative life experience and distressing life events can affect mental health resulting in a change to behaviour and emotional state which may be displayed in different ways such as withdrawal, aggression, affection seeking”.

“It is important that schools provide support at such times” (The Department of Education, 2018, P. 18).

By 2025 all schools and colleges will have designated senior leaders in schools to provide strategic oversight of a whole school approach to mental health and wellbeing. They will have access to a designated mental health support team to provide a link between the school and the NHS (Department of Education, 2018). It is encouraging to see a this systemic approach to mental health being recommended. However, as grief by suicide is complex support to survivors needs careful consideration. Hung & Rabin (2009) note that most bereavement groups for children are not specific to the cause of death, and most suicide survivor groups are intended for adults. A blanket approach to child mental health using policies made by adults could be inadequate for this prevalent and complex issue. Relatively scant attention has been paid to research on interventions for young survivors of suicide; I suggest that intervention should be compiled with a focus on and including the children and young person’s views of their experience, to maximise impact of support.

1.4 Support

Support for people bereaved through suicide has been identified as an essential strategy in suicide prevention (World Health Organization, 2014). However, there is limited research surrounding intervention for parental suicide, despite this being highlighted as a major risk factor associated with detrimental outcomes in children (Andriessen et al., 2018). Hung and Rabin (2009) carried out a critical review of research on outcomes, grief processes, and interventions for suicide survivors. Out of 66 interventional studies (randomised controlled trials), none included intervention for children who were next of kin. In addition to this, Lunde et al. (2018) carried out a systematic literature review of attempted suicide and highlighted that only a few studies concerned interventions to help children experiencing parental suicide.

Further, few studies have been carried out that describe the views of suicide-bereaved people regarding their needs for support (Pitman et al., 2017).

Nevertheless, the research that has been carried out suggests that it is not therapeutic support, but social support such as having friends, family and other people to turn to and optimal physical health which are associated with lower levels of depression in survivors of suicide, which again has systemic underpinnings. (Spino et al., 2017). Losing a loved one to suicide can have the opposite effect and segregate survivors from their family and even the community. Hence, there is a need to optimise social support for what is deemed a vulnerable population; a population who often feel stigmatised, shamed and isolated (Spino et al., 2017). A support network within the system that the survivor is embedded can offer a safe place for survivors to talk about their distress in an empathetic, open-minded and compassionate environment, where there is hope for normalcy (Spino et al., 2017). Indeed, social support is coupled with reduced grief and hopelessness and is argued should be a key focus for professionals' evaluations and intervention strategies. (Spino et al., 2017). However, Hung & Rabin (2009) point out that most bereavement groups for children are not specific to cause of death, despite evidence that highlights the unique aspects of suicide bereavement. The majority of suicide survivor groups are intended for adults; even so, it is suggested that principles used by these groups such as a focus on social support, (which may counteract negative consequences of suicide bereavement) can also be applied to interventions for child survivors of suicide (Hung & Rabin 2009). Group empathy, through shared experience, is especially crucial to suicide survivors due to the sense of reduced stigma and embarrassment or the feeling of being different (Hung and Rabin 2009; Mitchell et al., 2007). Research suggests that support groups benefit children in the aftermath of parental suicide by reducing the risk of withdrawal and isolation while grieving. This is embedded within the philosophy that we all have a strong need for belonging, acceptance and interaction with others (Hung & Rabin 2009; Mitchell et al., 2007). Indeed, Campbell (1997) highlighted that adult survivors of suicide reflected upon and agreed that they would have benefited from the chance to talk about the suicide experienced as children while still in childhood.

Caution is warranted, however, because most children want to avoid experiencing emotions associated with trauma and so may not be initially ready to attend a support group initially, and support should be offered over time (Mitchell et al, 2007). Pitman (2017) suggests a need for frequent and continual offers of support within the ecological systems such as from family, friends, and professionals following suicide so that support is available when they are ready. Participants indicated that they felt relatives, friends, employers, teachers and healthcare professionals have a duty of care to help the bereaved person access appropriate resources. This might be particularly important in the immediate aftermath of the loss when people indicated they were too overwhelmed and distressed to seek help or independently act on any information provided (Pitman,2017). Many survivors reported feeling let down by GPs, friends, relatives or other professionals by missing opportunities to help them access support especially at the early stage of grief (Pitman, 2017). Even if not ready to accept help at that time, survivors felt it was crucial that they were guided to the support available for when they were ready (Pitman,2017).US and UK suicide prevention strategies recommend providing support for people bereaved by suicide (Scowcroft, 2001; World Health Organization, 2014). However, there is a tendency for people bereaved by suicide to avoid seeking help, despite expressing clear unmet needs (Scoocco et al. 2016; Pitman et al.,2017). This may be linked to the shame survivors of suicide experience which reduces their sense of being worthy of any help (Pitman et al., 2016). Further, there is also avoidance from friends and relative's offering help, contributing to feelings of isolation and such avoidance is likely to be linked to stigmatising societal beliefs (Jackson et al. 2015).

In summary research surrounding support after suicide highlights the usefulness of taking a systemic approach utilising all the ecological system the survivor is embedded in. This seems more useful than placing emphasis on one method of support or relying on the resilience of the individual, to solely navigate and overcome the bereavement. However, the research also suggests that it is the systems that the individual is embedded within that may be acting as a barrier to the support needed.

1.5 Stigma

Suicide survivors experience higher stigma in comparison to natural death survivors in the form of shame, blame, social isolation and avoidance. (Hanschmidt et al., 2016). Detrimental consequences of stigma are associated with concealment of the death, social withdrawal, reduced psychological functioning, and grief difficulties, in addition to suicide ideation. However, evidence suggests that stigma is not equal in all survivors of suicide with parents experiencing less stigmatisation than other immediate family members. Thus, children and young people may need more help with navigating difficulties associated with stigma (Hanschmidt et al., 2016).

Evidence suggests that suicide survivors often conceal the death from others, withdraw from social interactions, and suppress their emotions to manage stigma. Arguably this contributes to a lack of dialogue surrounding the bereavement and contributes to a reduced ability for sense-making and/or being able to maintain connections with their loved ones by sharing memories (Hanschmidt et al., 2016; Peters et al. 2016); all of which are vital for re-adjustment following loss and are preventative for complicated grief reactions (Peters et al., 2016).

The stigma surrounding suicide originated before the 19th century when it was regarded as a crime and a sin; hence the expression 'committed suicide'. The deceased was not able to be punished for the crime. Thus, those close to the deceased were seen as responsible and held accountable (Botha et al., 2008). In addition, victims of suicide have been labelled "cowards," "selfish," and are sometimes accused of "taking the easy way out," and are blamed for their death. The labels placed on the act and how others talk about suicide contribute to complicating the grief process for those left behind (Powell & Matthys, 2013). It is argued that today such stigma has reduced vastly, and we now know there is a strong link between mental illness and suicide. In an attempt to reduce stigma further and increase awareness surrounding suicide not being a choice, but rather the result of mental illness or other issues, some advocate using the language "died by suicide" instead of "committed suicide," (Powell & Matthys, 2013). This highlights the contribution of wider society's, historical and cultural understanding (

macrosystems) in the construction of suicide phenomena .Despite attempts to reduce the stigma surrounding suicide, this is still evident. For example, suicide is still considered illegal in 25 out of 192 countries around the world (Mishara & Weisstub, 2016) and in other countries it is argued that stigmatisation of suicide continues in subtle ways such as denying an insurance policy to people with a history of suicide attempts (Scocco et al., 2017). Pitman et al. (2016) found that relatives and friends bereaved by suicide perceived stigma more acutely than those bereaved by other causes of sudden natural or sudden unnatural death. The study was the largest carried out in the UK with an estimated sampling frame of 659,572 staff and students from Higher Education Establishments throughout the UK. However, researchers acknowledge sampling bias favouring higher socio-economic classes, thus limitations to generalisability.

Nevertheless, if the stigma surrounding suicide adversely affects access to support in a population vulnerable to their mental health problems, this is concerning. Scocco et al. (2017) note that distress levels in individuals bereaved by the suicide were positively associated with levels of perceived stigma. As a result, they suggest that interventions specific to suicide survivors might help to alleviate both psychological distress and also stigma towards loss by suicide.

Pitman et al. (2017) found that people bereaved by suicide are less likely to receive social support in comparison to people bereaved by other causes of sudden death and are more likely to perceive delays in accessing both formal and informal support. This contrasts with the suggestions of Brent et al. (2009) who argue for optimum prevention of depression in survivors, support should be given shortly after the suicide. Pitman et al. (2017) found that one in four people bereaved by suicide received no formal or informal support after their loss, despite the significant emphasis of suicide prevention strategies on improved suicide bereavement support. If a child or young person who has lost a significant other from suicide is not accessing support, they are vulnerable to greater negative consequences. However, as Pitman et al. (2017) involved participants of young adults working or studying at

UK higher education institutions, it could be argued that this study had sample bias. Due to the often-majority higher social, economic status within the population of higher education institutes it is assumed that most participants came from less deprived backgrounds; thus, findings may not represent the general population. Indeed, the researchers acknowledge this limitation as well as gender bias due to no males' respondents. Nevertheless, the sample was sizable with 614 survivors of suicide responding. Therefore, thus far the largest and most comprehensive U.K study researching support received after bereavement from suicide.

In summary, it is evident that stigma surrounding suicide has a historic conceptualisation that is embedded within wider ecological systems. It is suggested that support for suicide bereavement may be more effective if a systemic approach is adopted. However, Stigma within the ecological systems that the individual is embedded has been identified as a possible barrier to support for survivors of suicide. It seems then that both risk factors/ barriers to support and protective factors are entwined and embedded within the ecological systems the survivor is embedded within. Thus, further highlighting the complexities of suicide bereavement (Bronfenbrenner & Morris, 1998).

1.6 Gaps in support

Even if a child or young person is accessing support, Peters et al. (2016) found that that health professional and other support services are unsure of how to support people bereaved as a result of suicide. Pitman (2017) highlighted negative experiences of professional support including lacking empathy, missed cries for help, or avoidance of talking about death. Indeed, people bereaved by suicide report relationships with professionals became strained which could further limit opportunities for support (Peters et al., 2016)

In addition to issues surrounding external support, Pitman (2017) highlighted problems associated with feelings of having been let down by close friends and

family and perceiving them as not providing emotional or practical support. Simone (2009) carried out qualitative interviews with child survivors of suicide in which a reoccurring theme suggested that there was often no shared expression of grief within the immediate family at the time of the suicide. This supports other studies outlining families who were bereaved by suicide were less likely to discuss the death than those bereaved by accidental or natural death (Hung & Rabin, 2009). This could also be due to the perceived stigma surrounding suicide. Research suggests that some children and young people hide the pain of their loss from their surviving family to avoid upsetting them more (Simone, 2009) which could lead to further isolation. In support Pitman (2017) highlighted a perceived responsibility towards others caused some survivors to hide and not talk about their grief. This was a way to appear strong, especially in younger survivors who felt obliged to support their surviving parent. Employment , or educational commitments also acted as barriers to grieving openly and to accepting or seeking support. (Pitman, 2017) . Survivors who initially suppressed their needs surrounding grieving highlighted that it was difficult to then seek support at a later point; they feared being judged for not having moved on or recovered (Pitman, 2017).

Ratnarajah & Schofield (2008) researched the impact of parental loss from suicide. Eligible participants were 18 years or over and had experienced the death of a parent through suicide when they were a child or young adult. A narrative method was used to allow the stories of parent suicide, loss, impact, and adjustment to unfold in the informants' language. Ratnarajah & Schofield (2008) found that information about the circumstances triggering the suicide was fragmentary in nearly all the narratives. A lack of communication was common in families as well as the belief that the family was best protected by keeping the circumstances secret.

In most cases, the natural enquiries of the bereaved child were not met in an open and caring manner (Ratnarajah & Schofield, 2008). The meaning made by the bereaved child was from fragmented memories and impressions at the time from the few family discussions that took place, and, in some cases, research undertaken by

the child in later years. A key theme in all was abandonment; not only the abandonment through the suicide itself, but other key themes related to abandonment : loss of family, loss of identity, emotional deprivation, unavailability of the surviving parent, alcoholism, violence, and mental illness (Ratnarajah & Schofield, 2008). Results of the study highlighted there was a lack of a coordinated response to family suicide and clear recommendations were highlighted which were embedded within the different ecological systems.

The first recommendation by Ratnarajah & Schofield (2008) was that information about available community support services should be advertised as widely as possible, mainly through the first point of contact services, following a suicide. These included local police, hospitals, hospital social workers, general practitioners, counsellors and psychologists, clergy, and funeral staff (Ratnarajah & Schofield, 2008). Further, the secondary losses (such as loss of family, loss of availability of the surviving parent) were seen by bereaved children as almost as damaging as their parent's suicide. Thus, it was recommended policies be developed to facilitate a proactive assessment of the family's needs. This then arguably ensuring a timely provision of a wide range of support available to the whole family. In effect, this may require a case manager or counsellor to review the varied aspects of family needs and functioning. All participants in the research stressed the importance of maintaining continuing bonds and supporting the family unit (Ratnarajah & Schofield.2008).

Further recommendations were that support might initially focus on shelter, food, safety, security of a home, cohesiveness of the family and continuation of schooling to stabilise the family. Assistance with the interface with government support agencies may also be required. Once the family has experienced the initial support offered by the case manager or counsellor in accessing practical support, the trust may be built. It was argued that this would then allow the family support counsellor to guide the family through the grieving and adjustment process and facilitate sensitive communications between family members (Ratnarajah & Schofield.2008).

The study also suggested that those offering support to a family bereaved by suicide need to be aware that there may well be a history of difficulties in the family system, which contributed to and culminated in the suicide. It was then suggested that where possible, the families should be supported to examine and reorganise the family system to create a safer and healthier environment for the growing child. Such an intervention may help to prevent future problems and strengthen the family's coping skills (Ratnarajah & Schofield.2008). However, this study was not without limitations. Firstly, it was carried out in South-East Queensland, Australia, not in the UK, so it is not generalisable for the UK. Secondly, there was gender bias with nine females and one male. Thirdly, participants ages ranged from 18 to over 80 years with the length of time since the parent's death ranging from 5 to 70 years. Thus, memory regresses over such time could arguably place limitations on the reliability of the narrative data. Also, the researchers themselves point out that it is important to note that in all the narratives, parental suicide was not an isolated incident, but the culmination of a chaotic family life marked by previous unresolved trauma. Thus, there may have already been a detrimental impact on the child's development and self-regulation due to previous attachment difficulties. This developmental effect is likely to be compounded when the surviving parent is further not able to provide support for the bereaved child following the suicide. Therefore, it cannot be said that suicide alone caused the devastating impact on the life of the surviving child, rather an accumulation of the circumstances and difficulties within the systems surrounding the suicide (Ratnarajah & Schofield.2008). Suicide impacts a family immediately; the emotional upheaval caused by the loss of a family member is the most obvious. However, there is also navigation of extended family and friends; how to notify them, including how honest to be about the cause of death. Since suicide is treated as a crime scene, the family have to deal with the police and the investigation surrounding the death. The family often have to face and/or clean-up of the death scene when the suicide has occurred at home and arrange for funeral services (Chapple et al. 2015). There are also longer-term implications for the family's life together; holidays and birthdays may not be celebrated, children may be neglected due to the surviving parent's own needs and inability to cope which can permanently disrupt communication, interaction, emotional availability and attachment

relationships (Chapple et al.,2015). This highlights the complexities the child survivor of suicide must navigate, which makes it even more important adequate support systems are provided for both the child/ young person and the surviving caregiver (Hung & Rabin, 2009)

Evidence seems to suggest that having access to a broad range of support, including peer support, in addition to professional support is much valued and knowing that support exists, even if not acted upon initially is useful. Professional, as well as friends and family, could have a significant role in being proactive to help bereaved people access support. The most significant means of support seems to be the ability to talk openly about death. However, this is challenging due to the availability of remaining family members, perceived a duty to conceal, individual needs to protect others and stigma often associated with suicide.

As in the other sections of this chapter, there is evidence for the usefulness of understanding the role of the ecological systems within the literature surrounding support. I argue that there is a need to take a systemic approach to understand better what is perceived to be helpful and unhelpful after suicide bereavement. This could not only inform appropriate interventions but also help enhance general responses in the aftermath of suicide. Arguably if adequate support is available from the systems that the child is embedded in, it could help reduce complicated grief responses, and could potentially prevent further suicides and further detrimental repercussions to the other ecological systems .

1.7 No voice

For effective postvention activities to be developed for those bereaved by suicide, it is essential that an understanding of the grief process for those bereaved is gained (Andriessen et al., 2018). However, despite the enormous number of people bereaved by suicide worldwide every year, this is a neglected and poorly understood population (Andriessen et al.,2018). It is argued that the knowledge surrounding the

experiences of the survivors of suicide is limited due to the majority of research surrounding suicide being carried out using quantitative methods (which may not be sensitive enough to capture the experience of the bereavement process) (Shield et al. 2017). In addition, there is a focus on the comparison of bereavement by suicide to other forms of bereavement, rather than focusing specifically on the experience of those bereaved by suicide (Andriessen et al., 2018). Instead, it may be more beneficial to use qualitative research methods, which enable participants to describe their experiences gaining access to a more systemic and thus arguably better understanding into this area (Andriessen et al., 2018) Furthermore, Andriessen et al. (2018) found that the majority of survivors by suicide are interested in participating in Suicide research. Indeed, research suggests that (73%) of study participants rated it as a positive experience with (90%) highlighting they would recommend it to other survivors. Participation helped with gaining an insight into the grief experience and providing opportunities to help others, thus contributing to personal growth (Andriessen et al., 2018). However, a small number of participants rated taking part in research to be a negative (2%) or upsetting (5%) experience. This was associated with feelings of guilt and the resurfacing of painful memories (Andriessen et al., 2018). Feigelman et al., (2012) (as cited in Andriessen et al., 2018) found that after a period of time a large number of survivors felt they had experienced personal growth from “giving back” and trying to “make a difference” in their support group circles by helping others. Nearly two-thirds of parents losing children to suicide 5 or more years earlier had personal growth scores. This suggests that taking part in studies before five years after the bereavement could be beneficial to some suicide survivors. This study involves participants who lost parents no longer than three years previous.

Despite this, there remains limited literature addressing the specific needs and the voice of child/young survivors of suicide (Jackson et al. 2014; Hung & Rabin 2009). A literature search using Google Scholar, Mendeley and the University of Sheffield's database generated scant results surrounding qualitative research exploring the voice of the child/young person in education who lost a parent by suicide. Only one case study was found exploring a child's experience of suicide which was based on

a participant over the age of 20 reflecting back to the age of 13. 11 years were lapsing which arguably results in memory depletion which may have impacted the accuracy of such research (Jackson et al., 2014). This area of research is limited despite the importance of children and young people's participation in decision making about them in times of transition, crisis or adversity now being recognised in practice guidelines and statutory processes (The Revised Code of Practice, SEN, DfE 2014).

It could be suggested that the voice of the child allows for more thorough evaluations, which lead to progress with policies and practice (Save the Children UK, 2000). Further, Ruddock (2007) found that if pupils genuinely listen to it could influence education reform. Children should have the right to express their views irrespective of their maturity (Lundy, 2007). Woolfsen (2008) suggests that young people can participate effectively by expressing their views about how mental health education should be delivered and the study found that young people had clear views on specific areas. It is evident then that having conversations with pupils themselves can provide possible improvements in the effectiveness of support. Arguably consideration of suggestions which arise from such conversations could make support more effective for pupils. How do professionals know what would be effective support to put in place for this vulnerable group of people if they are not asked?

It is argued then that more research into this area using the child's voice should be carried out. An Educational Psychologists work involves listening to and acting upon the voice of the child which are skills necessary to carry out such research. Indeed, EP research was carried out by Hall (2010) using focus groups to facilitate conversation surrounding mental health. The participants were encouraged to explore features of their school that promoted and demoted mental health and wellbeing. Although a small-scale study (eighteen children from Reception Year to Year 6) findings contributed to understanding, resulting in an action plan for areas of focus within school, both to 'keep' (areas which were currently promoting mental health within school) and to 'change' (areas that could be changed to promote

mental health further). The study was considered positive in accessing the voice of the children and the resulting action plan generated some change at an organisational level which was deemed successful (Hall, 2010). EP's have the skills and opportunities to elicit children's views naturally and include them in plans that affect them (Department for Education, 2000). EP's also recognise power imbalance and pay attention to those with the least power who are vulnerable and try to help redress this balance. I therefore suggest that the EP's research into this area is a valuable contribution to help understand this complex area.

1.8 Conclusion and rationale

Despite suicide being preventable (World Health Organisation, 2014) the figures discussed above highlight that suicide affects many families including children and young people. Grief by suicide is complicated and is arguably like no other (Simone,2009). Indeed Nam (2015) identifies that most individuals bereaved by suicide experience trauma connected to the violence surrounding the death and are often exposed to gruesome scenes. Survivors of parental suicide are left with the challenge of trying to understand why their parents died by suicide, but also of coping with the impact upon the surviving caregiver, who may not be available to offer the needed support (Mitchell & Terhorst,2017).

Research suggests that young survivors of suicide continue to be profoundly affected by events surrounding it long after the event. Survivors have experiences such as flashbacks and intrusive thoughts and are more at risk from the effects of complicated grief including depression, poor academic performance and indeed suicide itself (Scocco et al. 2017; Jackson et al. 2015; Ratnarajah & Schofield 2008). It is also evident that regardless of a more recent societal shift that stigma surrounding suicide is still prevalent. This arguably has a significant impact on the support received after death (Scocco et al. 2017).

Recovery after such a significant loss or trauma may involve a more systemic approach supporting the individual, the family unit, and their connections to the wider society rather than be dependent on the strength of the individual or family (Ratnarajah & Schofield, 2008). Counsellors, health and welfare service providers and education professionals may benefit from being aware of the links between mental illness, depression, addictive behaviours, and suicide risk, as well as the impact these problems may have on related children (Ratnarajah & Schofield, 2008). Research suggests that those working in the education systems that these children are embedded in could have a vital role to play in the family's recovery. This research aims to highlight CYP experience in education following the suicide of a parent hoping to raise awareness and help shape how education professionals support and respond to the children and young people. It is thought that by understanding some of the many complexities of grief from suicide and what survivor's needs are, professionals can support the survivors more fully. This alone may be an essential element in postvention and prevent a further tragic cycle of unnecessary deaths and devastation from suicide.

Support for people bereaved through suicide has been identified as an essential strategy in suicide prevention (World Health Organization, 2014). Evidence also suggests that research should value the experience of suicide loss survivors and should use this to understand experiences better and help with developments for postvention. However, most research and resources have been devoted to suicide prevention through raising awareness and helping individuals who are suicidal with little attention given to postvention and scant literature addressing the specific needs and the voice of child survivors of suicide (Jackson et al. 2014; Hung and Rabin 2009). Suicide is a prevalent topic, which negatively impacts many children; this research aims to increase awareness by exploring the experiences of this vulnerable group of individuals and what support they feel would be beneficial. It is hoped that the findings may help by contributing to the developing of postvention training, specifically for educational professionals who could play a significant role in supporting these individuals. A literature search using Google Scholar, Mendeley and the University of Sheffield's database was carried out. A general search for

literature surrounding suicide was used, with the aim of gaining some general facts and statistics on the subject. Papers were also searched for using key academic names to help develop an awareness of current interests and development in the area of suicide. I then searched papers connected to bereavement from suicide and experience of losing a close family member from suicide and the impact on education. Original my research was aimed at understanding the experience of losing a close family member to suicide. However, my participants all lost a parent to suicide, so the research was adapted for this. As outlined above the literature highlights that suicide is complex and that there is not one causation factor, rather it is seen as complex and systemic; literature also highlights that the trajectory for grief and recovery are also dependent upon systems that the survivor is embedded within, but that these same systems can act as a barrier for gaining support.

below are the research questions that will be addressed

1.9 Research Questions

1. What narratives do young people share surrounding losing a parent to suicide and what common themes emerge that can help shape how educational professionals support a young suicide survivor
2. How do young people think the suicide impacted upon their education.
3. What support would the child/ young person like to see put in place to help support young survivors of suicide

Chapter 2 Methodology

2.1 Overview

This chapter will outline my ontological and epistemological position and the philosophical assumptions of the research. I will clarify why individual choices were made regarding research methods and explain the procedures taken. Quality

assurance within research will also be discussed and ethical considerations reflected upon.

2.2 Ontological and epistemological positionality

For this research, I adopted a social constructivist epistemological paradigm. Certain philosophical assumptions underpinned this framework for inquiry, and I hope to clarify the reasons for my choice (Willig, 2008).

Ontology is the philosophical study of the nature of being, existence or reality 'what is there to know'. Two polar ontological positions are realism and relativism (Willig (2001; Hepburn, 2003; Silver, 2013). Realists argue that the external world is perceived the same by all human beings; there is one single 'truth'. Relativists agree that there is an external world but argue that there is no single truth; reality is created by individuals and the environment they are embedded within. Thus, we can only directly access representations of the world in our consciousness (Hepburn, 2003; Silver, 2013).

Epistemological assumptions underpin all research and are concerned with the theory of knowledge, 'how do we find out what there is to know'. The two polar epistemological positions being positivist and interpretive (Willig,2008). The positivist position is embedded within the realist ontological positioning and is very familiar in science; It uses an objectivist approach based on causality relationships, facts and numerical data. In contrast, interpretivism generates knowledge using a subjective approach and is embedded within relativism, rejecting the objectivity and measurability of positivism and acknowledges the role of independent realities (Kelly et al., 2008). Kelly et al. (2008) point out that within social sciences, particularly within educational psychology, there has been a development in scientific thinking in terms of 'critical realism'. Critical realism offers integration of both realist and relativism concepts and involves using both qualitative and quantitative paradigms for research.

There has been a great deal of research surrounding suicide. However, much of this is quantitative, aligned within the realist epistemology positionality. Arguably the domination of quantitative methodology could act as a limitation surrounding suicide research and the knowledge that has been generated to date. I suggest there to be a gap within the research, specifically using qualitative methodology exploring lived experience. Further, as previously mentioned, to the best of my knowledge no research exists that gives voice to the CYP who have recently been bereaved by suicide; despite acknowledgement that CYP should be involved in research and decisions about their lives (Hardy & Hobbs, 2017). Taking this into consideration I decided to use a social constructionist approach, which is embedded within the relativist positionality. My reasoning was to add to the research already available, by enabling a new dimension of knowledge to include the lived experience of the CYP.

2.3 Qualitative research

The focus of my research was to give voice to the experiences of CYP and to gain insight and understanding of their stories; therefore, it was necessary to employ a qualitative method. Qualitative methods do not attempt to test hypotheses and instead aim to explore detail and meaning around an area of concern (Langdrige, 2004). It could be suggested that qualitative research is not scientific, but merely descriptive, subjective and not generalisable, thus meaningless. However, Billington & Williams (2017) argue that qualitative research has led to better science, due to the questions it generates and highlights. Historically quantitative research has been the dominating paradigm.

Nevertheless, during the last three to four decades a growing number of psychologists, especially working within education, have produced qualitative research which engages with theory and critique of practice (Billington & Williams, 2017). There is also an increase in the use of qualitative methods within psychology, including discourse analysis, feminist research, phenomenology, narrative, case studies and grounded theory which have a shared theoretical underpinning which challenges the notion of knowledge and truth embedded within a positivist approach

(Billington & Willims, 2017). Qualitative research allows the participant to have a voice; it can capture emotion in areas that might not be possible with quantitative methods and is particularly suited to researching with vulnerable groups, such as children (Macdonald et al., 2008). Qualitative research not only enables the researcher to explore meanings, values and feelings but also allows data collection which is 'minimally intrusive' and enables the researcher to gather data compassionately which is essential for this research topic (Seymour, 1998).

2.4 Selecting a method

My research ontological and epistemological positionality was established which enabled the research paradigm to be then selected. The next stage was to determine the research method which would complement the philosophical underpinnings. The richness of human experience, giving agency to the CYP voice was at the main aim of the project. I wanted to give CYP who lack power space for their account to be recognised. Thus, to enable empowerment, the method needed emphasis on the importance of voice and the complexities of relationships, also acknowledging the presence of the researcher and their role in constructing the data (Billington & Williams 2017). I initially considered four methods that were potentially suitable for the research, Grounded theory (GT), Interpretive phonological analysis (IPA), Discourse Analysis (DA), and Narrative; after consideration and discussion with my supervisor I decided upon narrative.

2.5 Narrative Inquiry

Narrative psychology is a wide area, embedded within a person-centred, humanist approach and can be useful to elicit personal experience from respondents (Billington & Williams, 2017). Narrative is aligned with social constructionism and the notion that individual lived experiences and society's constructions surrounding experiences of the lived world impact upon us. It is concerned with self and identity and argues that we live through stories that we and others tell about us (Murray, 2008). Narrative knowledge is created and constructed through stories of lived

experiences, and the meanings created which helps make sense of the complexity of human lives (Bruner, 1986). Narrative treats stories as knowledge which constitutes 'the social reality of the narrator' (Etherington, 2004). It conveys a sense of the person's experience in its depth, messiness, richness and texture, by using the actual words spoken. It acknowledges the researchers' part in that conversation and is transparent about the relational nature of the research and how these stories are shaped through dialogue and co-construction (Etherington, 2004). Thus, there is an emphasis on co-construction of meaning which provides a reflexive layer regarding the researcher's positioning. While being involved in, listening to and reading the conversations the researcher makes sense of the information while comparing it to their own stories and personal understandings. The researcher does not fill in any gaps in understanding but rather explores how pieces of the stories make sense together. The process of 'data gathering' and 'analysis' therefore becomes an intertwined, singular and fluid process (Riessman, 1993; Clandinin & Connelly, 2000).

The term narrative has different meanings and perspectives; it is both a phenomenon and a research method (Gray, 1998). This research draws on Narrative Inquiry, which is an umbrella term that captures experience over time and takes account of the relationship between individual experience and cultural context (Clandinin & Connelly, 2000). Narrative inquiry is embedded within social constructionist epistemology and was therefore thought to be suited to this research. It requires a research relationship with high levels of ethical and critical engagement; mutual and sincere collaboration; the Storyteller having a full voice, but both voices heard with the reflexive engagement of the researcher throughout (Riessman, 1993). There is an assumption that if individual stories are given value and listened to a broader understanding of CYP who have difficulties can be developed (Cefai & Cooper, 2009); this then is aligned with the aim of this research in the context of suicide survival and its impact. I intended to give agency and equal value to each CYP's story with an aim for a better understanding and an aim to try to help shape future support from educational professionals.

2.6 Quality in research

It is argued that experimental psychology's standards associated with reliability, validity, generalisation and ethics are not appropriate for narrative research (Riessman, 2008). Instead, concepts such as rigour, trustworthiness and transferability are argued as more appropriate for qualitative research (Reissman,2008). Within a social constructionist paradigm where data is co-constructed the research is not expected to be replicated; thus, does not claim to be a reliable form of truth to confirm hypothesis (Merten, 2015). Narrative interviews are interpreted, and thus subjective; reliability is not a quality indicator in my research (Tracy, 2010). Instead, value is placed on reflexivity from the researcher. Reflexivity requires 'authenticity' and 'honesty' from the researcher, thus contributing to the trustworthiness of the research (Riessman, 2008). The stories, how they are told, and the interpretations that we make and share with others are no doubt influenced by our positionality as a researcher about our participants (Greene, 2014). Therefore, in order to achieve a deeper level of trustworthiness, I needed to be aware of my own subjective values and biases as a researcher. My own experience of losing my father from suicide at the age of 14 while still in fulltime education places my positionality as that of an inside researcher, which is the study of a social group or social organisation or culture of which the researcher is also considered a member (Greene 2014).

Greene (2014) highlights that there are advantages and disadvantages of insider research. Insider researchers are free from the effects of 'culture shock' and have a pre-existing experience and knowledge of the context of the subject (Bell, 2005). It is argued that insider researchers have the capacity to ask more meaningful questions, read non-verbal cues and can have a more authentic understanding of the participant's lived experience (Greene, 2014). However, it is argued that one of the most significant limitations to insider research is research bias and that the inside researcher is too close to raise provocative questions (Greene, 2014). Further, it is suggested that the inside researcher has a clear personal interest in the subject area and personal beliefs, experiences, and values will have undoubtedly influenced the research design, and results (Greene, 2014). Therefore, the inside researcher must

be wary of projecting their personal views onto participants, or the data analysis; they must be aware of potential biases and take measures to ensure that the research is as transparent as possible (Greene, 2014).

In contrast, Hertz (1995) acknowledges that the researcher does not merely report facts or 'truths' but actively constructs interpretations of their experiences in the field, and then questions how those interpretations came about. Regardless of whether my positionality is considered a strength or limitation to this research, it was a fundamental requirement that I took a reflexive approach, being transparent with the reader, by acknowledging my thoughts and feelings and the possible influence on the research. Therefore, I highlight my thoughts and beliefs throughout the research and allow availability of procedures, transcripts and analysis.

In addition to reflexivity, it is suggested that inside research credibility can be supported by carrying out member checks (Greene, 2014). This involves findings from the analysis being presented to participants with an attempt to gain their views and verification. Member checks allow for revision of the data to ensure interpretation is aligned with the participant's authentic experience, minimising any differing views (Yardley, 2008). After a discussion with my supervisor, I decided that member checks would be inappropriate for this research due to the sensitivity of the topic. The research required participants to revisit some painful and traumatic experiences. They gave up their time to speak to me in an interview, with a possible risk of resurfacing unwanted memories and associated emotions. It did not then seem ethical to return to the participants to discuss their traumatic experience further. In addition, I chose to disclose my positionality as an inside researcher after the interview. I did this because I did not want to impose my experience and influence their told story at the time of the interview with my story. I was mindful the power dynamics of me being an adult researcher into a topic that I was familiar with may have influenced response; participants may have perceived me as the 'expert' and thus, may not have felt comfortable sharing their story. Participant checks would have been carried out with their knowledge of my experience, and this may have influenced the member checks. There was a possibility that the participants would

just agree with my interpretations due to my own experience. This then raised questions to me as to how useful and valid member checks for this research would be.

In contrast to quantitative research, generalisability is not associated with narrative research, due to its reliance on smaller participant samples. The purpose is to seek depth and richness over breadth (Riessman, 2008). Transferability is the alternative term applied to qualitative research and is concerned with how the findings may be applicable beyond the context in which the original data was generated (Kuper et al., 2008). It recognises there may be transferable elements from the research findings by acknowledging the reader may engage with similarities of areas and their situations but does not try to force shared experiences (Willig, 2013; Merten,).

2.7 Ethical considerations

I acknowledged the vulnerability of participants and the sensitivity of the subject, and in no way wished to disturb natural grieving and add extra stress to this process. I originally wanted to open this research up to CYP from secondary school upwards. I feel that there is a gap in the area exploring the voice of the child. However, it was predicted that ethical approval would present as a barrier and not allow access to younger participants. Thus, in this instance, ethical approval was sought for participants in the age range of 16-25. The rationale was that participants of this age group are deemed more self-aware, enabling them to make more sense and articulate more fully what their experience was like, thus allow ethical approval more readily. I hope that this will be a starting point and that further research will be carried out using the voice of the CYP from a more comprehensive age range. The ethical application was guided by the requirements of the University of Sheffield ethics board and the British Psychological Society's (BPS) Code of Human Research (2010), (see appendix 1 for the ethical approval letter). I had previously undergone an Enhanced Disclosure Criminal Records Bureau check to work with children and young people in the capacity as an EP. One of the key aspects of working as an EP is to undertake research often involving children and young people.

Following ethical approval, an email was sent out to the charity with a letter attached to inform participants of the study and its objectives (see appendix 2). The charity then passed on this information sheet to potential participants and informed me of their interest. Only after providing this information and making initial contact with the participants was formal written permission then gained and in the case of under the age of 18 from the participant's parent. I was aware of power dimensions and that a child may feel obliged to consent because of a perceived duty to their support worker or even their deceased parent. Therefore, I took care to emphasise that their contribution was voluntary, and they could withdraw at any time. Throughout the study, I was attentive to the importance of on-going consent, and throughout each stage, I restated that their contribution was voluntary, that there was no obligation to continue and that they could withdraw at any time with no consequences.

In contrast to Smith's (2005) assertion that research ethics are followed to meet institutional and professional regulations rather than considering the needs and views of vulnerable communities, I was particularly concerned about ensuring I followed a set of moral and ethical considerations which focussed on being sensitive to the vulnerabilities of the CYP. I thought it essential to implement procedures to minimise the risk of distress and to protect participant wellbeing. Ireland & Holloway (1996) suggest that risk is minimised if interviews are carried out sensitively. Recognising the possibility of CYP experiencing some distress, it was essential to build rapport, comfort and familiarity. Thus, I conducted the preliminary getting to know you session, using the magical day technique which is discussed further in the procedure section. I aimed to help relieve anxieties and promote confidence in a safe environment, before proceeding on to the second stage of the research which involved talking about the bereavement (Gavin, 2008; Murray, 2015). This ensured the participants had time after meeting me to reflect upon if they wanted to continue with the second stage of the research.

The participants had the choice of having their support worker in the room throughout all the stages and the support of the charity support worker after the

interviews if needed. In addition, I signposted participants to available extra support services. I also emailed each participant a few days after the interview to check they were ok and getting any support if they needed it. When conducting the research, I assured participants that the research was exploring their story and that it was not an interview as such, that I may ask questions as we went along, to make sure I understood their experience, and that there were no right or wrong answers. Contingencies were also considered in the event of a CYP becoming distressed or upset. Interviewees were provided with a set of laminated traffic light cards. It was explained that as long as the participant was happy, they would keep the card on the green; if they did not want to answer a question, the card could be put to amber and if they wanted to stop the interview at any time, the card could be put onto red. It was hoped that this indirect way of expressing their needs and feelings would be reassuring for them; ensuring that the participant had control of the situation and could choose not to answer or stop at any time. Confidentiality was maintained in the write-up and pseudonyms were used to represent the participants, interviews were coded, and themes generated.

One of the most significant ethical dilemmas I experienced during this research was when to disclose my positionality to the participants. I felt that it was important to enable the CYP to tell their own stories without the influence of my experience. I did not want the interview to become a conversation involving comparisons. I acknowledge that my experience would ultimately influence the interpretation and analysis but did not want my experience to dilute their told story. However, I was concerned with how the participants would feel once I had disclosed my positionality and if they would see this as a negative and feel deceived by me. There is the question of why I chose to disclose my position to my participants at all. I did not want to feel like I was deceiving them in any way. In addition, one of the arguments in suicide research is that it is stigmatised, not talked about and created a feeling of isolation and disconnection, as a suicide researcher then, it would have felt hypocritical of me not to let my participants know of my experience. This was the primary consideration in my pilot study which involved my eldest participant with the most prominent time lapse between the interview and the suicide of his dad. I decided to not disclose my positionality until after the interview and then asked him how he felt about this. I told

him my concerns with not wanting to deceive him or future participants, but that I did not want the knowledge of my experience to hinder their own story. I checked how the participant felt about this and if he thought that I should pre-disclose to the next participant. I was reassured that my decision was the right one with this participant; he told me that as long as I did disclose, then he felt it was ok to do it after the interview. He said that he had an intuition that I had experienced suicide during the interview, due to my body language and facial expressions to his narratives; he said: “you can just tell when someone else has gone through it”.

Given that I decided to not disclose my positionality until after the interviews, I have since considered how the outcomes of the storytelling may have been different if I had pre-disclosed. I wonder if participants would have opened up more (because they felt safer and more understood by me) or been more guarded (because they did not want to go against the researcher’s experience, thus, pre-empt my thoughts and tell their story to stay in alignment with mine)?. I have concluded that there is no way of telling if the time of my disclosure has been helpful or a hindrance, but I am satisfied with my decision and the reasoning behind it.

The final consideration was for the wellbeing of myself as a researcher. This research is a sensitive topic, and I had a duty of care to both myself and my participants to protect my wellbeing. It was essential that I had support throughout this project because any detrimental impact this project could have had on me would ultimately have been reflected within the research as a whole, thus not doing justice to my research participants’ contributions. Protection for myself consisted of support from my research supervisor. Also, I also had access to support agency contacts such as the charity's central helpline and Samaritans helpline.

Further, before carrying out the data collection, I attended the Early and Mid-Career Research Forum (EMCRF) in Glasgow for suicide and self-harm. Attending the forum enabled me to network with other researchers in the area (most of whom have personally been affected by suicide in some way; it was reassuring to me to hear that

the value of lived experience in the involvement of suicide research is acknowledged as being an important contribution). I am also attending the conference again this year to present my findings. I joined the International Association of Suicide prevention Early Career Group (IASP ECG) and the International Network of Early Career Researchers in Suicide and Self-harm (NetECR) both of which offer support for colleagues and peers to network with each other and aims to raise the profile of suicide and self-harm research being conducted internationally.

2.8 Procedure

Participants

Gaining access to vulnerable groups of CYP was the most challenging aspect of this research due to the two gatekeepers, both professionals and parents. Participants were revelatory samples, being approached because they had been part of a specific group (Cohen et al., 2011). I initially contacted charities that are known to support CYP in the event of a bereavement, by email. Emails with an overview of the rationale for the research were sent to, Winston's Wishes, Samaritans, Cruse Bereavement care and Child Bereaved UK. This was itself a significant hurdle for the research and only one charity replied who was willing to support this research. The charity has support centres located throughout the UK. However, none were within easy access for me and access to participants required an amount of travelling, which impacted upon the number of interview participants I was able to engage with within the time constraints of the project. The criteria for participants were that they had a current relevant educational experience, but a suitable period (as guided by the charity and CYP themselves) had elapsed since the loss. There were 3 participants (including one pilot); a 16-year-old female who was 15 and in year ten just starting her GCSEs when her mother died by suicide (Recruited by a southern branch of the charity). A 19-year-old male who was 16 and in his final year of GCSEs when his father died by suicide and a 20-year-old male who was 18 and in college when his father died by suicide (both of whom were recruited by a northern branch of the charity). All three participants were of western ethnic backgrounds and had different support workers. No other details of participant are included in this research to avoid the potential of their identities being exposed.

Pilot study

Following ethical approval, one pilot interview was carried out prior to the other two. This was to help shape further interviews regarding what was useful and not useful when questioning the participant. As previously described, it was mainly to gauge at what time I should disclose my own experience. Due to the sensitive nature of this research, it did not seem ethical to carry out such an intense interview and use this only for pilot purposes. Thus, it was evident in the ethical application and to the participant, that the data generated from this pilot was to be used for the final data analysis.

Interviews

Billington (2006) asserts that narrative approach is both valuable as a research tool and as a method of practice, particularly when working with vulnerable children and their families. In narrative, open conversations are encouraged, and I was aware that to facilitate this with young people it was necessary to make the process flexible and enjoyable so that they did not feel threatened in any way (Clarke, 2005). I decided to approach the research in two sessions to allow for trust to be built between the participant and myself. I reasoned that this approach would help to reduce pressure and give the participant space to reflect upon and decide if they wanted to move on to the next stage; it provided a 'cooling off period' for if they decided they did not want to progress further than the first activity.

When planning the interview, I initially considered using the personal construct psychological activity of the ideal self (Moran, 2001) or an introduction activity from the beads of life narrative approach (Portnoy et al., 2016). However, on reflection, I decided that these approaches could potentially lead to the participant engaging in more in-depth discussions surrounding the suicide, which was not the intention of the initial meeting. Further, I did not have consent at this stage for an in-depth interview, due to the rationale behind giving the CYP a period to reflect before approaching the subject of suicide in depth. I decided to use a narrative exercise called the magical day that I was introduced to during a narrative therapy's seminar at university (Franklin, 2017). The activity follows guided questions asking what activity an

individual would be doing if they had a magical day, who would they do it with, where they would do it, how long they have enjoyed the activity, why it's important to them, who would know this about them, and how the activity expresses itself in their everyday life. I explained the purpose of the activity to the participants and told them that it would not form part of the research data. I allowed the CYP to draw pictures of the magical day or just speak to me, with me taking notes. This enabled the CYP a 'taster session' with me to talk about things they enjoyed, and it was my intention to give the CYP a 'safe space', to express their views about themselves and different things that were important to them without being problem saturated or bringing in the topic of suicide (Weidberg, 2017). I felt that it allowed the CYP to have the experience of an unfamiliar adult asking them personal questions then allow them to decide if they wanted to talk to me further. It also allowed the CYP time to experience being interviewed with their caseworker in the room, decide if they wanted them there for the next stage or if they would prefer to just talk with me. I allowed a cooling off period between the magical day and the interview of between a week and two weeks and the participants signed a separate consent sheet for the second stage of the research.

During the second stage of the research interviews, my aim was to listen to CYP telling their own stories, rather than a version that adults have decided for them. I wanted to create a space for having a conversation with a purpose shaped by the CYP. I chose to take a naturalistic approach which offers a more natural conversation aspect and allows participants to share as little or as much as they want (Williams, 2017). I had some Semi-structured interview questions, and some narrative type prompts written down to develop the conversation if needed, but I wanted the main part of this to be led by the CYP. Thus, instead of responding in a therapeutic manner and planning ways forward, I remained with the story that they shared. Narratives allow for continuing interpretation and re-interpretation of life experiences and through listening to and co-constructing their stories, I felt I would enable the CYP to feel like their story was authentically heard. Co-construction in narrative research refers to stories and narratives which are jointly constructed by partners about moments in their lives (Riessman, 2008). Through careful questioning, this approach allows interviewees to actively construct a version of

events, to provide insight and reflection on what has occurred. Co-constructed narratives help the interviewer and interviewee to make sense of ambiguities in their lives and situations. I used questioning techniques to confirm that I had interpreted and understood correctly what the CYP was telling me, this is evident in the interview transcript.

Additionally, I used questioning to explore their feelings and thoughts about situations rather than a set of structured questions to follow. The Interviews varied in the length of time from 90 minutes to 75 minutes and 50 minutes with variation to the amount of questions/input I had as the researcher; this can be seen in the transcripts (Appendix 5,6,7.)All interviews were auditory recorded and transferred on to a secure UBS pen stick, anonymised, transcribed and coded.

Analysis

The focus of my analysis was the told story (the fabula; the plot) rather than how the story was told (the sjuzet; the delicate details) therefore thematic analysis appeared to be the most useful analysis to employ (Riessman,2008). In order to stay true to the narrative approach it was vital to keep individual story's intact rather than form components themes across cases; something Riessman (2008) terms thematic narrative analysis. As a researcher, I am relatively new to thematic analysis and as such sought, some structure, therefore drew on aspects of Braun and Clarke's (2006) thematic analysis approach. I was conscious that I wanted to preserve and provide a rich thematic description of each participant's story and to give the reader a sense of the predominant or important themes. To enable this, I was aware that the themes that I identified, coded, and analysed would need to be an accurate reflection of the content of each data set as well as including a synthesis of some kind from the entire data set.

The generation of themes was carried out using an inductive approach (data-driven, with no attempt made to fit the data into a theoretical framework) (Braun & Clarke 2006). However, themes are generated using the researcher's thoughts; I

acknowledge that these may have been subconsciously influenced by thoughts surrounding previous research and my affiliation with certain theoretical frameworks in association to suicide. In order to generate themes from each data set each interview was listened to, and then the transcripts read and re-read. It was clear at this stage that each participant's narrative had a chronological ordering. This may have been shaped by the structure of the interview question and thus influenced by me.

Nevertheless, after a discussion with my supervisor, it was evident that each narrative had a 'before the suicide', 'discovery' and an 'aftermath' episode/section. Riessman, (2008) points out that narrative thematic analysis may involve the researcher working with a single interview at a time isolating and ordering relevant episodes into a chronological biographical account. However, in the case of this research, the ordering of episodes seemingly developed organically as they were spoken and was duplicated throughout each data set. I decided that to enable the further organisation of the data each data set would be broken down into the three episodic sections and codes developed for each of these sections. At this point in the analysis, each episodic section of each data set was reread, and notes were taken to develop codes.

Codes were linked to words and phrases that were deemed relevant and important to the research questions which were highlighted within the transcripts. Codes were then reordered on the right-hand side of the transcripts linking the corresponding text (Appendix 5,6,7). Codes were then grouped into subthemes (sub-themes are themes-within-a-theme and are essential to give structure to a broad and complex theme) and placed into a thematic map (Appendix 8,9,10). Subthemes were checked, and some codes moved into other subthemes and finally, the themes were generated for each data set. Three main themes were generated for each data set, a theme for each episodic section (before, discovery and the aftermath). These themes will be discussed in more detail in the findings and analysis section, and similarities across the whole data set will also be identified. The data analysis and thought process surrounding the analysis was supervised throughout the project.

Codes, subthemes and themes were checked by my research supervisor to support my reflexivity and interpretive process.

Chapter 3 Findings and Analysis

3.1 Overview

This chapter will explore the participant's narratives within the context of answering research question 1:

1. What narratives do young people share surrounding losing a parent to suicide and what common themes emerge that can help shape how educational professionals support a young suicide survivor
2. How do young people think the suicide impacted upon their education.
3. What support would the child/ young person like to see put in place to help support young survivors of suicide

However, as stated previously I did not want to reduce the stories to generalised themes. Instead, I wanted to keep each story intact and pay homage to my participants' individual experience. Therefore, I have analysed each told story separately, organising each story into episodes. To help retell each story, I decided to discuss the themes for individuals under the subheadings for each episode. By creating some organisation this not only helped me to engage with single data sets, but it enabled more accessible exploration of commonalities between the data sets. Extracts from participants transcripts are included within this chapter to support the codes; I have included the line number at the end of each quote to enabling the reader to quickly locate it within the entire transcript if they so wish to do so. In chapter 4 I will synthesise information from the analysis, seeking to answer all the research questions fully.

K's Narrative

3.2 Episode 1 (Life before) for K

K was the eldest participant in my study (age of 20) and gave the most extended

account. K was 17 and working on his A levels in college when his dad hanged himself; K's dad was 55. I have called the main theme for K's narrative in this episode 'Complex Ecological Systems'. This theme was generated from three sub-themes 'dad's difficulties', 'K's own difficulties' and 'home relationships' (see appendix 5 for K's full narrative and appendix 8 for K full theme map including codes).

Life before lines 23 - 740

Theme 1 Complex ecological systems

Sub-themes

Dads difficulties

Relationships

Own needs/difficulties

Dad's difficulties

K spent a large proportion of the interview describing life prior to his father's suicide. During this episode, K highlighted aspects of his father's early childhood. As mentioned, research highlights that suicide is rarely caused by one thing alone. However, literature does highlight early life adversity and disruption to attachment relationships to be a risk factor (O'Connor & Williams, 2014). K discussed his father's past in detail, and at length, something which he seemingly felt was significant.

"He was taken into care, and he was adopted by who I call my Nanna now". He wasn't feeling like he was wanted" (42 -58.)

In addition to the adoption K pointed out that his father was also bullied as a child, that his first marriage broke down, his second marriage also broke down and that he had significant health difficulties; all of which could be described as adverse life experiences.

" He was he was bullied over the course of a couple of years" (59).

"That marriage split up within six months due to adultery. Her side, she cheated on him, so he was very heartbroken by that and obviously from being an adopted child and not feeling wanted and where he came from its sort of a bigger blow than for anyone else really"(79 -82).

“ my mum said I have had enough. I love you; you need to get help, and the only way that you are going to get help is if you learn the hard way and this hit him quite hard” (557-560).

“My dad had been diagnosed with a heart attack and had to have a triple heart bypass. My mum said that it was possible that my dad gave up at that point (294-405).

These quotes highlight aspects of K’s narrative that describe his father’s background and of which could be argued as a risk factor (O’Connor & Williams, 2014). However, it should be noted that in no way are they an attempt to identify the cause of his death.

Throughout this episode, K often spoke about various aspects of his father’s mental health difficulties and associated struggles.

“ I think he came out of work once and started drinking and was stood talking to the window. It was quite hard, and my mum found it particularly hard as well, especially with his drinking. I think it was twice he had a binge drink and had a go at her. It got to the third time; he got so out of control we had to move all the ornaments out of the house because he threatened to smash them all” (141,148).

“ He suffered from depression. He couldn’t just go from one mood to the other like a normal parent could. He came off the tablets; he just went back down into depression. He went from one side of the coin to the other” (154-181).

“He had been isolating himself” (696).

It is evident that K’s father struggled with mental health difficulties. This impacted upon his daily life, his relationship with his children and wife, and alcohol consumption. Several studies state that those who died by suicide had suffered poor mental health before death (Sveen and Walby, 2008). Worryingly, many of these disorders had a genetic component. K did talk about his own mental health challenges which can be seen under the next theme heading ‘own needs/difficulties’; however, it is not known if those were genetically linked. Nevertheless, it is clear from reading the narrative and from the quotes included that K’s father’s mental health difficulties had a significant impact on K’s life before the suicide.

Own needs/difficulties

K's difficulties surrounding his education and mental health were highlighted throughout the episode of life before as seen in the quotes below.

" I was getting bullied at school. I started to then go a little bit depressed because of it. You know part of my issues is because I am Asperger's, you know I have trouble understanding" (194- 593).

I interpreted that not all K's needs were always being met surrounding these difficulties; this could be due to his father and/or mother not always being available due to his father's difficulties which impacted upon relationships within the family.

Relationships

K's account described a turbulent home life with a mostly unpredictable father, who for the most part did seem unavailable. For example, K said:

"When he'd come home my dad was more like let me get in, let me have my time, and he'd go upstairs. He couldn't shift it because it is a disease depression and he couldn't get out of it, so rather than take it out on you, he thought the best way was to go away. Now as a kid you don't understand that, so it was quite hurtful for my sister and me" (150-161)

" I picked up in a sense that my dad was. You know not there. Sometimes I used to wonder you know what he would be like when he gets home. It could be one day when I got home, and it could be you know how's your day son did you do good in maths blah blah blah, did you do good in the mocks and stuff. And then other days he'd never come up to me"(220-228).

" He got quite frustrated, and that led to a house where I couldn't stay in a lot of the time. I had got my bike, so I could go out you know anywhere" (536-538).

Research suggests that Young people who have lost a parent to suicide are more at risk for suicide. However, as is presented in K's narrative there may well be a history of difficulties within the family system, which contributed to and/or culminated in the suicide. It is therefore questionable how much of life before the suicide (in association to disorganisation, chaos and the unavailability of the suicidal parent) contributes to this risk factor (Ratnarajah & Schofield, 2008). K's father was described as unavailable for the most part, which could have impacted on K's attachment relationships. In addition to K's absent relationship with his father and

his father's mental health difficulties K also talked about other complicated relationships dynamics within the family. For example, between his mother and father:

“ My mum and dad used to argue a lot more, you can't even go to the places that you love with them because they are spoiling it, but then they want to spend time with you, you are in this sort of limbo place” (202- 513)

“my mum said to my dad I am getting close to hating you I'm going to hate you if you carry on and I heard that from my bedroom; It hurts quite a lot; it was very emotional “(735-738).

After K's father had his heart operation, K account suggests that his father needed to try somehow to repair their relationship. However, it was evident that rather than gaining a father, it seemed that he gained responsibilities.

“ It was like playing catch-up, so he was like well why didn't you invite me, and I said well I was going out with my mate's dad; well I'll come with you to the next one. I knew that if I were out, I would tell some of the lads go see if he's okay (494 -601)

“I knew that with the depression It was a lot riding on my shoulders, I was the only one with him at this time. I had girl trouble; I couldn't go talk about that to my dad, I had to make sure that he was okay (599-669).

“I needed a break, but I didn't want to tell that to him, because if I do tell him, it would have broken his heart” (731,732)

K had a supportive role and he may have felt responsible for his father in life and death. Research highlights that children and young people bereaved by suicide

Reflections

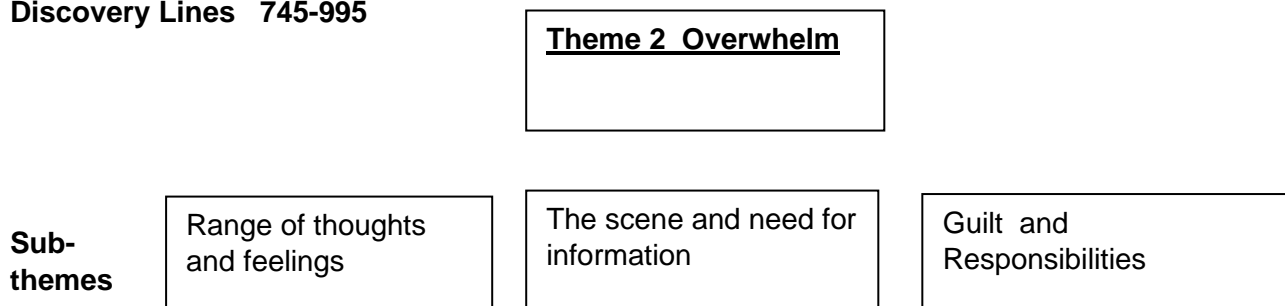
During the interview K spent a long time talking about his dad's early life. K brought me a photo album of his dad with pictures of his first car etc. At the time of the interview I felt like most of this information was irrelevant to my research and I was conscious of the time that had been spent on this. However, on re listening to the interview and during transcription it became apparent how relevant K felt his dad's early life was and how it impacted upon his dad. It was then apparent that this was linked to the literature and fitted within a systemic framework. K disclosed a lot of detail about his home life and his own difficulties. This helped me build a picture up, although during the interview I was caught up with my narrative technique it was during the re listening and transcribing the chaos of the life before episode of K resonated. It was then I decided this was an important section of K's story and this also became apparent within the following interviews.

need support to help them navigate and deal with any sense of responsibility. They need the space to be able to grieve as a child/ young person, free from the extra burden of any perceived responsibilities Ratnarajah & Schofield (2008) which K clearly had. K's life before the episode is embedded within the complexities of ecological systems (Bronfenbrenner and Morris, 1998). There are difficulties within the microsystem (family relationships, dad's difficulties, friendships) and his own needs and difficulties surrounding his mesosystem (school). It is evident that K was bound up within chaos and instability prior to his father's suicide which supports

3.3 Episode 2 (Discovery) for K

I named the main theme for K under the discovery episode 'Overwhelm'. This theme was generated from 3 sub-themes of 'range of thoughts and feelings', 'the scene and need for information' and 'guilt and responsibilities.

Discovery Lines 745-995



Range of thoughts and feelings

During the narrative interview K referred to a full range of thoughts and feelings:

“Sometimes when you have gone through this it goes blank sometimes because you don't want to remember it. I was quite frustrated and irritated and very angry”. I would say it was a mixture of shock, upset covered by this anger.”

“The next day I obviously cried, I wanted my dad. I was walking around quite a lot; I was looking for him. All the emotions started coming to me; I was upset , angry, upset, disappointed. It was like my worst nightmare had come true” (745 -836).

Supporting research that highlights survivors of suicide are more likely to experience more frequent feelings of confusion, shame, anger, rejection, intense emotions of embarrassment, or perceived stigmatisation (Bailey et al. 1999; Botha et al., 2008; Simone, 2009; Hung & Rabin, 2009).

The scene and a need for information

During the initial range and intensities of thoughts and feelings, K seemed to want to visit his father's house (the scene of his father's death); he indicated a strong need to gain information surrounding his loss both immediately after and during the time since the death. This supports Powell & Matthys (2013) who found there is a need for survivors to search for information, questioning co-workers, friends, or anyone who may have interacted with their loved one in the days or hours leading up to the suicide.

“ I said to my mum I want to see the garage; I want it done I want to get it over with and then I can deal with it. Over the years I have had to piece things together and ask a few people”(928-944).

“You could picture it in your head, what it looked like”. The police had not cleaned the scene up, so when we go there, the ladders were still there, the knife that had been used to cut the rope. We saw this like the plastic covering on the on the bench, so I walked up to it, and it just said body bag extra-large” (951-960).

It is unclear from the narrative if K found visiting the scene helpful or if it just added to his pain. Chapple et al. (2015) point out that sometimes suicide survivors have to face and/or clean up the death scene itself when the suicide has occurred at home, something that is unique to suicide and arguably something that is traumatic for anyone, particularly a CYP. It indeed came across in my interpretations of K's narrative as being a traumatic event.

Guilt and responsibilities

Guilt It is arguably something that survivors of suicide are more likely to experience on an elevated level (Botha et al., 2008; Mc Menamy, 2008; Simone, 2009; Hung & Rabin, 2009; Bailey et al. 1999) which was apparent in K's narrative:

“I knew I could never stop him, but I should have spoken up, at the time I should have spoken up, but I couldn’t. I can’t just say well I knew he was going to do it because then the whole family would have never forgiven me” (815- 820).

Along with guilt, there is often a perception of responsibility and research suggests that children and young people hide the pain of their loss from surviving family to avoid upsetting them more (Simone, 2009). This can be a way to appear strong, especially in younger survivors who often feel obliged to support their surviving parents(Pitman,2017). The feeling of responsibility that K had towards other people was apparent throughout this episode:

“I wanted to look after my mum, I wanted to make sure my sister was okay, and now he’s gone, I am only the only adult male there, so I had to hold it in for them. I felt like I had to keep my feelings to myself, in order to not put it on them because they were going through enough. Especially my mum; because she had to deal with her grieving and two children and I thought if I could just relieve her of some of that pressure, then I’ve done the best I can” (839- 967)

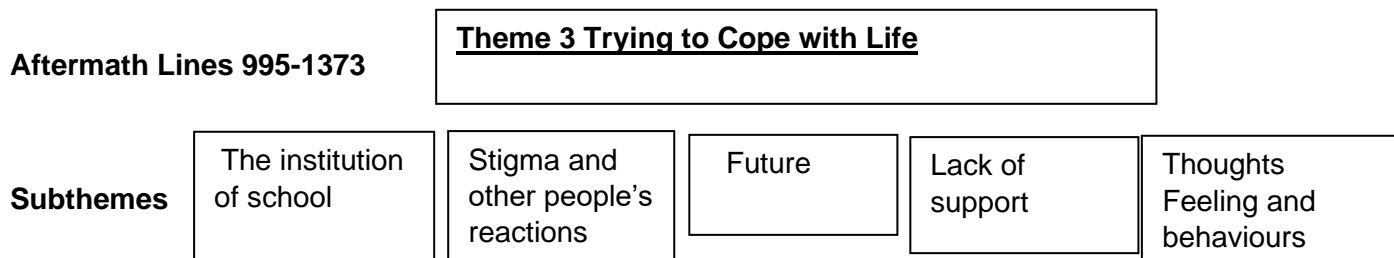
Reflections

This was a difficult section for me in two ways. The first was that I found this really sad when I was listening back to the interview and during transcription. I really felt like I connected to K with his longing for information surrounding his dad’s death and the different emotions that he felt. However, I found it difficult to hear about the garage and the description of the rope, as this was how my dad died. Unlike K I did not see the scene of my dad’s death, but I started to imagine it, and I really felt for K having this image in his head. It was evident that this was still a vivid image for K, and it was hard for me to lift out and write down, but I felt that this was so important and gave an insight in to the traumatic scenes that some survivors are exposed to.

3.4 Episode 3 (Aftermath) for K

This was the most extended and most complex episode for all 3 participants. The main theme generated for K was ‘Trying to cope with life’. This theme was

generated from 5 sub-themes of: ‘The institution of school’, ‘Stigma’ and other people’s reactions’, ‘significant thoughts, feelings, behaviours’, ‘lack of support’, and ‘future’.



The institution of school

K was in 6th form and so embedded within the education system during the aftermath episode of his narrative. Research suggests that many survivors are too overwhelmed and distressed to seek help or independently act on any information provided. Therefore, teachers, along with other support systems have a duty of care to help the bereaved person access appropriate ongoing resources (Pitman,2017). However, during analysis, it became apparent that somehow the pressures within the education establishment prevented this; instead, K’s narrative interpreted accounts which seemed to demonstrate a lack of empathy, sympathy and indeed humanity. Some example of quotes used to generate codes for this sub-theme are:

“it was 28th of November a month after he died, the teacher went right we are going to do a mock exam today and I was like okay you are going to be excused, but he gave me the mock exam paper and said don’t worry about if you fail and I thought you know you are just setting me up to fail then. I said Sir I can’t do it and he said well you are going to need to do it because you have got your exams in six months” (1095 -1111).

“ who’s not handed their homework in K ? and I looked at him, and I said you know why, and he said I know what you are going through, and he said the words, you need to buckle up. What angered me the most, is the fact that I was treated like I was normal again and I wasn’t normal you know” (1112 -113).

“All I wanted was for him just to say what can I do to help, and I would have said I can’t do the work. Maybe then he would have said okay do you want to sit down, and we will go through it together. I felt like I was on my own and I wasn’t in the right frame of mind, and I couldn’t do my homework” (1133-1138).

K's experience seems to support Pitman's (2017) findings that many survivors feel let down by professionals by missing opportunities to help them especially at the early stage of grief. Pitman (2017) highlighted negative experiences from professional support in association to lacking empathy and people bereaved by suicide report relationships with professionals became strained which was evident for K:

"I think one teacher said to me if you don't buckle up, I'm going to kick you off the course and I said go ahead you have not done anything for me in the last seven months so piss off" (1239 -1241)

Peters et al. (2016) found that that health professional and those informal agency support services are unsure of how to support people bereaved because of suicide. This seemed to be the case for K when he did access school support; it just seemed to cause further frustration for him:

" well, how do you how to you counsel something that you don't understand"(1247).

This arguably further limits opportunities for support for the CYP survivor and rather than acting as a place of 'normality', help and support, returning to school, became added pressure and frustration for K to navigate at an already challenging time for him.

Stigma and other people's reactions

Suicide survivors experience higher stigma in the form of shame, blame, and social isolation and avoidance (Hanschmidt et al., 2016) and it is evident that K's narrative supports this:

" When its suicide and because mental health is only just becoming something that we recognise, people don't know what to say, and that's the worst bit about it because I felt like on my own at college. I couldn't talk to anybody about it. I couldn't talk to anybody about what I was feeling, because of the fear that they wouldn't understand and that I would be rejected (1004-1112).

“I think if he would have died of heart attack or cancer, I think they would have understood, and they could have related to it I would have probably been able to go up and talk to them about that” (1144-1150).

“I think someone was brave enough to come up to me and say I think your dad was selfish. Because what people get from suicide is that they went and did it. It’s prejudging when people die of lung cancer because they were smoking you don’t go oh they were selfish because they smoked so why is it different for suicide; so it made me like no one understood about it and because I was the only one there. I felt like I was in this bubble when no one else could get into” (1160-1171).

Thus far K’s narrative highlights some of the complexities suicide survivors still in education have to navigate. However, in addition to the above external complexities surrounding school practices and stigma K was still navigating his thoughts and feelings mainly surrounding fear of abandonment which as times were presented as behaviour.

Significant thoughts, feelings and behaviours.

For a child and young person there is the additional uncertainty and fear surrounding the concept that a primary caregiver can “choose” to die and leave you (Lunde et al., 2018); worry surrounding being left was certainly evident in K’s narrative:

“ I used to get stupid thoughts like you know are my friends going to leave me. Is my mum going to leave me and other bits like that” (1054-1058)?

This fear can impact the ability to reorganise and cope, which leads to reduced social adjustment (Simone, 2009). Children and young people who have experienced suicide of a close family member are at risk of delinquency and higher than average psychological difficulties and more likely to have school problems, spare-time problems, peer problems, (Simone, 2009; Sethi & Bhargava, 2003). In addition survivors of suicide are more likely to experience more frequent feelings of anger and rejection (Bailey et al. 1999; Botha et al., 2008; Simone, 2009; Hung & Rabin, 2009). All of which emerged from K’s narrative:

“I just went like that, and I knocked him off the chair, and he just fell back, and I went you, absolute ogre, you absolute bloody bastard. Then I started to assault the

teacher. I dragged him out the door, and I said you want to know what it feels like I'll push you down the" (1117-1129).

"They didn't know what I was going to do. One minute I would be crying, the next minute I would be punching, but that's grief you know. I'd walk in there sometimes with alcohol and just have a drink. I'd just ride home you know, if I'd have got pulled over, I would have got banned instantly. I would go to class, and you know just walk out halfway through the thing, and he would go what are you doing, and I would go I'm bored"(1036 -1037).

"I said what are you fucking smiling at and he said well I can smile if I want. And I pushed him, and I did karate at the time, and I put him on the floor, and this guy is disabled; His not in a wheelchair or anything I think he had anorexic so I've bent his arm, and I could have easily snapped it, and I said don't you dare smile at me again don't you even bother smiling at me; next time you are going to your grave do you understand you will be joining my dad"(1265-1270).

Reading the above, it becomes apparent that as a young person who had recently lost his father from suicide K needed social and emotional support, in addition, to support with his academic work. However, Lack of support was a subtheme within this episode.

Lack of support

Support for people bereaved through suicide has been identified as an essential strategy in suicide prevention (World Health Organization, 2014). It was evident in all the narratives the complexities each survivor had to navigate, and Hung & Rabin (2009) point out that this makes it even more critical that adequate support systems are put in place. Research suggests there is a lack of a coordinated response to family suicide (Ratnarajah & Schofield, 2008) and K's experience supports this, his narrative suggests that he was left to navigate the situation himself with no support or guidance:

"there wasn't anything different it was just if you want to talk then you can come and talk, and I was well that's just no flaming use I won't visit I don't want to talk anyway. I could have easily repeated a year if I did want to and if I had been given the option to. They did say why don't you take some time off, and I said because of my mum, and I don't want to upset my mum, and then they left it at that. You know I wasn't in a fit state to tell myself oh yes, I need to do this. I wish that someone had, said look these are your options we can have a word with your mum as well " (1258- 1207)

Indeed, support was lacking to the point that K reached what seemed like crisis and luckily, he sought his own support which seemed to be a turning point for him.

Future

K father's death clearly had a detrimental impact on his education and had the potential to undermine his future wellbeing. However, at the time of the interview and after bereavement support from the charity K's future sounded promising.

"A lot of the jobs now want A-levels, and I haven't got good A-levels you see I can't go for some jobs I want to go for" (1325,1328)

"I was so lucky to get on the apprenticeship; if it had been up to me, I would have been probably now working in Mcdonald's for three or four years because I wouldn't have been bothered. I would have quit my lifeguard job, and I would have gone to work in McDonald's; wouldn't have had a car I wouldn't have had anything. I would have just gone oh I don't care. My mum was the one that got me that apprenticeship, and that was the thing that pulled me through because I needed that apprenticeship" (1365- 1374)

Exposure to suicide is a risk factor to many adverse outcomes including lower educational achievement and suicide itself with feelings of defeated and entrapment thought to be a contributing factor (O'Connor & Portzky,2018). K sought help from a

Reflections

I think it was this point during the interview that I really felt like I connected with K and his experience. I could feel the mixed emotions when he was talking, the sadness, helplessness and anger. The frustration of lack of understanding. I was conscious that I did not want to use K story as a vehicle to channel my own emotions surrounding my story and so during the interview I kept checking in using active listening, checking what I had heard and asking about his feelings rather than using mine. After the interview with K when I disclosed my positionality K told me that he could tell that I had experiences suicide and I think it was my ability to empathise and my nonverbal reactions during this section when this became apparent. K was passionate about his experience and that he wanted to use it to help others and this reminded me of myself and why I set out to do this research. It was at this point I realised the importance of including a high amount of the participant's actual words, so try to ensure what they said was clear rather than my interpretation using my experience .

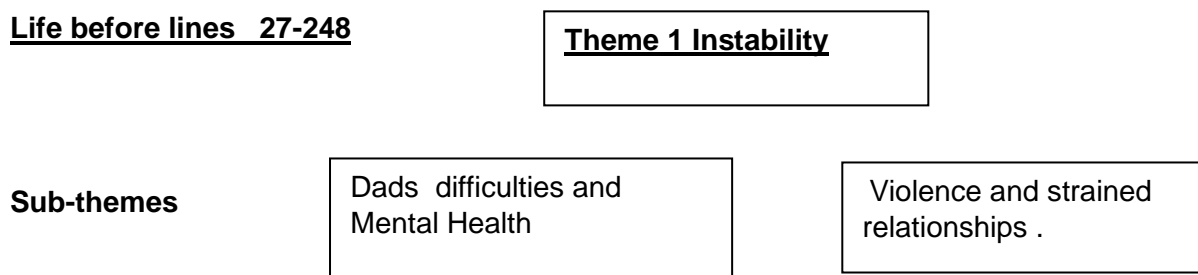
bereavement charity and with the support of his surviving parent secured a place as an apprentice. It is my interpretation that this gave K a focus and hope for the future which may have reduced any feelings of defeat and entrapment. For K this seems to be a crucial part of his recovery helping to provide him with a narrative of a positive possible future self.

Narrative for J

3.5 Episode1 (Life before) for J

J was 19 at the time of the interview; he was 15, in year 11 and just about to start his GCSE's when his dad hanged himself; J's dad was 42 years old. The main theme for J under the life before episode was 'Instability'. This theme was generated from two sub-themes of 'dad's difficulties and mental health', and 'violence and strained relationships' (see appendix 6 for J's full narrative and appendix 9 for the theme maps). I have been explicit in informing the reader that I wanted to preserve each story and carry out a separate analysis. Although the analysis for J generated different named themes, there are many striking similarities to K.

Life before lines 27-248



Dad's difficulties and mental health

As with K, J's narrative indicated difficulties within his father's early life surrounding attachment relationships and adversity surrounding abuse. Also, his father's mental health difficulties and substance abuse were also a significant aspect to life before for J which again is comparable to K :

His mum passed away when he was 18 months old, so he didn't grow up with a mum. His dad didn't want him, so he was pushed to an uncle. He was involved in a

grooming ring, one of the church leaders, youth leader people took advantage of him”(58 -67).

“Yeah and he was in and out of hospitals and facilities and suffered from mental health his whole life, and he'd made false attempts on his life before”(73,74).

“ He was off his head on all sorts; he'd been drinking, he had been putting stuff up his nose” (170- 177).

This again linking into research surrounding adversity, disruption to attachment relationships and poor mental health as risk factors (Sveen and Walby 2008; O'Connor & Williams, 2014). As with K J's father's difficulties impacted upon relationships within the family.

Strained relationships and violence

J's narrative includes a sub-theme in association with relationships. However, J's narrative surrounds mainly strained relationships and the difficulties surrounding unpredictability and violence within the family life and the wider community:

“ I was on edge a lot; he wasn't allowed into my school. He'd made threats on my mum” He started to get violent. He'd call me names and stuff like that” (133- 211).

“ You didn't know who was coming through the door one day to the next. There would be times when because my mum hadn't cooked the dinner, because she was at work herself, you know he'd smash everything. All my toys would be smashed if they weren't away. There were times when me and my mum had to go to the neighbours at like two in the morning because he was just on one” (108-123).

“ He started to punch my chest and pull my hair and stuff like that. If she were to turn the attention, she would have got it, and then we both couldn't have got home, so he went in on me, you know I got the brunt of it all” (178-185).

J gave a very open and honest account of what appeared to be a very distressing homelife for a child to grow up in and I got the impression that J wanted me to acknowledge his difficult home life prior to his father's death by suicide. J gave an insight into how this impacted upon him psychologically as a child

“My head was just constantly, you know on the outside; is he going to come and get me, you know is my mum ok. A normal six-year-old wouldn't worry about is my mum not going to pick me up because she's been you know battered” (152-205).

It is well known throughout professionals working with children living in an abusive environment can have a detrimental impact on a child's development and educational attainment. A child can become anxious, hypervigilant and cognitive functioning can be impaired (Bomber,2015; Lave and Wenger, 1991). In order for development, a child's basic need for feeling safe and loved is needed (Maslow, 1943). J's narrative indicated that all his needs in these areas may not have been fully met due to his dads' difficulties.

Reflections

J overcame his barriers of needing his support worker in the first session, to wanting to talk with me on his own for the narrative interview and I was surprised how open J was with me. Again, as with K I think I was caught up with getting my interview technique and making sure I didn't miss anything; this also acted as a protective barrier for me and my emotions during in the direct interview. However, on transcribing I found myself connecting to the interview on an emotional level. I could actually hear J's voice when I was reading the transcription back and it was hard for me to choose which quotes to use. I initially put a lot more direct quotes into this section, however, with guidance from my supervisor it became apparent that some of the quotes were interpreting the same messages and this helped me to decide which to keep in.

3.6 Episode 2 (Discovery) for J

The main theme for J in the discovery episode was 'shock and confusion'. This theme was generated from three sub-themes of 'confusion', 'emotional shut down' and 'responsibility'.

Discovery lines 249 – 355

Theme 2 shock and confusion

Sub-themes

Confusion

Emotional shut down

responsibility

Confusion

survivors of suicide are more likely to experience feelings of confusion (Bailey et al. 1999; Botha et al., 2008; Simone, 2009; Hung & Rabin, 2009) and it was apparent that the discovery episode was one of confusion for J:

“she went he’s gone, and I’m like who? Where’s it gone? And she’s like, we need to go, we need to go, and I’m like you now, okay and throw some clothes on, and we drove about a hundred miles an hour to his house. I started to peg on. I was just looking at his flat like oh my God, just really, you know after all this, everything everyone’s been through and then this is happening now. The police were there, we weren’t allowed I, and stuff like that and he got taken away; my mum wasn’t allowed to see him” (259- 302).

“I didn’t know what was going on half the time. I knew he died. I knew he committed suicide; I don’t know how he did it”(338- 341).

This was a traumatic event for J and many children, and young people want to avoid experiencing emotions associated with trauma (Mitchell et al., 2007) which was apparent within the next theme of emotional shutdown.

Emotional shutdown

For many children and young people rather than being something that happens immediately, grief takes place over time (Mitchell et al., 2007). J identified that he had an initial burst of emotion and then he described an emptiness which may have been a subconscious avoidance of experiencing the emotions of trauma.

“ I went to go sit in the car, and I had about two minutes of just hysterics of just a complete breakdown of everything, then I sort of sorted myself out, and I went back; as of that moment, it was like nothing. There was complete emptiness, and the sky that day was white as well like not a cloud, or blue or anything, it was just white; so it was like, empty, everything was just like empty. I was, the sky was, his house was, everything”(303 318).

“I didn’t want to talk to anyone; I didn’t want to look at anyone” (339)

Survivors of suicide often suppress their emotions to manage stigma which can contribute to a lack of dialogue surrounding the bereavement (Hanschmidt et al., 2016; Peters et al. 2016). J’s narrative highlighted that J was suppressing his emotions and avoiding dialogue at the time of death. However, it should be noted that this may have been due to shock, rather than to manage any stigma. Also, J

may have suppressed his emotions subconsciously in an attempt to protect his remaining family members due to perceived responsibility.

Responsibility

As with K, J also had a sub-theme in the discovery episode relating to responsibilities. J took it upon himself to inform other family members of his father's death, immediately going to visit his uncle. This again supports research that suggests that children and young people hide the pain of their loss from their surviving family due to a perceived responsibility (Pitman, 2017; Simone, 2009)

"I said, I need to tell him, so I went, I went there on my own, and told him"(329-332).

Reflections

The thing that stuck me the most during this section was the way that J found out about his father's death. When he heard his mum scream and then had to drive and he did not realise what had happened until he saw the police cars. The confusion, shock and the helplessness that he must have felt was really apparent to me during this section and that is what I wanted to capture. The moment that he described the emptiness of the sky really touched me and then how he somehow put that to one side and take on responsibility. I could empathise with the shock and emptiness, but could not relate having to be responsible and suppressing emotions at such a traumatic time, but felt that this was important to include during my findings and interpretations section

3.7 Episode 3 (Aftermath) for J

I named the main theme for J under the aftermath as 'Adapting to a new way of being'. This theme was generated from 4 sub-themes of 'school practice and no time to grieve', 'hidden and isolated', 'mental health difficulties', and 'inconsistent support' .

Theme 3 New way of being

Aftermath Lines 356 – 803

Subthemes

School practices
and no time to

mental health
difficulties

Hidden and isolated

Inconsistent
support

School practice and no time to grieve

A substantial proportion of J's aftermath episode surrounded his return to school. As with K, J also returned to school soon after his father's death, which seemed to be due to external pressure rather than his choice; J returned to school before his father's funeral and then had time off for the funeral. It was apparent to me that J found the return to school difficult and the reactions and interpreted insensitivity of the school seemed to exacerbate his difficulties:

"And the woman said right but, he's got his GCSE art to start because you start art GCSE in January. She was a director of something or another, she was the head busybody of some attendance thing, and she just wasn't[sigh] breaking at all. School actually called my mum the day of the funeral and said Where's Josh. My mum told them [laugh] where Josh is? He is at his dad's funeral"(338- 570).

"I realised quickly within a few weeks, that actually the teachers hadn't been told" (522-533).

" The English teacher came to see me and said we need you to come to the lesson because were doing a type of assessment; he said you know this is what you need to do. I was like okay, okay that's fine. I got into class, and on the board, it said your dad did what? And It was like that sinking feeling of my God I'm the talk of this class. Your dad did what is the name of the poem" (439-444).

"My psychology teacher couldn't understand that my dad had passed away and that was still affecting me. She said you are using it as an excuse and that I need to put into my work to make it into something positive, you know so that I could come out within an A Star In psychology. A psychology woman whose studies psychology told me that I need to pick up essentially" (665-697).

J felt he needed a fresh start and something to give him a focus. He saw an opportunity for an exchange trip and approached the head teacher. However, he was rejected due to attendance, which is arguably him being punished for having time off after his father died:

“ I went to the headteacher, and I said you know, I think this opportunity would be really good for me, and he said no, we don't want you to do it; I was like okay why, and he said lesson attendance” (687-690).

J's experience of school following his father's suicide is described as being difficult with lack of understanding from others which could have led to a feeling of isolation for J.

Hidden and isolated

Losing a loved one to suicide can segregate survivors from their family and even the community, and there is a need to optimise social support for what is deemed a vulnerable population; a population who often feel stigmatised, shamed and isolated (Spino et al.,2017). Social support is one of the elements associated with lower levels of depression in survivors of suicide (Spino et al.,2017). Nevertheless, in addition to lack of empathy and understanding from educational professionals, it seems that J was indeed actively isolated. Although initially this was suggested to help J, it seemed more detrimental.

“but like my art teacher got me into the corner and said its ok no one's mentioned anything it is a right you can stay in this room as long as you want. He said you know J obviously feels comfortable in the art room we will set him up there permanently even if it's for a few weeks and we will come and see him and give you the work; someone could come and sit with him every a few hours a day to coach him through stuff. So, my mum was like yeah, yeah that's fine. I was like, I was like not talking, but I was like yeah that's fine, so that's what happened, but nobody did come and see me. I withdrew completely. I was straight A's in school, and I withdrew; obviously not going to lessons didn't help. Obviously, no one coming to find me didn't help”(404-495).

J 's narrative highlighted that he did not receive any social support, which contributes to a reduced amount of grief strategies and increased feelings of hopelessness (Spino et al.,2017). It is apparent that J received little support from school which supports Pitman et al. (2017) who found people bereaved by suicide are less likely to receive informal support than people bereaved by other causes of sudden death; they are also more likely to perceive delays in accessing any formal or informal support. This could be due to the stigma that surrounds suicide (Simone, 2009). It was clear to me that J felt isolated and isolation such as this could have contributed to feelings of defeat and entrapment, which has already mentioned is a contributing

factor of suicide ideation and the act of suicide itself (O'Connor & Portzky,2018). Indeed, J did describe having thoughts and feelings surrounding suicide ideation.

Mental health difficulties

Research suggests that children and young people that have lost a parent to suicide may need specialised mental health care and are more at risk of suicide themselves, (Mitchell and Terhorst, 2017). J described having experiences with mental health difficulties surrounding depression and suicide ideation.

“It would have been nine months later I was diagnosed and put on medication I got referred to Broadoak it’s a psychiatric unit because they were so worried about me, they thought I was going to go the same way. My mum told them that I was also in Broadoak on suicide watch” (603-623).

As mentioned, grief by suicide is complicated and is bound up with many ecological systems, both prior to and after the event itself. However, Social support is one of the elements associated with lower levels of depression in survivors of suicide (Spino et al.,2017). I do then question how much the added pressure and social isolation that J experience contributed to the difficulties that emerged for him.

Inconsistent Support

It is argued that a support network can offer a safe place for survivors to talk about their distress (Spino et al.,2017). It has been acknowledged that J experienced social isolation within the school. However, J’s art teacher did reach out to him in what I would describe as an informal, supportive and nurturing way and this was greatly valued by J. I argue that this highlights the importance of relationships and social support within the community the survivor is embedded. Unfortunately, it was clear that this was not consistent throughout the teaching staff and that different teachers had different approaches.

My art teacher gave me the sketchbook and said you don’t have to you could just look at it. She was great; at that time, she was the only one that really checked with me and helped me along. She was amazing; she said, you know you need to do this, but you can do it at your own pace. She helped me a lot. She helped me figure out where to put stuff and what to do. She was emailing me after school hours and stuff like that to help me am so grateful that I had her” (417-414).

Evidence suggests that grief takes place over time (Mitchell et al., 2007) and with complicated grief such as with suicide, there is a need for regular ongoing proactive offers of support from family, friends, and professionals which should be repeated regularly (Pitman,2017). Campbell (1997) found adult childhood survivors of suicide reflected upon and agreed that they would have benefited from the chance to talk about the suicide that they experienced as children while still in childhood, However, J highlighted feelings of being uncomfortable seeking support two years after his father's suicide. Receiving the support from T at the bereavement charity seemed to be a turning point for J and a major contributing factor in his readjustment.

“ I went into an apprenticeship and been on my apprenticeship for two months now, its special needs teaching assistant. I've have gone all the way round the woods to get to get to the cheese, but I'm goanna get there eventually”(767-772).

Reflections

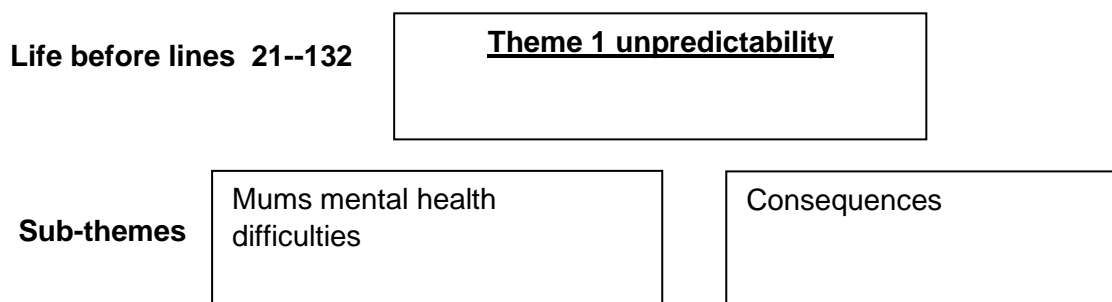
I felt disbelief during the interview stage and then anger when transcribing and interpreting this section. I found myself becoming angry with the whole reaction of the school and again this very much resonated with my experience. I wanted participant's to have had positive experiences, because I was conscious that my experience in education after my father was negative and I was aware that it may seem like I was reliving my experience and telling my story through my participants. I wanted to highlight how an experience could be different with support. However, it was hard to find any positive during my interpretation and it was reassuring that when my supervisor read them, she said the same. The one positive was the art teacher and the finding of the charity. I thought that this was important to include as it represents how the support of any sort and no matter how little can have a big impact upon the bereaved and demonstrates the importance of a systemic approach. In contrast however, this also demonstrated to me the complexities, stigma and lack of understanding and how well-meaning support such as the art teacher finding J a room, can actually turn into a negative phenomenon and in this case contributed to isolation

Narrative for G

3.8 Episode 1 (Life before) for G

G was the shortest interview of the 3 and G was the youngest of my participants

aged 16 of the time of interview and was 15 and in year ten at school when her mum died of suicide. G could not remember the exact age of her mum but thought that she was 53; the method of suicide was not discussed. The main theme for G under the life before episode was 'unpredictability'. This theme was generated from two sub-themes relating to her 'mum's mental health difficulties' and 'consequences' (see appendix 7 for G's full narrative and appendix 10 for the full theme map).



Mums mental health difficulties

As with the previous two participants, G's mum's mental health difficulties were of significance to G's home life prior to her mum's death. G was quite open to telling me the details regarding her mum's mental health difficulties. For example, G said:

" I think she had schizophrenia or something like that; she went to a mental hospital the doctors were meant to keep commenting on her, but they didn't, and obviously I think they didn't make sure that she was taking her medicine or something" (52-58).

"I was telling her that it's in your mind and you're making things up and she would seem to get angry at you and say I've got this recording on my phone and there was nothing on a recording; she just thinks that in her head" (101-104).

Consequences

Although brief in comparison to the previous two accounts G gave me insight into the consequences of her mum's mental health difficulties on her own life again demonstrating kayos and unpredictability. For example, G said:

" it made me upset, because like, she accused her boyfriend of raping me. She kept taking my phone, even though it had a password; she kept trying to get into it and then she blocked my phone. Then I had to reset it, and I lost all my pictures and that (66 -77).

“ I remember it was parents’ evening and then she went into the office with my form tutor Miss B and obviously they were talking. I was getting really like annoyed; I didn’t tell my friends about it all” (130- 118).

Reflections

I found this the hardest interview to navigate, both due to G being female and her age, which was similar to mine at the time of my dad’s death. The interview was more closed and required me to intervene more and ask more questions. This interview did not seem to flow as much as the other two and I felt like G was holding things back from me. However, it did again highlight the chaos of her home life that G experienced prior to her mum’s death, which as with the other two participants it seemed important for G to tell me about

3.9 Episode 2 (Discovery) for G

The main theme for G under the discovery episode was ‘Disorientated’. This theme was generated from three sub-themes of ‘confusion’, ‘ responsibility’ and ‘escape’.

Discovery Lines 132-171

Theme 2 Disorientated

Sub-themes

confusion

Responsibility

Escape

Confusion

Again, as with the other participants, there was confusion surrounding the discovery, with G finding out about her mum by social media.

“Coming home from school and my dad phoned me, yeah, and my brother had put on Snapchat RIP mum. I was like what? What you mean? No, she hasn’t, and he was like why you would put that then? And I was like, or maybe he meant Gran or something I don’t know, and then me and my dad were just confused with it. So, then I went home yeah, and there were all the police. Nan was there, and I was like Nan what’s going on. I thought my brother done something to my mum; I’m not gonna lie because my brother like he used to hit mum. It was like she’d hit him, and he hit her back” (136-152).

As explained in chapter 1 reasons for the suicide can remain unanswered. Thus, the grief experienced by survivors is unique and more complicated compared with other losses because of the level of uncertainty and suddenness of the death (Powell & Matthys, 2013). Even when a suicide note is left there are still unanswered questions and uncertainty. However, G's mum did not leave a note, which would arguably generate even more uncertainty:

“when people commit suicide, they leave notes or something, but she never and I was thinking well that's a bit weird. I don't know, I don't think I'd want to know what she is said in the note anyway; I wouldn't like to” (156-168).

Responsibility

G's narrative generated a subtheme of responsibility. However, this was connected to telling her sister of her mum's death rather than hiding emotions to try to protect others. For such an early age this is a great responsibility for a child.

“I went around, and I had to tell my sister and didn't want to tell over the phone, so I told her to come and see me; she was just like really confused she didn't believe it” (157-163).

Escape

As mentioned, research suggests that most children want to avoid experiencing emotions associated with trauma (Mitchell et al., 2007). It seemed that in the discovery episode G was overwhelmed and in possible shock and seemed to need to withdraw. However, this may be associated with denial, a stage of the grief cycle (Kubler-Ross, 1969)

“And I was like naaaa, and then I wanted to go and went to get my dog. I went and got my dog, and I just tried walking away” (149-154)

G seemed to want to distract herself from and avoid the trauma both at the time of the event itself and when describing this episode to me.

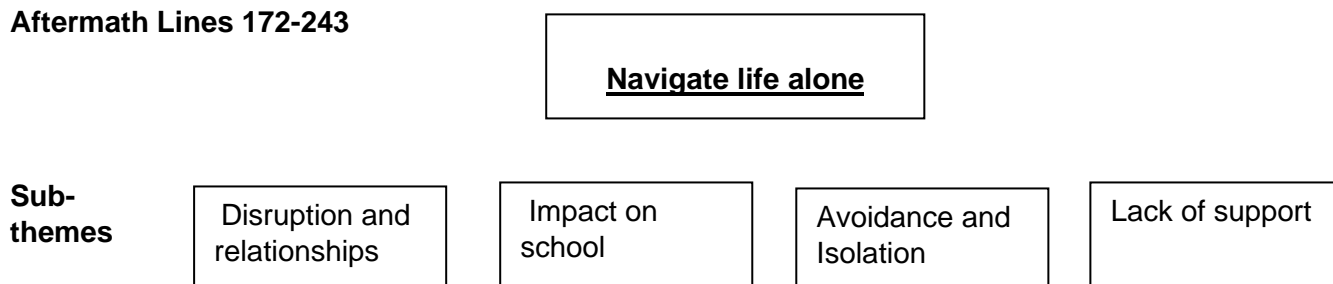
Reflections

I really felt sad for G, and I was really surprised by how she found out about her mums' death. During the interview G seemed quite calm talking about her experience and I really wanted to go into a therapeutic stance but had to stick to the role of researcher collecting my data. G's support worker was in the room throughout and I had mixed feelings about this; I was reassured that she was there to support G, but I also felt exposed and was conscious that I did not want to be perceived as inducing upset for G

3.10 Episode 3 (Aftermath) for G

I named the main theme for G under the aftermath episode 'Life alone'. This theme was generated from 4 sub-themes of 'disruption and relationships', 'impact on school', 'avoidance and isolation', and 'lack of support'.

Aftermath Lines 172-243



Disruption and relationships

It is argued that a support network is vital to survivors of suicide (Spino et al.,2017); it was clear that immediately after the suicide G had support from extended family members:

“So basically, all my aunts they all took turns and to stay at the house”(298).

Chapple et al. (2015) point out that in addition to immediate effects upon a family, there are also longer-term implications for the family's life together following a suicide. Children may be neglected due to the surviving parent's own needs and inability to cope which can permanently disrupt communication, interaction and decreased emotional availability and attachment relationships (Chapple et al.,2015). It was clear from G's narrative that not only did she endure the trauma of losing her

mum, but that there were disruption and uncertainty surrounding her living arrangements. Also, G's relationship with her surviving parent was not described as nurturing, which may have exacerbated attachment difficulties and complicated her grief further.

"I was gonna get put in foster care. I didn't want to live with my dad it was kind of if you don't want to live with him just say; then I was, I do not want to get put in foster care, and my sister can't look after me" (308-313).

In addition

"Well he was sort of being nice to me, and now he is just really rude to me all the time"(323-324).

G's story highlights the complexities young survivors of suicide face. Her narrative supports Ratnarajah & Schofield (2008) who suggest supporting the family unit with recommendations of support to initially focus on shelter, food, safety, the security of a home, the cohesiveness of the family and continuation of schooling to stabilise the family. This would have been useful to support G in this tough time, which would be challenging for any young person to navigate alone (Ratnarajah & Schofield.2008). In addition to supporting with her challenges surrounding living arrangements and family relationships school support would have been beneficial.

Impact on school

As with the previous two narratives, G went back to school within a week of the death and before the funeral. However, unlike K and J, G seemed to want to return to school as a means of bringing normality to her life.

" I just kind of wanted to go to school because it took my mind off it " 262).

It is my understanding from G's narrative that there was a lack of support and empathy from school staff with schools perhaps not knowing how to respond in this situation. The description highlights a lack of coherent response from the school system.

"My teacher knew that I had missed a lot, but he was like you have missed a lot just revise the book. On a Tuesday I had revision of history, and I can't go, and I was just oh yeah, I've got counselling; my teachers just told me to like to read a certain section which I did, but I still failed. In RS right, as soon as my mum passed away,

they talked about suicide. Like they had topic on it, and my teacher said that I could miss the class.

When I asked G if she was set any other work while she was missing class due to the topic being on suicide, she said no. Therefore, it seems that G was excluded from learning as a consequence of her mother's death. At a time when she was seeking normality and needed social support, it seems that G was avoided, excluded and isolated.

Avoidance and Isolation

Research suggests that suicide survivors often see a need for concealing the cause of death (Sveen and Walby 2008). G indicated this when she told me that her friends did not want to talk about it and that she did not want to talk to them about it. G also indicated her wanting to conceal her mum's death from others in her new setting and her anger when it was spoken about:

Friends were like; I don't know they didn't want to talk about it, but I didn't want to talk about it to them. My aunt told the college and I got like this lady who came up to me. She was like oh yeah I'm here for support and that, and I was just like; I didn't really want them to know, and I was a bit angry at my aunt. I didn't want anyone to know; I haven't told anybody in college, it's not their business"(185 –376).

This supports the findings that suicide survivors often conceal the death from others to manage shame and stigma (Hanschmidt et al., 2016; Peters et al. 2016). In addition to concealment from G, practices from school surrounding avoidance strategies possibly contributed to a feeling of isolation (Jackson et al. 2015). It is evident from G's narrative that there is a need to optimise support for a vulnerable population (Spino et al.,2017). G's narrative highlights that she was offered some support in the form of counselling services at school. However, this was seemingly unhelpful at the time.

Lack of support

Pitman et al. (2017) found that people bereaved by suicide are less likely to receive informal support than people bereaved by other causes of sudden death. Also, they are more likely to perceive delays in accessing support, which seemed the case for

G. G's narrative also supports research by Peters et al. (2016) suggesting that health professionals and those informal agency services are unsure of how to support people bereaved as a result of suicide. In addition, and as with K, G's narrative also supports Peters et al., (2016) findings that people bereaved by suicide report relationships with professionals become strained, limiting opportunities for support further. G also had to miss some of her schoolings to attend the school counselling sessions; this then may have been more detrimental than helpful both emotionally and academically:

"it was about five months later when I got counselling at school (239)

"But the lady she didn't really talk about anything to do with my mum, she was just wanting to know about my personal life and what I'd been doing in school and stuff. Because I had like fake mocks for my GCSE and she was just like oh and what mock do you have today and stuff like that. I didn't like it to be honest (230-277).

" I told her about a situation at home and then she went and called my dad and was like oh I want a meeting with your dad, but my dad never went; but then my dad got mad at me for telling the counsellor about it. It wasn't about my mum; it was about how my dad was. I didn't tell her anything after that" (283-293).

"I had counselling and had to leave early as well in school" (532,533).

Reflections

G was the participant that I felt was the most vulnerable, but out of the 3 she had not experienced any explicitly known repercussions as in mental health/medication, substance abuse or aggressive/antisocial behaviour. However, I wondered if that was because she may internalise her thoughts and feelings. She did not want people to know about her mum and although I was the same sex and age when I lost my father, I could not relate to G the same during this episode as I could with the previous two participants. G really highlighted to me, that although there are similarities to be shared, all are individuals, with individual complex stories and responses. I relied on the help of my supervisor to narrow down my choice of quotes and hoped that interpretations would highlight some of the complexities that may accompany suicide bereavement .

3.11 Summary

In comparison to other research using the same analysis technique, the results section in my research may be lengthy and is mainly made up of direct quotes. This is intentional; I wanted to retell the stories authentically and compellingly and to use the participant's own words enabled me to do this. Naturally, I have used interpretation to an extent; this was essential to enable the generation of themes. However, it is not my sole intention to merely reduce these narratives to make generalisations across young people and child survivors of parental suicide.

Each of these narratives is unique, and I hope this is captured within my analysis. Nevertheless, there are important similarities both in the details of the episodes and within the themes. These will now be discussed in the following chapter which will answer research question 1. Questions 2 and 3 will be explored separately to the thematic analysis using a summary from the responses given by the participants when they were directly asked both these questions.

Chapter 4. Discussion

4.1 Overview

Despite suicide being preventable (World Health Organisation, 2014) the amount of people dying by suicide is significant with 6,213 suicides in the UK and ROI in 2017. Suicide affects many families including children and young people and grief from suicide is also complicated and is arguably unique (Simone,2009). Young survivors of suicide can continue to be profoundly affected by events surrounding it long after the event; repercussions impact upon the ecological systems that the survivor is nested within and survivors are more at risk from suicide itself. (O'Connor & Williams, 2014; Scocco et al 2017; Jackson et al 2015; Ratnarajah & Schofield 2008)

Support for people bereaved through suicide has been identified as an essential strategy in suicide prevention (World Health Organization, 2014). However, most

research and resources have been devoted to suicide prevention through raising awareness and helping individuals who are suicidal with little attention given in association to postvention; with scant literature addressing the specific needs and the voice of child survivors of suicide (Jackson et al., 2014; Hung and Rabin 2009). It is argued that knowledge surrounding the experiences of survivors of suicide is limited as the majority of research surrounding suicide uses quantitative methods, which may not be sensitive enough to capture the experience of the bereavement process (Shield et al. 2017).

In this research, I have sought to explore the experience of a CYP when a parent or carer has died by suicide. My aim has been to highlight themes that may help shape how professionals within the survivor's ecological systems , specifically educational professionals, respond to CYP bereaved by suicide. In this chapter, I will discuss the research questions in an attempt to fulfil the aims of my research. I will relate the implications for practice, the limitations of my research, my reflections and conclusions and recommendations for further research.

4.2 Question 1

What narratives do young people share surrounding losing a parent to suicide and what common themes emerge that can help shape how educational professionals support a young suicide survivor?

To answer this in a coherent and organised manner, I will draw upon the episodes of life before, discovery and aftermath from the results section. My rationale for this, (even though as a researcher I acknowledge that I will have influenced and co-constructed this format somewhat) all 3 participants organised their narratives this way and I feel that each of these episodes are significant in trying to understand the complexities of suicide. It gives insight into the various aspects of CYP experiences suggesting complexities surrounding their need for support that goes beyond the actual bereavement itself.

Life before

Parents' disruption to attachment relationships and early life adversity.

It was clear from K and J that their fathers experienced difficulties associated with their biological parent. Therefore, I argue that in this research there is a theme surrounding possible attachment difficulties with the deceased. Both men were separated from their biological parents, placed into care and experienced adversity and trauma. This is not an attempt to identify a cause of participants' parental suicide or make generalisations. Indeed, this is not to infer that being placed into care is a cause of suicide. What I am highlighting is that both K and J felt that their fathers' early experiences surrounding care and adversity were significant enough to talk about as part of the research. This also supports literature emphasising early life adversity and disruption to attachment relationships to be risk factors in suicide (O'Connor & Williams, 2014). Further, Ratnarajah & Schofield's (2008) narrative research, highlighted that parental suicide was not an isolated incident and previous unresolved trauma may be a contributing factor.

Instability

All 3 participants highlighted the difficulties their parents had in association with their mental health. K's father suffered from depression and was ultimately taking medication. J's father had mental health difficulties and had spent time in the hospital. He had a history of suicide threats and self-harm. G's mum had mental health difficulties, had also spent time in hospital and was on medication. All 3 participants grew up with a parent whose mental health difficulty impacted them. Two participants described their parents' difficulties with alcohol and the impact this had upon them and the family unit. All participants highlighted experiencing abuse and violence in the form of verbal, physical and emotional abuse. My interpretation was that the participants had unpredictable relationships with their deceased parent, with emotionally and physically unavailability, and participants taking on a responsible role for their parent to some extent.

Both these themes support Ratnarajah & Schofield's (2008) narrative research,

which highlighted that parental suicide was not an isolated incident, but the culmination of a highly dysfunctional family life marked by previous unresolved trauma. Thus, there may have already been a detrimental impact on the participants development and self-regulation due to previous attachment difficulties. This developmental effect could then be compounded when the surviving parent is further not able to provide support for the bereaved child following the suicide. Therefore, it cannot be said that suicide alone causes a devastating impact on the life of the surviving child rather it is complex and arguably required a systemic approach.

Those offering support to a family bereaved by suicide may benefit from awareness that there may well be a history of generational difficulties in the family system, which contributed to and/or culminated in the suicide (Ratnarajah & Schofield, 2008). I argue that an awareness of this, not only for those who offer direct support but generally, especially within the education system would be useful when thinking about supporting individuals bereaved by suicide . Many professionals within education are becoming aware of the impact of attachment difficulties, abuse and neglect, parental substance misuse, and parental mental health upon a child/ young person's social and emotional development and cognitive functioning (Bomber, 2015). However, this is not always obvious within families. Adults who encounter young survivors of suicide may not associate the loss to any previous adversity that may have been experienced for years prior to the death. I argue that this needs to be taken into consideration when developing postvention strategies and where possible, the family as a whole should be supported utilising a systemic approach . It may be of significance to offer help to reduce the impact of the experience of adversity and disruption to attachment relationships, thus potentially reducing the cycle of suicide (O'Connor & Williams, 2014; Ratnarajah & Schofield, 2008). It appears that there is a need for early recognition of difficulties, both to address the immediate impact of death and to reduce risks of long-term maladjustment (Sethi & Bhargava, 2003); unfortunately this did not seem to be the case for the three participants who all highlighted gaps within the support and understanding.

Discovery

In all three narratives, this episode was relatively short in comparison to the other episodes. This could be due to trauma and not wanting to 'relive' this episode in detail. The survivor could have suppressed this as a coping mechanism, to avoid experiencing emotions associated with trauma (Mitchell et al., 2007). This supports Ratnarajah & Schofield's (2008) narrative research which found that information about the circumstances triggering the suicide was fragmentary in nearly all the narratives. Indeed, K said that sometimes it goes blank because you do not want to remember. Nevertheless, commonalities in the discovery episode were:

Confusion and overwhelm

Simone (2009) point out that one of the most traumatic experiences that can occur in children is the death of a parent and that death by suicide further complicates bereavement adaptation. All three participants described finding out about their parents' death in what could be described as traumatic ways. The police told k, J heard his mum scream and then did not know what was happening until driving to his father's house when he guessed, and G found out from a post on social media. All these I argue are possible contributing factors to shock.

All three participants were exposed to traumatic scenes, which in many aspects resembled a crime scene with emergency services and restrictions on the family being enforced. All described what I interpreted to be an overwhelming combination of emotions, including shock, confusion, disbelief, anger, fear, sadness, frustration, irritation, lack of control and disappointment. They all talked about a need to get away/escape from the scene which may be linked to the primary flight or fight response that humans experience in times of high anxiety and stress (Bomber, 2015). Two participants then talked about a need for information surrounding the death to help answer their questions.

The narratives from this research support other research suggesting survivors of

suicide are more likely to experience feelings of confusion (Bailey et al. 1999; Botha et al., 2008; Simone, 2009; Hung & Rabin, 2009). In the immediate aftermath of the loss, people indicate feelings of being too overwhelmed and in distress which can be a barrier to them seeking help. Further, there is additional confusion surrounding questions that may remain unanswered and a need for information that is arguably unique to suicide.

Responsibility

Responsibility was also a commonality between participants of this research. There was not only a perceived responsibility and feeling of guilt relating to the deceased parent; there was also an indication of a responsibility to protect the surviving parent. Two participants described suppressing their grief and emotions to protect other family members. All three participants also had a sense of responsibility to tell other family members about the death. This aligns with other research that suggests a perceived responsibility to others causing some survivors to hide and not discuss their grief. This was a way to appear strong especially in younger survivors who felt obliged to support their surviving parents (Simone, 2009; Pitman, 2017). Also, survivors of suicide are more likely to experience feelings of responsibility for the death and guilt (Bailey et al. 1999, Botha et al., 2008; Mcmenamy, 2008; Simone, 2009; Hung & Rabin, 2009;).

This highlights the complexities the child survivor of suicide have to navigate, which suggests that it is important for adequate support systems to be provided for both the child/ young person and the surviving caregiver (Hung & Rabin, 2009).

Aftermath

This episode seemed the most complex and generated the most considerable number of subthemes, and there were similarities between participants.

Stigma

Suicide survivors experience higher stigma in comparison to those from natural death (Hanschmidt et al., 2016). All three participants of this study were impacted by stigma in some way. K indicated feeling alone and a perception of people not knowing what to say unlike other forms of bereavement such as cancer. He felt that no one understood what he was going through, could not talk to people about suicide and feared rejection. K experienced judgment when someone called his dad selfish and felt he was in a bubble that could not be accessed by anyone. J's narrative highlighted isolation; the concept of silencing the suicide was reinforced by someone saying, 'it is ok no one knows, and no one has said anything'. J did not want to speak to anyone, and no one came to speak with him; he described himself as becoming withdrawn. G felt that her friends did not want to talk to her about her mother's suicide and she did not talk to them. G did not want people at her new educational establishment to know about her mum's death and was angry with her aunt for telling college staff.

These findings support previous research which identifies detrimental consequences of stigma including concealment of the death, social withdrawal, reduced psychological functioning and grief difficulties in addition to suicide ideation. Literature indicates that losing a loved one to suicide can result in feeling stigmatised, shamed, and isolated. Survivors become segregated from their family and their community (Spino et al.,2017). Therefore, it would be useful to take a systemic approach to optimise social support for this vulnerable population. However, there is a tendency for people bereaved by suicide to avoid seeking help which may be linked to the shame survivors of suicide experience, and there is also an avoidance of friends or relative's readiness to offer help. Arguably such avoidance is likely to be linked to stigmatising societal beliefs which adversely affects access to support in a population vulnerable to their mental health problems. (Scocco et al. 2016; Scocco et al.,2017; Pitman et al.,2017).

Support

Sheehan, (2018) found that families bereaved by suicide were viewed as being partly responsible for the suicide through abuse, neglect, denial, or failure to provide adequate help. Survivors were seen as either emotionally strong, victims of the suicide, or as contaminated by association. Survivors experienced pressure to keep the suicide a secret and lack of support systems. Pitman et al. (2017) also found that people bereaved by suicide are less likely to receive informal support than people bereaved by other causes of sudden death and are more likely to perceive delays in accessing any kind of support. The support experienced by the three participants in this study appeared to be fragmented and compartmentalised, with no holistic / systemic approach. Some experienced offers of what seemed concealed and inconsistent support. G was offered support five months after her mother's death despite research that suggests support should be offered shortly after the suicide (Brent et al.,2009).

Further, this support seemed to cause frustration and focused mainly on her academic attainment, rather than giving G a space to talk about her mother. K expressed his frustration with no specialist support offered and indicated a lack of understanding surrounding suicide from school pastoral services. All three individuals eventually sought their own support from the Charity. Even then J indicated that he felt "silly" because it was two years since his father's death and that he should not need it after that period, despite acknowledging that at the time other pressures resulted in delayed grief. This supports research that survivors who initially suppressed their needs surrounding grieving highlighted that it was difficult to then seek support at a later point, out of fear of being judged for not having moved on or recovered (Pitman, 2017).

Education

All three participants were embedded within the educational system at the time of their parents' suicide; two were at school studying for GCSE's (year 10 and 11) and one at college studying A levels. Research identifies that it would be valuable for

education professionals along with other professional services to be aware of the complexities of suicide and the impact these may have on related children (Ratnarajah & Scofield, 2008). However, from this research, I argue that the experience within education systems could exacerbate what is already a traumatic time for these vulnerable young people. J, K and G, all went back to school before their parents' funerals and returned to school again immediately after the funeral; this was not always their choice. All three experienced what I interpreted as being insensitive practices, with a lack of empathy. Pressures surrounding academic attainment and the needs of the educational institution seemed to override nurture, understanding and emotional support. I would argue that some practices these participants experienced seemed to dehumanise, reducing them to statistical grade performing subjects, that did not have time to grieve their parent's death. Listening to and analysing these experiences as an EP, I argue it is important that education professionals are aware of the complexities regarding the grief and distress surrounding suicide. EP's, teachers and other educational professionals may benefit from specialist training in this area. By using a systemic framework to understand some of the many complexities of grief from suicide and what survivors' needs are, educational professionals may then be in a better position to help support survivors both emotionally and academically.

Repercussions and difficulties

Death by suicide is linked to complicated grief and can result in the development of PTSD, lower mental health and internalizing symptoms such as depression, lower attention and global cognitive performance, poor social adjustment, delinquency, alcohol or substance abuse, a need for specialised mental health care and lower quality of life (Mitchell and Terhorst, 2017; Hall et al, 2014; Brent et al, 2009; Simone, 2009; Mitchell et al 2004)

Both K and J highlighted the negative consequences of suicide contributing to their own psychological difficulties. K expressed fear of further abandonment from his mum and friends. Both K and J experienced depression with J having suicide ideation and needing hospitalisation. K discussed his alcohol consumption,

aggression and violence. G experienced difficulties around the insecurity of where she would live, the possibility of going into care and her strained relationship with her father.

It is evident from this research and other supporting research that the circumstances surrounding each suicide are complex and embedded within the system the survivor is nestled within. As said, by understanding some of these complexities' professionals may be in a better position to support survivors and this may be an essential element of postvention and prevent a further tragic cycle of unnecessary deaths and devastation from suicide.

4.3 Question 2

How do they think the suicide impacted upon their education?

Individuals enduring complicated grief can demonstrate lower attention and global cognitive performance which could ultimately impact their school attainment (Hall et al., 2014). All three participants in this research went on to some further learning, two apprenticeships and one at college. However, this was not in line with their predicted or preferred trajectory or end goal prior to the suicide. All indicated that the loss and complications impacted upon their educational attainment. Further, their narratives suggested that achievement correlated with receiving specific bereavement support from the bereavement charity, sought by themselves, rather than support from their educational establishments. Indeed, while in school and college all participants indicated difficulties arising from lack of empathy and support. Participants also highlighted that reduced attainment in school following the suicide had wider repercussions. For example, K noted he did not achieve the A level grades that he wanted and that he wished he achieved higher results as he could apply for jobs that he would like. J talked more specifically how the trauma and reorganisation of life after the suicide impacted upon his education. J highlighted the impact of depression on his education, noting that he could not cope resulting in him leaving education. G also described the negative impact upon her educational attainment, indicating that she had to retake some GCSEs. G said she wanted to go on to do A

levels and would like to do law. However, G then said that she did not think she would be able to do law now.

Lack of educational attainment is linked to lower social and economic status. Samaritans (2018) highlight that risks of suicide in both genders are thought to be associated with social and economic factors connected to inequality and affecting the most vulnerable and disadvantaged in society. I argue that lower academic attainment and the inability to secure desired jobs could lead to a feeling of defeat and being trapped which are also said to be contributing factors to suicide (O'Connor & Portzky, 2018). I suggest that suicide survivors need a structured and systemic approach to support within their education settings to help them both socially and emotionally and academically. I have therefore developed the web of complexities to help to highlight and understand some of the difficulties associated with suicide bereavement and how these difficulties may result in entrapment. My hope is that the web can be developed into a working model and thus become a useful tool to help with developing individualised suicide postvention.

4.4 Further discussions and the web of complexities

Literature suggests that utilising a systemic approach and having access to a broad range of support, including peer support, in addition to professional support is greatly valued. Knowing that support exists, even if not acted upon initially is useful. Professionals, as well as friends and family, are thought to have a role in being proactive to help bereaved people access support. The most important means of support seems to be an understanding surrounding suicide and the ability to talk openly about the death. However, this does not seem to reflect current practice.

More recently suicide figures have decreased in males, and it is believed that this is correlated to the recent focus on suicide prevention in males over recent years (Samaritans, 2018). However, suicide rates are increasing in young people in the UK and Ireland (Samaritans, 2018). It is evident that children and young people who have been exposed to suicide are more at risk of suicide and postvention is now

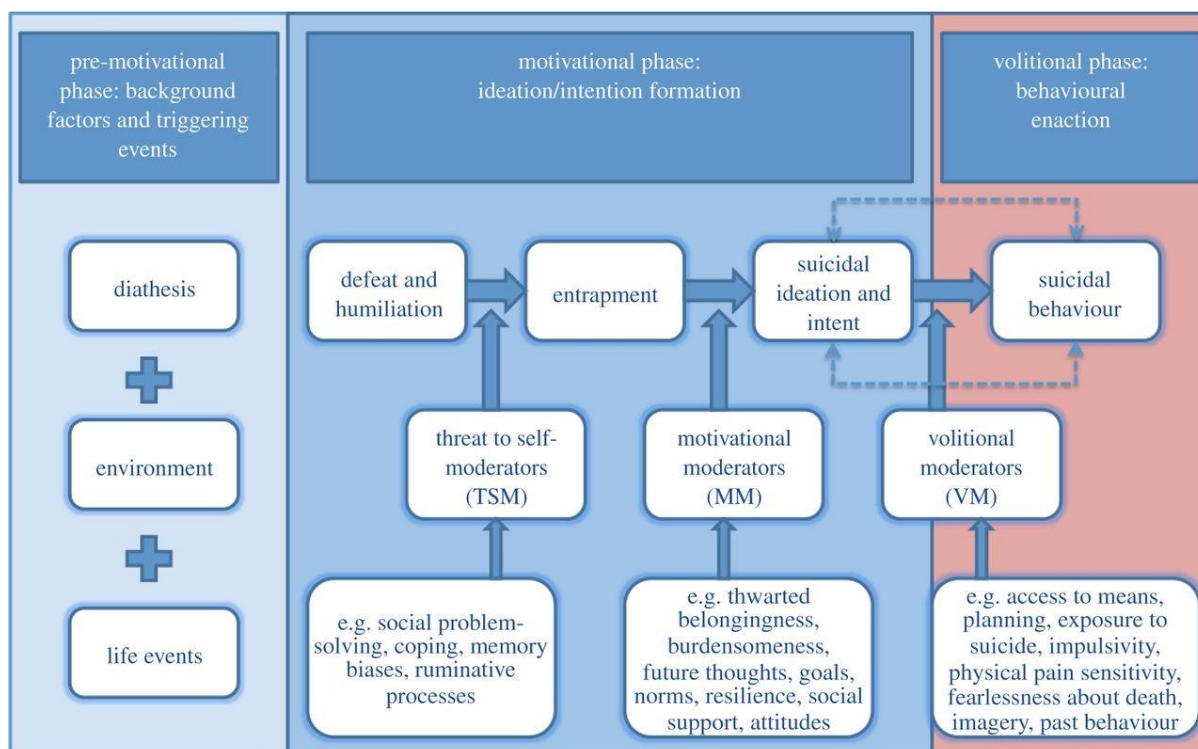
recognised as a critical area in suicide prevention.

This research was conducted to give young survivors a voice in the hope of gaining an insight into the experience of losing a parent to suicide and better understand what may be helpful and unhelpful after suicide bereavement to support the development of effective postvention. Arguably if adequate support is available from the systems that the child is embedded in, then this will help minimise complicated grief and help to prevent further suicides. One of the significant systems that a child is a part of is the educational system, and this research was ultimately carried out to inform practice within the education systems. However, this is useful for anyone coming into contact with a young survivor of suicide.

Scocco et al. (2017) suggest specific interventions dedicated to the bereavement of suicide survivors which might help to alleviate not only psychological distress but also stigma towards loss by suicide. However, research suggests that professionals who come into contact with a survivor feel ill-equipped and have limited training and experience and are therefore uncertain about how to help (Jordan 2017). To offer specific interventions, it is vital that there is an understanding of the complexities that may surround the individual. To aid in the understanding of this, I have developed the 'web of complexities' **Figure 2**.

The web was developed building on the concept of entrapment from the integrated motivational-volitional (IMV) model of suicide behaviour developed by (O'Connor & Portzky,2018) **Figure 1**. Entrapment is linked to suicide behaviour and there has been research interest in exploring the relationship between the role of escape potential (or entrapment) and suicidal behaviour. The IMV model illustrates how entrapment is central to the development of suicide ideation and behaviour. (O'Connor & Portzky,2018).

Figure 1 The integrated motivational–volitional model of suicidal behaviour



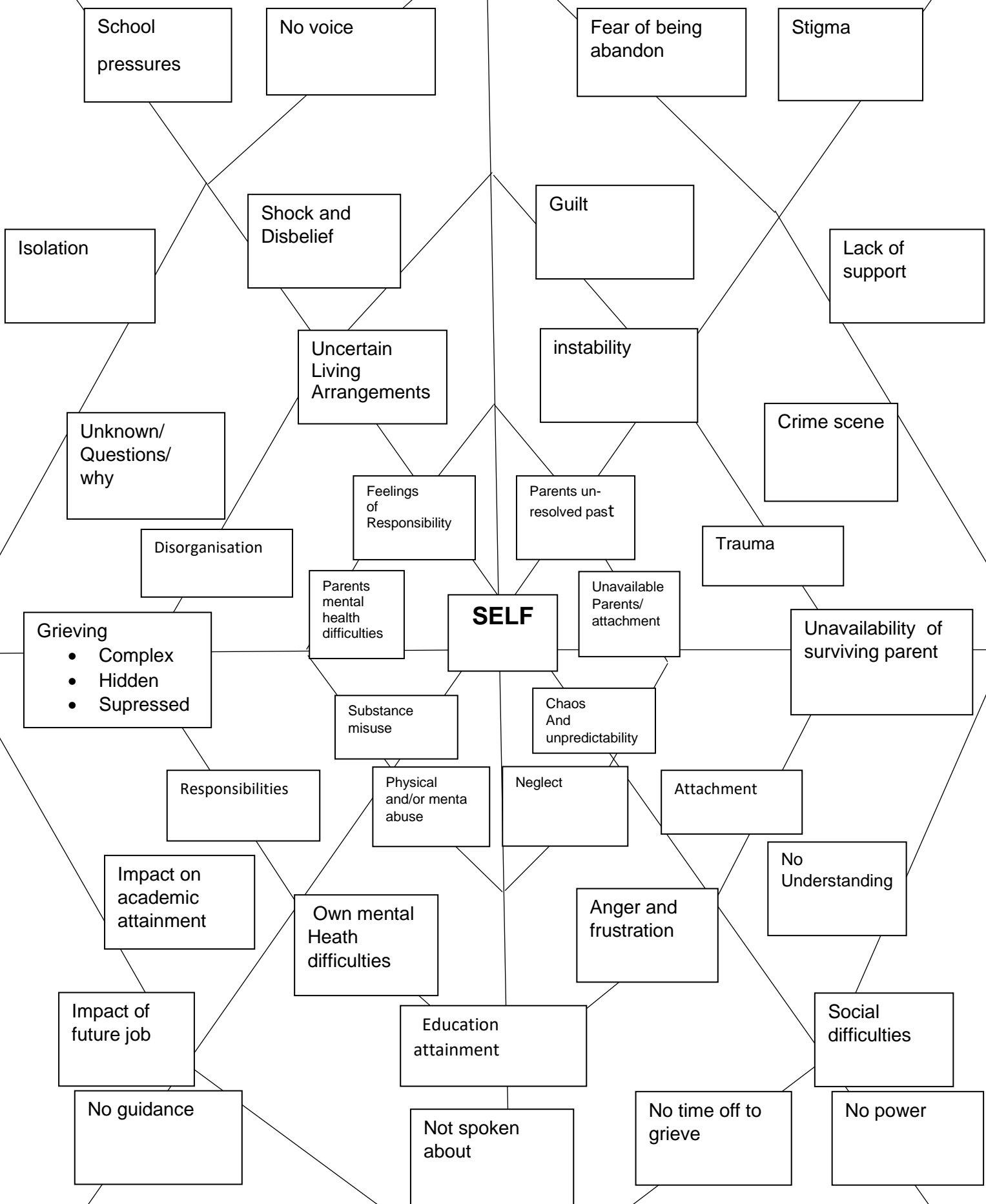
O'Connor & Portzky (2018) suggest that professionals should have an awareness of the importance of assessing and targeting entrapment in suicidal patients. It is suggested that incorporating perceptions of both internal and external entrapment into the risk assessment of psychiatric patients could be useful to detect individuals at heightened risk of suicidal ideation and behaviour. They argue that interventions could focus on reframing the defeating and entrapping situation (O'Connor & Portzky, 2018). I argue that the same concept can be drawn upon for post-vention support. By developing an understanding of the concept of entrapment and what factors may lead to the feeling of entrapment and defeat, individual support can be targeted within the individual's ecological systems. This could help to reduce some of the feelings of entrapment and lead to a more positive/freeing outlook, helping to reduce further suicides.

Using themes that were generated during the chronological episodes of each participant's narrative, the web illustrates some of the complexities that young suicide survivors experience during these episodes (before, discovery and the aftermath). It highlights the self-stuck in the middle of the web and illustrates how the complexities isolate the survivor from the outside world, thickening and strengthening

feelings of being trapped. This network of traps risk exacerbating the direct effects of the bereavement and reduce prospects of recovery or reclaiming self-esteem, self-efficacy and agency. As the young survivor's life progresses, the web may grow with further complexities and traps added or experience may thicken and strengthen strands of the web already present. Both of which traps them further, which may lead to feelings of defeat (O'Connor & Portzky,2018). However, if the young survivor gets support this may help navigate and break down some of the web's traps. I argue that this may be the case with the participants of this research, through the support they gained from the bereavement charity the participants feelings of entrapment were reduced. However, it is my belief that some of the participants such a G still feel a certain amount of being trapped and or defeated, G does not have the same aspirations for her future as she did prior to her mums' suicide.

I propose the web of complexities as a framework for any professional encountering a survivor of suicide. After consultation, the web can be used to identify complexities for that individual. The survivor can then be supported in specific areas reducing reinforcement of the web structure. Instead, help with breaking down the web will reduce the feeling of isolation, entrapment and defeat. Weakening the structure of the web during postvention will arguably hinder its growth and capacity for entrapment at a later stage in life. Components of the web are related directly to the literature supporting a systemic approach to suicide support and some of the suggested intervention strategies in the next chapter which were highlighted by the participants themselves. I do not suggest that all child/young survivors of suicide experience all the listed complexities in the web. Every suicide is different, with unique circumstances and systemic components leading up to the death and every survivor's experience after death is individual. Some survivors may have all the complexities illustrated, others some and others may experience different or additional complexities.

Figure 2: Web of Complexities



The web of complexities also supports Ratnarajah & Schofield (2008) who recommend development of policies to facilitate the holistic assessment of the family's needs so that timely provision of a wide range of support is available to the whole family. In effect, this may require a case manager or counsellor to review the varied aspects of family needs and functioning. Once the family has experienced the initial support offered in accessing practical support, trust may be built. This will then allow the family support counsellor to guide the family through the grieving and adjustment process and facilitate sensitive communications between family members (Ratnarajah & Schofield.2008).

4.5 Question 3 / recommendations for practise .

What support would the child/ young person like to see put in place to help support young survivors of suicide?

It is suggested that to prevent further suicides and other long-standing psychological related difficulties in young survivors of suicide it essential to put in effective systemic postvention strategies (Shneidman,1972). However, within the suicide prevention field, postvention is not currently the main focus (Hung and Rabin,2009; Mitchell et al.,2017) despite recommendations that a full postvention response for people exposed to a suicide fatality must be a core element of all suicide prevention (Hung & Rabin, 2009). I suggest that to enable maxim effectiveness in postvention, approaches should be compiled using the inclusion of and a focus on the children and young people's views of their experience and what they feel would help. I therefore developed the web of complexities developed using CYP direct experience. However, to explore this further and help develop actual interventions, I directly asked each participant what support they would like to see put in place in school to help support young survivors of suicide. In bold is my interpretation that could be developed into specific interventions within the education system,(which is one of the main system that the CYP is embedded within), followed by the direct quotes from the participants.

- **More understanding surrounding suicide.**

“Because nobody understands it still.”

“That’s what I would like to see you more understanding.”

- **Guidance and support in association with having an option for time off to grieve.**

“I wish I had got my A-levels. I wish someone would have had a procedure, not a procedure how can I say this right I didn’t know; I wasn’t thinking straight at that time because I was grieving, but I am thinking straight now, and I wish I’d done, I wish I had of got my A-levels. I wish you know that there was just someone, someone to say you need time off. You know, you need time off K and tell my mum that he is not suitable to come to college. He will fail if he comes to college with the mindset that he is in, he will fail, and that will make him go like this; we know this from previous experiences. If you want to bring or if your child wants to come, we can’t stop him, but at least then you’ve been given the option, and then if it does happen, they can blame the college all they like and say that they didn’t force me to take time out, but over time they will think well they did try to prevent this from happening. Which I will never feel”.

- **Education establishment to have discussions with the pupil and family regarding the possibility of an adapted time table and postponing exams.**

“If you’re happy to just come to college and just be here if you just want company. You can do that; you can come and stay with those in here, you can go to a lesson and take notes that you may be using next year when you go and do the exam next year, so there’s just no pressure. You are just going in to have a chat with your mates listen and being in public view. Given that option, I wish someone would have done that because for me I love going in the lesson, and I love taking the notes, but I had an exam at the end.”

- **Structured catch-up and revision plans.**

“I don’t want to put words into your mouth so please correct me if I’m wrong, but I am hearing some kind of revision plan for you G.yeah P.and a kind of catch up plan that you would have liked in place to help G. yeah.”

- **School to make arrangements for the pupil access to specialist support**

“ So you know if somebody like me, a 17-year-old or 16 or whatever age has lost a parent from suicide, that if school don’t have the facilities to know how to, then you’ve got to find someone who does. There are places that understand suicide that understand it’s a chemical imbalance.”

- **To have access to the support of people who have experienced suicide bereavement.**

“There are people like me that could come up and talk to these students and say look I’ve been through what you’ve been through talk, talk to me or do whatever you want, people express themselves in different ways.”

- **Teachers need some sensitivity training on topics like suicide**

“I think teachers need some sort of sensitivity training. Something on topics like suicide.”

- **Posters in schools to increase awareness of bereavement by Suicide**

“As all these posters in schools for arranged marriages and terrorism, and you know stuff like that but where is it for bereavement, of any description to be honest, but suicides?”

- **Schools need to be aware of the negative impact of complicated grief surrounding mental health.**

“Thing is that schools just need to be aware that this can lead to depression and have mental illnesses. Kids can fall into depression and have mental illnesses.”

- **Awareness around mental health and suicide and that it can happen to anyone.**

“People don’t want to say hello to you in case they say the wrong thing. So, it just needs a little a little bit more prepared for that because it can happen to anyone. Parents or pupils as well as what happened in my case. Anyone, anyone else, just because you have got a mortgage and house and a car it doesn’t mean that they can’t have anything can’t be like that.”

- **Specific school counsellors, not pastoral advisers.**

“I think there needs to be multiple councillors, specific school counsellors not pastoral advisers.”

- **Talking about the subject openly.**

“I don’t want you to talk to me mum when I’m upset; I want you to talk to me when I am upset because I can’t I can’t deal with it.”

*“ would it have helped if they would have approached you and talked about it G.yeah
P.and actually have been open with you about your mum and what happened ?
and I know that you’re nodding, now but I’m just saying that for the tape G.yeah
P.now that’s fine, so you think that would have helped G. yeah”*

- **Approaching the pupil and talk about it asking if they need help and support rather than leaving the pupil to approach the teachers.**

“So what would you like, If you could tell them what would you would like. You wanted the one-to-one revision. Would you have liked them to approach you and talk to you G.yeah instead of me going up to them.”

- **Teachers being more helpful.**

“I don’t know; I think teachers being more like helpful, in a way because my teacher was like yeah, he just like told me to revise he didn’t like. Well they do revision classes, but I didn’t go to many of them.”

- **Offer one to one support with school work.**

“But I feel like if they had done a one to one thing with me because I kind of missed; my teacher knew that I had missed a lot.”

- **Understanding the impact that it has on functioning in everyday life and learning in school.**

“Because I can just about, just about wake up.”

One issue prevalent with all survivors was the need to talk about the suicide and the lack of opportunities, which support Campbell (1997). Campbell (1997) highlighted that adult childhood survivors of suicide reflected upon and agreed that they would have benefited from opportunities to talk about the suicide that they experienced as children while still in childhood. Research suggests that support groups benefit children in the aftermath of parental suicide by reducing the risk of withdrawal and isolation while grieving (Hung & Rabin 2009; Mitchell et al., 2007). However, most bereavement groups for children are not specific to cause of death, despite evidence that highlights the unique aspect of suicide bereavement (Hung & Rabin; 2009). The

majority of suicide survivor groups available are intended for adults (Hung & Rabin 2009) resulting in a gap of support for young survivors and following question 3 responses from participants of this study, highlighting a need to talk and be understood by someone who has experienced suicide. Therefore, I argue that this should be considered for the development of postvention support groups for CYP, to help ensure conditions necessary to facilitate effective, sensitively attuned, person-centred support .

4.6 Limitations

There are limitations to this study that should be considered. The research method is interpretive, and so the reader may generate different meanings from the data. The reader has been provided with information relating to my positionality, the research process and the steps of my analysis. Additionally, the appendix contains the transcripts, coding and the final code maps, to help the reader understand the decisions and processes followed.

Secondly, the research was restricted somewhat by accessing a limited number of participants. I relied on charities to support my research and help recruit participants. Out of the five charities, I approached (Child Bereaved UK, Samaritans, Winston's wishes, Cruse and SOBS) only one bereavement charity was willing to support me in my research. I then relied on the support workers from this charity to use their judgment in approaching participants. The charity has centres across the UK. However, I was constrained somewhat due to logistical difficulties and time pressures surrounding the doctoral programme. Two participants were from the North of England and one from the south. In addition, two participants were male who lost their fathers to suicide, and the remaining female participant had lost her mother. Thus, there are limitations surrounding the relationship between the survivor and deceased with all participants losing the same-sex parent. Further, each participant's experience is unique and intertwined with individual experience within many distributed systems, and to generalise any findings from such research is impossible. However, the findings may apply to many survivors of suicide and those who support these individuals.

Sheffield University's ethical committee also acted as a gatekeeper for the researcher's access to participants, and as a result, I was only permitted to enrol participants aged 16- 25. This despite charity support workers informing me they had younger survivors who would have liked to have been involved and to contribute their story to the research.

Ethical barriers and access to participants is highlighted as problematic for suicide research despite literature highlighting the majority of survivors by suicide being interested in participating in postvention studies(early career and suicide conference, 2018). Further, Andriessen et al (2018) suggests that those that have participated in research usually found it to be a positive experience Thus overprotection may deny many children and young people an opportunity to exercise choice in the research, and as such I feel the aim to provide a platform for children and young survivors of suicide has been restricted . Therefore, I feel strongly that the majority of child young survivors continue to remain unheard and as a result, I fear that postvention will not be as effective as it could be.

Another limitation of this study is researcher bias. I acknowledge that by using a social constructionist approach, this research has been generated through interactions and interpretations between researcher and participants. However, as a child survivor of suicide myself, who had a negative experience in education following my father's death, I acknowledge that this will have undoubtedly impacted upon the research outcomes. I have accounted for this somewhat by being open and honest throughout. I have used a reflection, and reflexive diary had regular supervision sessions throughout all stages of the research discussing my potential bias and to gain 'an outsiders view' regarding my interpretations. I have tried to use minimal interpretations that are grounded within the CYP own words, hence the considerable volume of quotes used in the previous chapter. The reader will have scope for their own interpretations of the stories. However, subjectivity and researcher bias is still a limitation to this project.

I tried to follow the lead of the CYP as much as possible due to the concept of the narrative being reliant upon the participant being able to express themselves. However, I found that I had to talk and ask more questions during G's interview than for K and J's interviews, and I was mindful that I may have led and influenced the direction of the narrative. I was conscious of this throughout and tried to ensure this was not the case by repeating back what I had heard, checking with the participants. I am also aware that being interviewed and recorded is not a natural phenomenon and regardless of any attempts to create a relaxed and informal atmosphere being asked questions (especially within such a complex, and sensitive subject) will have impacted upon participants, and their contributions may not be a full reflection of their experience. Further, Nunkoosing (2005) points out that what participants think is not always what participants verbalise and that thought may contradict the shared spoken version. Therefore, what was said may not have been an accurate account of their experiences.

4.7 Further reflections

I have tried to be reflexive in my thinking by considering my influence as a researcher throughout the whole research process. I have had regular discussions with my research supervisor surrounding this and kept a research diary throughout. I will now follow with some of my reflections in an attempt to facilitate transparency and thus, increase the trustworthiness of the research.

From the beginning, this research has encountered barriers which have caused frustrations. Seeking out participants for this project was the first challenge. Many charities were not able to help with the process due to other demands. I started to think that I might have to rethink my whole approach to the research. Luckily, one bereaved charity replied to say they were happy to help find participants and I felt honoured to have such a well-established charity backing my research. I did have concerns regarding logistics, because the nearest Child Bereavement centre to me was 1.5 hours away, with centres also placed at the other side of the country.

However, at this point, I was happy to travel to my participants. Luckily, two participants were 1.5 hours away and one in the South of England.

The other major hurdle regarding participants was getting the project through the university's ethics committee. I knew that this would be a challenge due to the sensitive nature of the topic and the age of participants. This is, in my opinion, pioneering research, as there is no related research that I know of; which meant no other researcher had either tried or succeeded in passing a research ethics committee. I contacted professor O'Connor at the Glasgow suicide research centre and attended the suicide conference in Glasgow, networking with other researchers in this area. Difficulties surrounding ethics was an area discussed at the conference, and Professor O'Connor confirmed that ethics would be a challenge.

Further, when sharing my research idea to tutors at university, it was suggested that I use participants of 18 +, or rather than interviewing access suicide bereavement chat rooms for my data to avoid a problematic ethical application. This was disheartening because my research questions could not have been adequately addressed, the research would need to be adapted, and the voices would continue to be unheard. I discussed this with my research supervisor and decided to persevere with my ethics application for access to young participants. However, due to time limitations, I decided on participants of 16+. This then left a moral dilemma. As I was aware that I was not giving the opportunity to all and in effect continuing to silence under 16's. As mentioned previously, support workers in the charity expressed interest from younger participants who wanted to become involved in this research but were not 16 at the time. This created a feeling of unease within me; mainly because I was 14 when my father died, and I know at 15 I would have become upset if someone had have decided I was not able to express my views.

Due to my personal experience with suicide, I was aware that I might find the research challenging not only academically, but also emotionally. I was aware the university staff and the ethics committee had their concerns surrounding this.

However, after working on cases as a trainee EP with children and young people bereaved by suicide, the complexities surrounding this and the complications that arose my view was that there is still a lack of understanding from educational professionals, and I knew that this was an area I was passionate about . I understood the concerns that people may have had, but 30 years after my own personal experience I felt emotionally strong enough to carry out this project. I also joined the International Association for Suicide Prevention (IASP) in addition to the Early Career Group (ECG) for support. I have also recently been accepted to join the international special interest group for Suicide Bereavement and Postvention had the support from the charity and my supervisor. Nevertheless, I knew it would be hard to hear the stories of my participants.

Considering my own experience with suicide a dilemma was when to disclose this to my participants. As discussed in my methodology K was my pilot study, and after much thought, I decided to disclose my positionality after the interview. I felt like I was deceiving K to some extent and was uncomfortable with my choice once the interview was started. However, I told K, explained my reasons for not telling him earlier and then felt that I had made the correct choice. I asked K how it made him feel, if he felt like I had deceived him and if he thought I should tell the other participants at the start or the end. K reassured me that the end was fine with him as long as I did tell them. Although I felt better with my choice on when to disclose with the second two interviews, I did still feel slightly uncomfortable. It felt like I was being like some kind of 'hero' (this is where you are, and here, I am; I have achieved, and you can also get here at some point). I did not want to be seen as patronising or as inspirational; this could then be seen as part of some kind of therapeutic approach, and my research was by no means this. I still feel somewhat uncomfortable with my part in this research. I feel like I have opened this up for participants and then had to pursue my research without their further involvement. One participant is keen to become further involved and would like to take part in conferences and presentations to help develop postvention.

During the interviews themselves, I felt I became detached somewhat. I was focused

on making sure the participants felt comfortable and at ease and able to get their story heard. I was focused on my narrative technique and making sure that I had heard and interpreted correctly. In concentrating on this, I think that my emotions were suppressed somewhat. It was during the transcribing and coding that the stories resonated within me. Because of this, I was aware that my own negative experience might have become a template for my analysis and coding. The codes generated were mainly negative, and I felt I needed to discuss and check these with my supervisor. I did not want to be projecting my experiences, both as a survivor and as an EP on to the participant's voice. My supervisor read the transcripts, checked and discussed the analysis with me, and this reassured me in my choices.

During the results section, it was challenging to select which quotes to include. I wanted to keep as much of their story intact as I could but was also limited to word count and being an academic paper; I had to carry out some interpretation and incorporate literature. However, when reading and adding the quotes, I found I was hearing the actual voices of the participants talking which then made it difficult not to include. I sent the draft to my tutor for her to advise me if I had included too many quotes and which I could cut out.

This research feels unfinished. I am aware that it is not exhaustive, instead, metaphorically saying it has only scratched the surface as this area needs much more in-depth exploration. This research then has only ignited my passion further, and I now want to carry on work in this area. However, I know that as a practising EP I will not have the same time to dedicate to research as a university student and so I am now wondering how I can build upon this. I also wonder if that is what my participants are thinking. I am carrying out an oral presentation of my research to the 4th international mid and early suicide research conference in Glasgow in June 2019. In addition, I am submitting my abstract to present a poster at the 8th international suicide conference in Manchester. I am to continue some work with the University of Sheffield surrounding the CYP voice, and we have interest from publishers surrounding a book dedicated to the voice of the child. Also, the bereavement charity who supported my project wants to use my research as part of their training on the

subject in schools. I also hope to work in Rochdale (where I am a practising EP) training schools, offering assemblies and setting up support groups. This, however, still leaves me thinking about my participants, what they have gained from this, what they are doing and how they are getting on. I have sent follow up emails, but this does not seem enough.

4.8 Concluding remarks and recommendations for further research

This research supports and adds to the previous literature surrounding suicide postvention. However, this study was a small-scale study and due to ethical restrictions were limited to the age group of 16 plus. More research is needed to build upon this using further qualitative studies with a more diverse sample group. I suggest that this should then be added to using quantitative research to gather a more comprehensive viewpoint and that measurements for the effectiveness of recommended postvention (using a systemic framework approach) for young survivors should be added to the literature.

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Appendix 1

Doctorate Dear Paula

PROJECT TITLE: School

After Suicide

APPLICATION: Reference

Number 018862

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 29/06/2018 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 018862 (dated 19/06/2018).
- Participant information sheet 1046506 version 1 (19/06/2018).
- Participant information sheet 1042431 version 4 (19/06/2018).
- Participant consent form 1042434 version 2 (01/05/2018).
- Participant consent form 1042433 version 2 (01/05/2018).

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Yours sincerely

David Hyatt Ethics Administrator School of Education

Appendix 2

Participant Information Sheet

School after Suicide

You are being invited to take part in this research project, but before you decide to do so, it is important you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this.

1. What is the project's purpose?

There is a lot of research surrounding the topic of suicide. However, there is very little exploring the impact it has upon children/young people while still in education. The overall aim of this project is to give children/young people a platform for their voice to be heard regarding their own experience. The research specifically aims to explore what it's like for a child/young person in education following suicide. It seeks to highlight what children/young people themselves found helpful or unhelpful by means of support offered. The intention is to explore useful ways of how educational professionals may respond to and support children/young people.

2. Why have I been chosen?

You have been identified by child bereavement UK as someone who has had the support of the charity while grieving; the charity feel that you may be willing to contribute to this research. By agreeing to the research, you will meet with the researcher individually, but you will be 1 of a possible 4 participants to contribute to this research overall.

3. Do I have to take part?

Taking part in this research is entirely voluntary and it is up to you to decide whether to take part or not. If you do decide to take part, you will be able to keep a copy of this information sheet and you should indicate your agreement on the consent form. You will be asked for consent throughout the research and you can withdraw at any time, you do not have to give a reason.

4. What do I have to do?

Shortly after receiving this form I will be in contact with you so that you can ask any questions you may have. If you are happy we will arrange a date and time for our first meeting. The date and time will be one that is also convenient for a member of the child bereavement team to attend, if you require support. During the first session you will be asked to draw a series of pictures and we will then

have brief discussions surrounding the drawings. The first session will be used as a 'getting to know you session' and will not explore in depth the subject of suicide or your experience. This allows you the time to reflect upon your feelings and emotions; if after this you do not feel comfortable discussing things in more depth you can withdraw after stage 1.

A few days after the first meeting I will be in touch to ask if you want to continue with the research project and take part in an interview. If you decide you want to carry on to stage 2 of the research you will be given a further consent sheet. Part 2 will consist of a 30-minute informal interview/chat about your experience of suicide. You will not have to answer anything or talk about anything you don't feel comfortable talking about. During both sessions you will be given a set of traffic light cards that you can use to indicate how you feel throughout the process. A green card indicating you feel OK, Orange you don't want to answer that question, and red you want to stop the process either for a break or to withdraw. Again, a child bereavement support worker will be available to support you if you wish .

5.What are the possible benefits of taking part?

Whilst there are no immediate benefits, it is hoped that this work will have a beneficial impact on how educational professionals can support children and young people in the future .

What are the possible disadvantages and risks of taking part?

Talking about your experience may be emotional and at times it may become distressing to re visit. You will have the extra support from the charity child bereavement if required. You need to decide if participation in this research is in your best interests. If you do decide to participate, but at any time throughout the research change your mind, the research can be stopped, and you can withdraw totally if you require.

6.What happens if the research stops earlier than expected? Should the research stop earlier than planned and you are affected in any way we will tell you and explain why.

7.What if something goes wrong?

If you have any complaints about the project in the first instance you can contact Paula Baxter or Penny Fogg whose contact details can be found at the bottom of this form . If you feel your complaint has not been handled to your satisfaction you can contact the University of Sheffield's registrar and secretary to take your complaint further

8.Will my taking part in this project be kept confidential?

All the information that we collect about you during the research will be kept strictly confidential You will not be able to be identified or identifiable in any

reports or publications.

9. Will I be recorded and how will the recorded media be used?

The first session will consist of drawings and notes and will be kept strictly confidential. In the second session the interview will be audio recorded and will be stored on a secure pen stick. The interview will then be transcribed for analysis and the recording will then be deleted. All recordings and transcripts will be kept strictly confidential

10. What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

The aim of this project is to explore the experience of education after a loss from suicide. The project seeks to highlight themes that may help shape how educational professionals respond to children and young people bereaved by suicide. You will be asked to discuss how you thought the suicide impacted upon your education. I will then collaborate all the interviews and look for common themes emerging throughout.

11. What will happen to the results of the research project?

Your interview will be used alongside other interviews and emerging common themes will be generated. The themes will be discussed in the write up and quotes taken directly from your interview may be used. However, you will in no way be identified by these. Results of the research may be published in academic journals but will not be identified in any report or publication.

12. Who is organising and funding the research?

The School of Education, University of Sheffield

13. Who has ethically reviewed the project?

This project has been ethically approved by The University of Sheffield's Research Ethics Committee

Contacts for further information

Paula Baxter, School of Education, University of Sheffield, UK. Tel: +44 (0)114 222 6347, email: p.baxter2@sheffield.ac.uk

Under the supervision of Dr Penny Fogg, School of Education, University of Sheffield, UK. Tel: +44 (0)114 222 6347, email: p.fogg@sheffield.ac.uk

Appendix 3

I confirm that (please tick box as appropriate):

1.	I have read and understood the information about the project, as provided in the Information Sheet dated _____.	<input type="checkbox"/>
2.	I have been given the opportunity to ask questions about the project and my participation.	<input type="checkbox"/>
3.	I voluntarily agree to participate in the project.	<input type="checkbox"/>
4.	I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.	<input type="checkbox"/>
5.	The procedures regarding confidentiality have been clearly explained (e.g. use of names, pseudonyms, anonymisation of data, etc.) to me.	<input type="checkbox"/>
6.	If applicable, separate terms of consent for interviews, have been explained and provided to me.	<input type="checkbox"/>
7.	The use of the data in research, publications, sharing and archiving has been explained to me.	<input type="checkbox"/>
8.	I understand what I have said or written as part of this study will be used in reports and may be published .	<input type="checkbox"/>
		<input type="checkbox"/>
9.	I, along with the Researcher, agree to sign and date this informed consent form.	<input type="checkbox"/>

Participant: (plus parental signature for under 18s)

Name of Participant Signature Date

Researcher:

Name of Researcher Signature Date

Contacts for further information

**Paula Baxter, School of Education, University of Sheffield, UK. Tel: +44 (0)114 222 6347, email: p.baxter2@sheffield.ac.uk
Under the supervision of Dr Penny Fogg , School of Education , University of Sheffield, UK. Tel: +44 (0)114 222 6347, email: p.fogg@sheffield.ac.uk**

Appendix 4

School after Suicide

The interview will take approximately 30 minutes. We don't anticipate that there are any risks associated with your participation, but you have the right to stop the interview or withdraw from the research at any time. This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation. Would you therefore read the accompanying **information sheet** and then sign this form to certify that you approve the following:

- The interview will be recorded, and a transcript will be produced
- The transcript of the interview will be analysed by Paula Baxter as a research investigator
- Access to the interview transcript will be limited to Paula Baxter and her supervisor Dr P Fogg any summary interview content, or direct quotations from the interview, that are made available through academic publication or other academic outlets will be anonymized so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed
- The actual recording will be destroyed

By signing this form, I agree that;

1. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time;
2. The transcribed interview or extracts from it may be used as described above;
3. I have read the Information sheet;
4. I don't expect to receive any benefit or payment for my participation;
5. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality;
6. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

Participants Signature (Plus parental signature for under 18s)

Date

Researchers Signature

Date

Contacts for further information Paula Baxter, School of Education, University of Sheffield, UK. Tel: +44 (0)114 222 6347, email: p.baxter2@sheffield.ac.uk Under the supervision of Dr Penny Fogg , School of Education , University of Sheffield, UK. Tel: +44 (0)114 222 6347, email: p.fogg@sheffield.ac.u

Please note that the full interview appendix have been removed from this copy

Appendix 8 K Theme maps

Theme 1 Complex ecological systems

Sub themes

Dads difficulties

Relationships

Own needs/difficulties

Codes

Physical health
 Depression
 Alcohol abuse
 Inconsistent treatment
 Medication
 Negativity
 Helplessness
 Not talked about
 Became normality
 Unpredictable aggression
 dad's own needs/projection
 Irrational behaviour

Adopted
 Difficult childhood
 Identity
 Lack of love
 Failing at school
 bullied
 Survival
 Separation
 Betrayal loss
 Rejection
 Change of life plan
 Lack of job satisfaction

Instability
 Role reversal
 Responsibilities
 Aggression and violence
 Separation
 Broken family

Unavailability of dad
 Inconsistent
 Parents volatile relationship
 Different relationship with both parents
 Tensions
 Dads guilt and needs
 Inconsistent
 Separation
 Controlling
 Protective
 Stay out of his way
 Mums needs

Learning difficulties
 Teaching assistant support
 School life
 College
 Importance of education
 Focusing on school
 Education attainment
 Future
 Goals

Bullied
 depressions
 Need for space
 identity/ not belonging
 Asparagus
 Had to grow up
 Missed childhood
 Need for space
 Holding in own emotions
 Impact on self esteem

Discovery Lines 745-995

Theme 2
Overwhelm

Sub themes

Range of thoughts and feelings

The scene and need for information

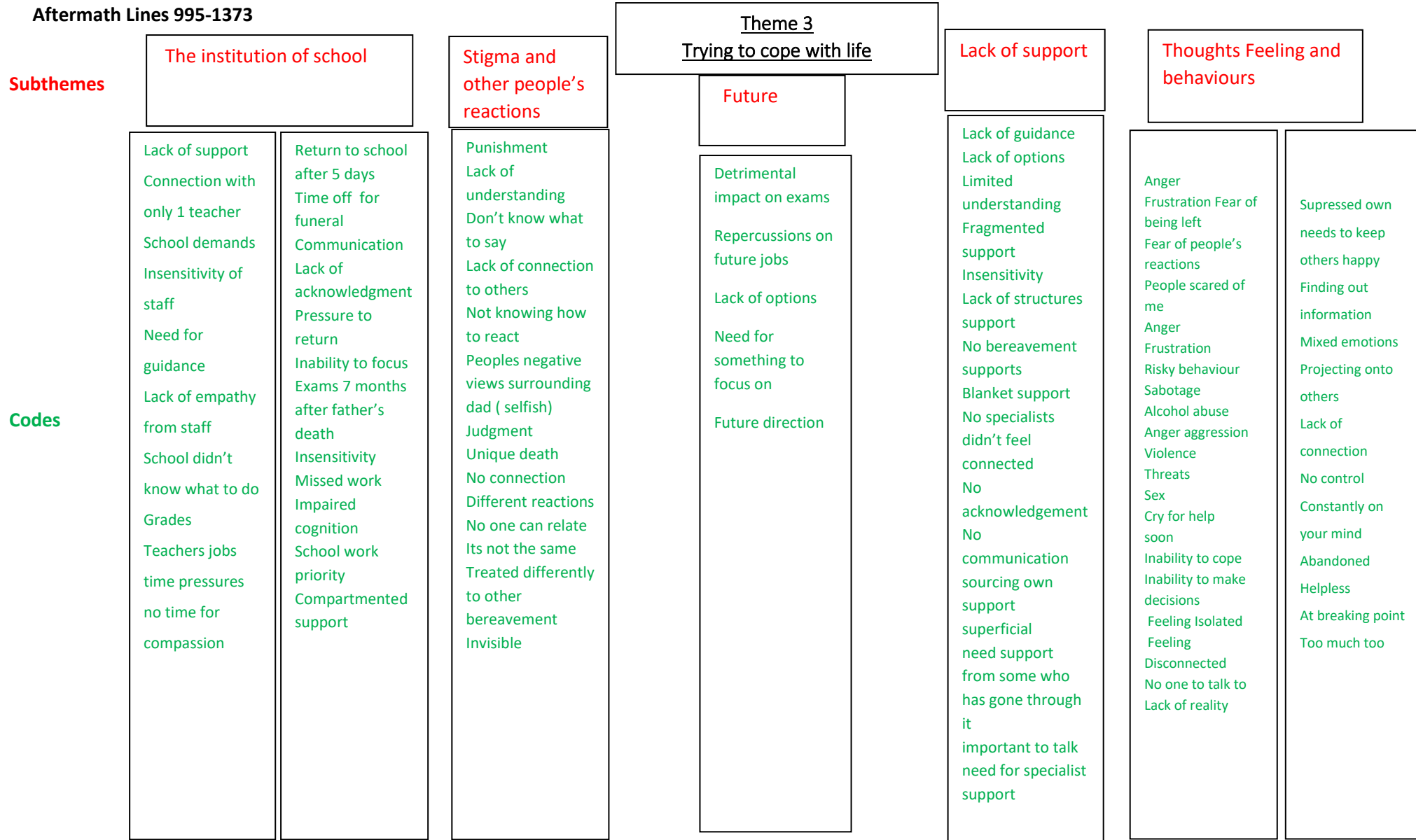
Guilt and Responsibilities

Codes

Mixed emotions
Guilt
Helpless
Anger
Upset
Pining for dad
Emotional distress
Abandonment
Shock
Reality
Emotional release
Disbelief
Violence
Aggression
Escape

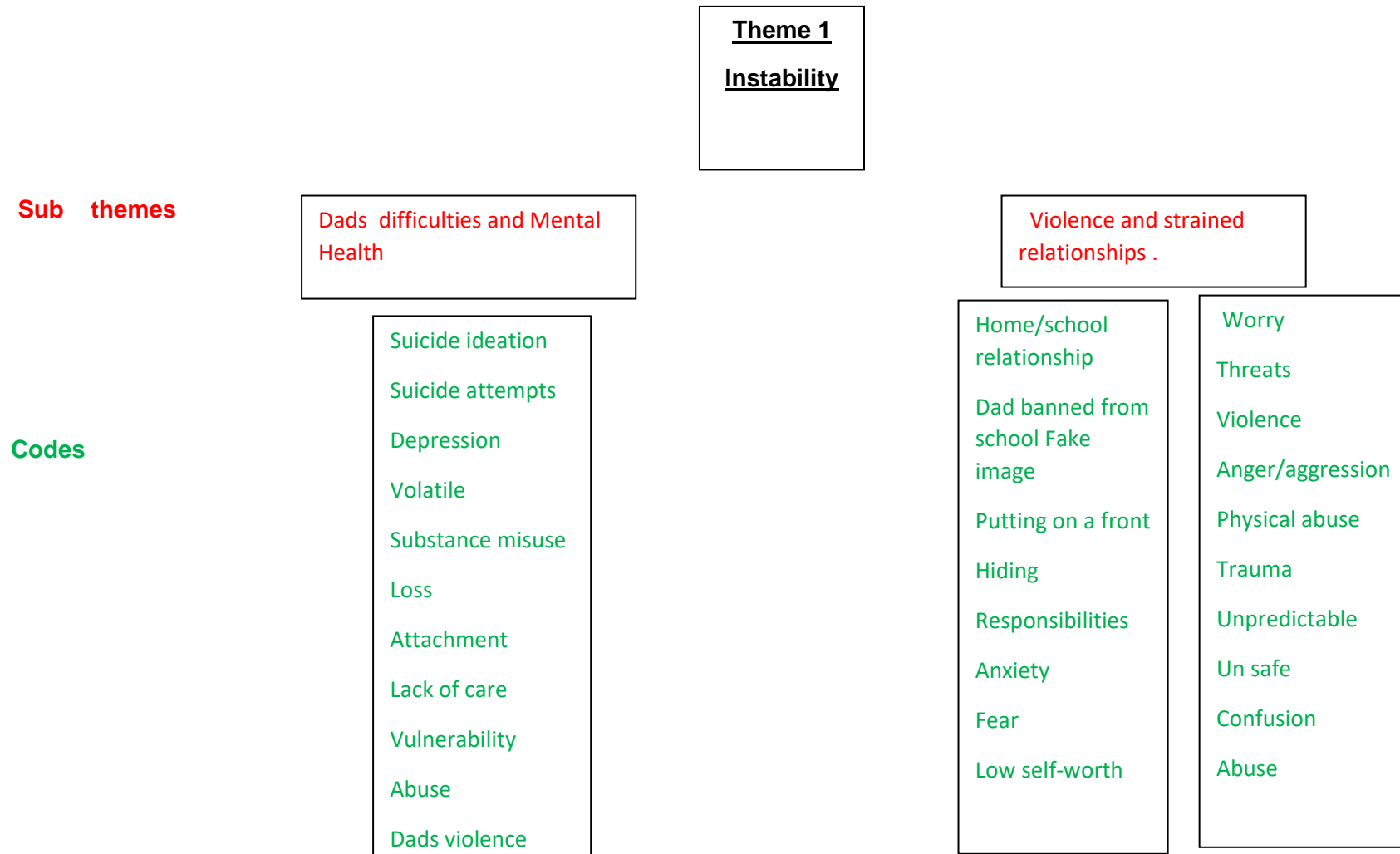
Emergency services
Nightmarish
Crime
search for body
Traces of dad
needed to go to see
Dignity
The body
A need to know details
Questions
Unknown
Piecing information together
Needed to see the scene
Images of dad
Imagining death

Supressing own emotions
Inability to show emotions to others
Protecting others
Duty to do the right thing
Being strong
Responsibilities to others
Missed signs
Unusual behaviour
Feeling of unease
Aware something was wrong
Lack of response
Self-blame
Remembering last words



Life before lines 27-248

Appendix 9 J Theme maps



Discovery lines 249 – 355



Aftermath Lines 356 - 803

Subthemes

School practices and no time to grieve

Codes

Return to school
Time off for funeral
Relationships
Communication
Lack of support
School demands
Pressures
Insensitivity of staff
Need for guidance
Lack of empathy from staff
School didn't know what to do
Grades
Needed
Something to focus on

Didn't have time to grieve
Responsibilities
Returning to school
Home/school communication
Differences in Teaching staff
One supportive member of staff
Lack of empathy
Training and awareness
School pressures
Placing a time frame on grief

Theme 3
New way of being

mental health difficulties

Needed to escape
Shut down
Depression
professional involvement
Suicide ideation
Concerns from others
Suicide concerns
Impact on Life trajectory
Couldn't cope
withdrew
Isolation
Afraid that people were talking about him

Hidden and isolated

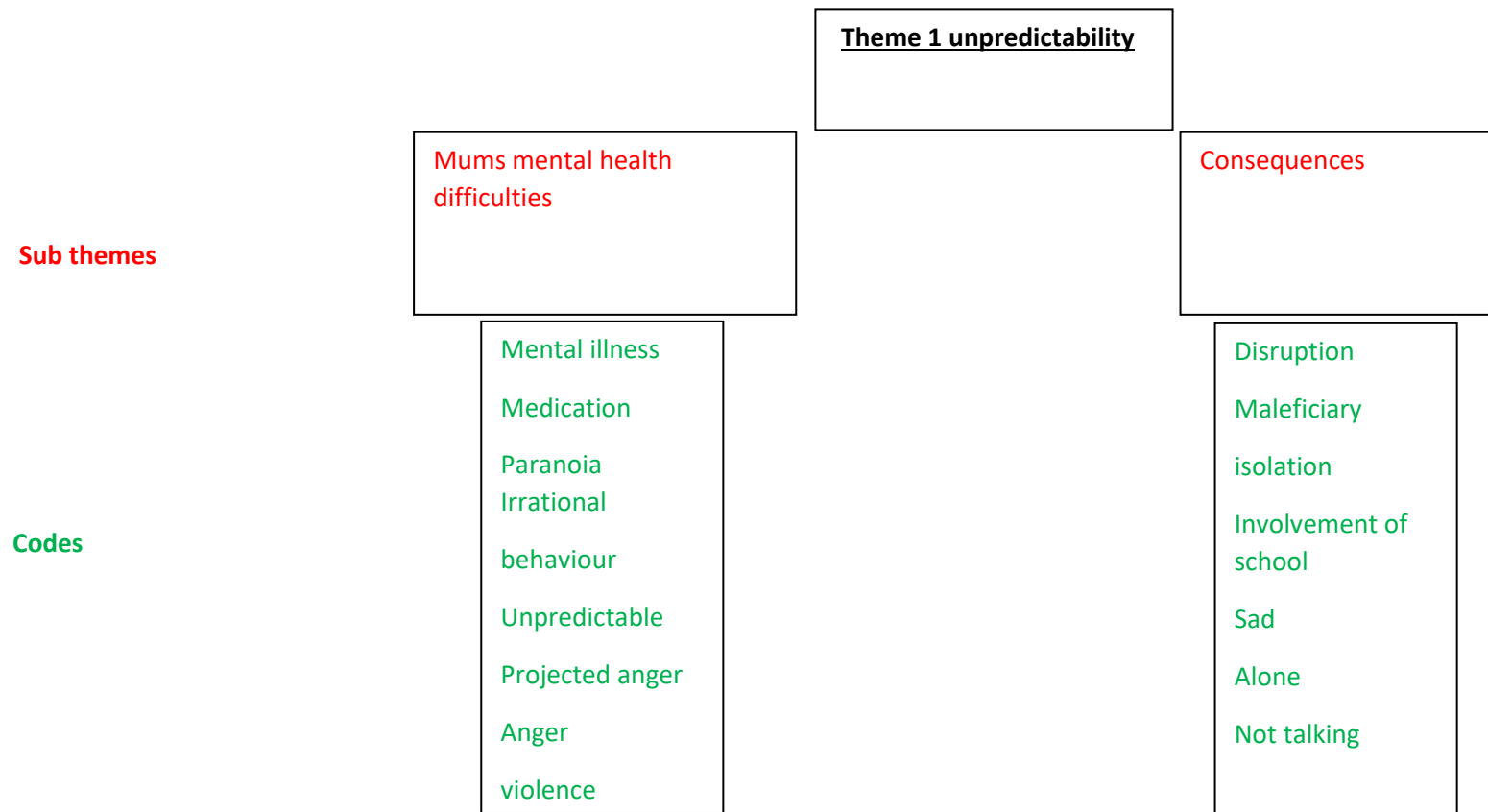
Disappeared
Not talking
Hidden away
Own space
Abandoned
Left alone
Avoidance
Forgotten
Isolation
invisible
Pre emptying other people's intentions
People's Emotions
People's Reactions
Avoidance
Fear of what to say
Not discussed
Not knowing how to react
Within person Judgment
Afraid that people were talking about him
Isolation
Not fitting in

Inconsistent support

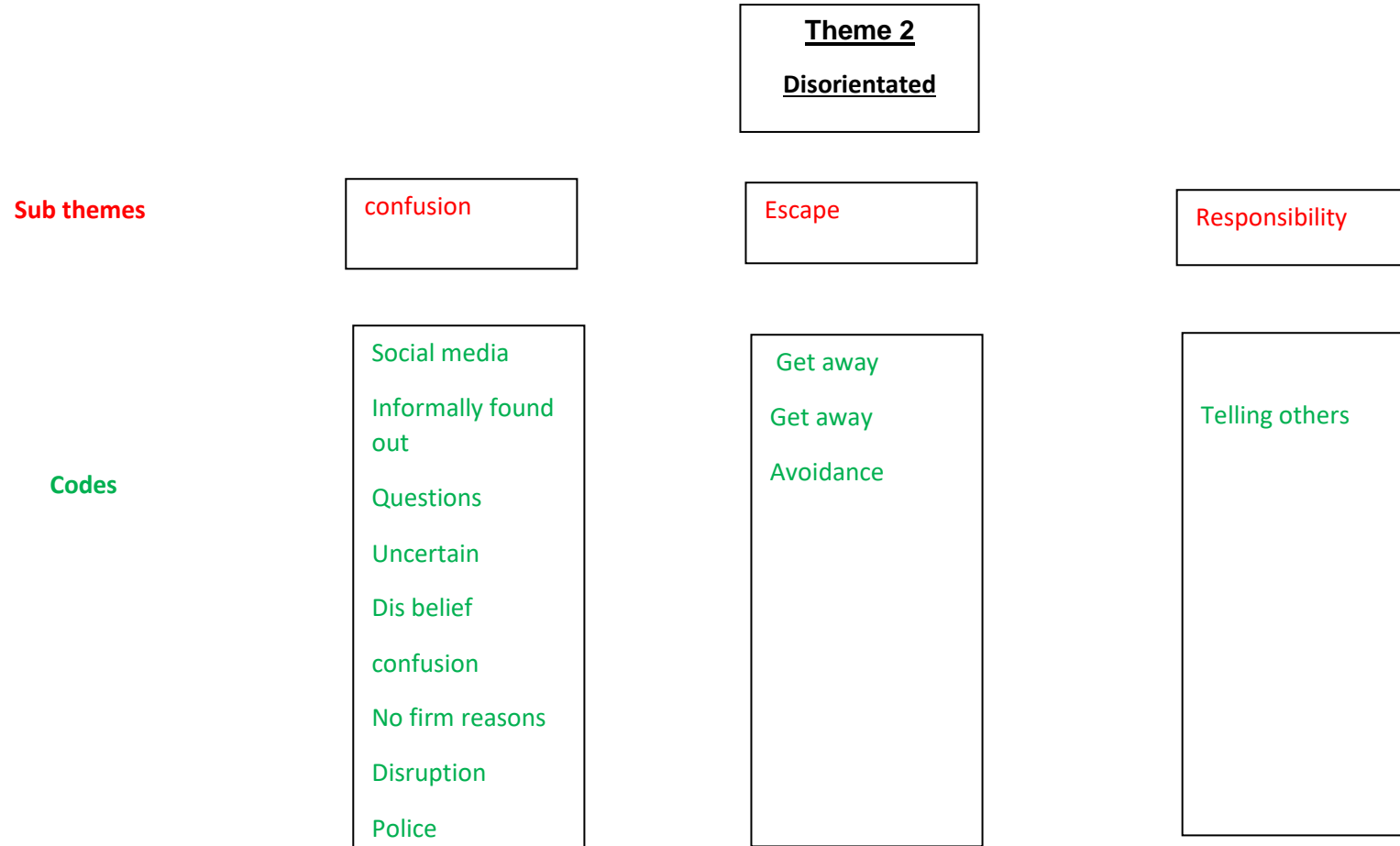
Individual support needed
Appreciation of support
Cause of death impacted response
Lack of sympathy
Not spoken about lack of acknowledgment
Organised own support
Lack of information sharing
Minimal access to services
Within person
Being punished
Training needed
Awareness needed
Direct support in schools needed
Teacher support
Girlfriend
Counselling
Winston's wishes
People had other commitment
Within person problem
no one to connects with

Life before lines 21--132

Appendix 10 K Theme maps



Discovery Lines 132-171



Theme 3

Aftermath Lines 172-243

Navigate life alone

Sub themes

Disruption and relationships

Impact on school

Avoidance and Isolation

Lack of support

Codes

Rallied round
Support
Anger
Unpredictable
Inconsistent
Abandon
Lack of parental support
Other family commitments
Poor relationships
Moved out
No power
Uncertain living arrangements
Disruption
Lack of choice
Abandoned

Time off
Missed revision
School priorities
Normality
Missed work
Exclusion
Lack of guidance/
support from staff
Left alone
In sensitive
Effect on grades

Silence
Avoidance
Not talking
Not wanting them to know
No mention
They didn't want to talk about it
Did not tell anyone
Annoyed with her telling them
Not talking
No acknowledgment
Lack of support
Exclusion
Silence
Not approaching me
Left
Sourcing own support

Initial acknowledgment by friends and head
Lack of guidance
Delay
No acknowledgment
Wrong focus
Broken trust
Seeking support information sharing